

Assessing Denial Among Sex Offenders

by

Sandy Jung
B.Sc., University of British Columbia, 1993
M.A., Lakehead University, 1996

A Dissertation Submitted in Partial Fulfillment of the
Requirements for the Degree of

DOCTOR OF PHILOSOPHY

in the Department of Psychology

© Sandy Jung, 2004
University of Victoria

All rights reserved. This dissertation may not be reproduced in whole or in part, by photocopying or other means, without the permission of the author.

Supervisors: Dr. Janet B. Bavelas and Dr. D. Richard Laws

ABSTRACT

The primary focus of this dissertation was the development and evaluation of a clinically-relevant measure of sex offender denial called the Comprehensive Inventory of Denial—Sex Offender version (CID-SO). In recent decades, the sex offender literature has evolved from a dichotomous view of sex offender denial (i.e., as present or absent) to a multifaceted view. Furthermore, virtually all of the extant measures of denial use self-report questionnaires, which assess denial as an inferred attitude rather than focusing on it as overt communication and behaviour. The CID-SO was designed to apply to all types of convicted sex offenders, to measure both behavioural and communicative aspects of denial, to assess multiple facets of denial, and to utilize the judgments of experienced clinicians, including an interview and a review of collateral information about the offense(s). This dissertation evaluated the reliability of the CID-SO and the validity of its uses and interpretations, using the new perspective outlined in the most recent edition of the Standards for Educational and Psychological Testing (AERA, APA, & NCME, 1999) rather than the older, traditional approach to validation. This contemporary approach puts test uses in the forefront of validation and puts validity categories (e.g., content validity) in the background. Four groups of uses of the CID-SO were evaluated, including methodological, conceptual, practical, and hypothesis-testing uses. The findings demonstrated that the CID-SO has good inter-rater reliability and validity for the methodological, conceptual, and practical uses. Limitations of this research, clinical implications, and future directions are discussed.

TABLE OF CONTENTS

TITLE PAGE	i
ABSTRACT	ii
TABLE OF CONTENTS	iv
LIST OF TABLES	viii
LIST OF FIGURES	x
ACKNOWLEDGMENTS	xi
DEDICATION	xii
CHAPTER ONE: INTRODUCTION	1
The Need for Valid Measures of Denial	2
Conceptualization and Assessment of Denial	4
Criteria for a Good Denial Measure	8
Summary	10
CHAPTER TWO: THEORIES OF SEX OFFENDER DENIAL	12
Cognitive Capacity	12
Cognitive Deconstruction	13
Schema Theory	15
Summary	18
CHAPTER THREE: A NEW MEASURE OF DENIAL	19
Criteria for a Better Measure Revisited	19
Comprehensive Inventory of Denial – Sex Offender Version	23
Summary	25
CHAPTER FOUR: DESIGN FOR EVALUATING RELIABILITY AND VALIDITY	27
Reliability	27
Validity	28
The Traditional Approach to Establishing Validity	29
A New Perspective	31
Validating the Uses of the CID-SO	35
Conceptual Framework	35
Proposed Uses	38
Evidence Required	40
Summary	46

CHAPTER FIVE: METHOD	47
Participants	47
Materials	48
Comprehensive Inventory of Denial – Sex Offender Version	48
Shipley Institute of Living Scale	48
Personality Variables	50
Balanced Inventory of Desirable Responding	50
Self-Monitoring Scale	52
Rosenberg Self-Esteem Scale	53
Deviant Attitudes	54
Measures of Attitudes about Child-Adult Relations	54
Revised Cognition Scale	54
MOLEST Scale	56
Measures of Attitudes Towards Women	57
RAPE Scale	57
Burt Attitude Scales	58
Measure of Attitudes about Sexual Fantasies	59
Procedure	60
CHAPTER SIX: EVALUATION OF RELIABILITY AND THE VALIDITY FOR METHODODOLOGICAL, CONCEPTUAL, AND PRACTICAL USES	62
Reliability	62
Validity	64
Validity 1: Methodological Use of the CID-SO	64
Use of Several Sources of Data (1a)	65
Expert Clinical Judgment (1b)	65
Reliable Assessment (1c)	66
Validity 2: Conceptual Use of the CID-SO	66
Specific Use with Sex Offenders and All Kinds of Sex Offenders (2a)	66
Test Content	66
Broad Sample	67
Differences Between Categories of Offenders	68
Summary	70

Dynamic Characteristic (2b)	70
Test Content	70
Difference Between Treated and Untreated Offenders	71
Summary	72
Behavioural and Communicative Assessment (2c)	72
Distinct from Other Variables (2d)	73
Patterns (2e)	75
Previous Literature	75
Test Content	76
Internal Structure	76
Summary	80
Validity 3: Use for Assessing Treatment Variables	81
Summary	81
CHAPTER SEVEN: EVALUATION OF VALIDITY: USE OF CID-SO FOR HYPOTHESIS TESTING	82
Validity 4: Use for Hypothesis Testing	82
Cognitive Capacity (H ₁)	82
Cognitive Deconstruction (H ₂)	83
Social Desirability	83
Self-Monitoring	84
Self-Esteem	85
Schema Theory: Child Molestation and Cognitive Distortions (H ₃)	86
Revised Cognition Scale	86
MOLEST Scale	86
Schema Theory: Offenders Against Adults and Cognitive Distortions (H ₄)	89
RAPE Scale	89
Burt Attitude Scales	90
Schema Theory: Deviant Sexual Fantasies (H ₅)	92
Summary	93
CHAPTER EIGHT: DISCUSSION	96
Development and Evaluation of the CID-SO	96
Limitations	99

Clinical Implications	101
Future Directions	104
Summary	106
REFERENCES	107
APPENDIX A – Comprehensive Inventory of Denial—Sex Offender Version (CID-SO)	155
APPENDIX B – Balanced Inventory of Desirable Responding Version 6 (BIDR-6) . .	192
APPENDIX C – Self-Monitoring Scale (SMS)	196
APPENDIX D – Rosenberg Self-Esteem Scale (RSES)	198
APPENDIX E – Revised Cognition Scale (RCS)	200
APPENDIX F – MOLEST Scale	216
APPENDIX G – RAPE Scale	219
APPENDIX H – Burt Attitude Scales	222
APPENDIX I – Appropriate Sexual Fantasies Scale (ASFS)	226
APPENDIX J – Ethical Approval: University of Victoria, Human Research Ethics Committee	230
APPENDIX K – Ethical Approval: Forensic Psychiatric Services Commission, Research Application	232
APPENDIX L – Ethical Approval: Correctional Service Canada, Pacific Region . . .	246
APPENDIX M – Statement of Informed Consent (Provincial and Federal Forms). 257	
APPENDIX N – Procedural Guidelines	263
APPENDIX O – Debriefing	267
UNIVERSITY OF VICTORIA PARTIAL COPYRIGHT LICENSE	269
VITA	270

LIST OF TABLES

1.	Degrees of Denial	120
2.	The Denial and Minimization Checklist	121
3.	Denial Scales and Ratings	122
4.	Comprehensive Inventory of Denial – Sex Offender Version (CID-SO)	123
5.	The Cluster Breakdown of the CID-SO	124
6.	Proposed Uses of the CID-SO	125
7.	Proposed Uses of the CID-SO and Evidence Gathered in this Dissertation	126
8.	Demographic Information for the Total Sample	127
9.	Offense and Treatment Information for the Total Sample	128
10.	Means and Standard Deviations for CID-SO Items and Total for Each Rater	129
11.	Means and Standard Deviations for CID-SO Clusters and Total for Each Rater	130
12.	Interrater Reliability of CID-SO Items, Clusters, and Total Score with Percentage Agreement, Kappas, and Correlation Coefficients	131
13.	Internal Consistencies of the CID-SO for Different Categories of Offenders	133
14.	Means and Standard Deviations of the CID-SO for Different Categories of Offenders	134
15.	Means and Standard Deviations for the CID-SO for Treated and Untreated Offenders	135
16.	Internal Consistencies of the CID-SO for Treated and Untreated Offenders	136
17.	Correlations Between the CID-SO and Measures of Social Desirability, Intelligence, and Educational Level	137
18.	Means and Standard Deviations for Measures of Social Desirability, Intelligence, and Educational Level for the Total Sample and for Subgroups of the Sample	138
19.	Internal Consistencies and Intercorrelation Coefficients Among CID-SO Clusters and Total	139
20.	Internal Consistencies and Intercorrelation Coefficients Among CID-SO Clusters and Total with Full Deniers Removed	140
21.	Means and Standard Deviations of the CID-SO Clusters and Total Score	

	by Total Sample and by Restricted Sample (excluding full deniers)	141
22.	Correlations Among the Intellectual, Educational, Personality, and Attitudinal Measures	142
23.	Correlations Between the CID-SO and Personality Measures	144
24.	Means and Standard Deviations for the Personality Measures for the Total Sample and for Subgroups of the Sample	145
25.	Correlations Between the CID-SO and the Categories of the Revised Cognition Scale	146
26.	Means and Standard Deviations for the Revised Cognition Scale and the MOLEST Scale for the Total Sample and for Subgroups of the Sample	147
27.	Correlations Between the CID-SO and the MOLEST Scale	148
28.	Correlations Between the CID-SO and the RAPE Scale	149
29.	Means and Standard Deviations for the RAPE Scale and the Burt Attitude Scales for the Total Sample and the Subgroups of the Sample	150
30.	Correlations Between the CID-SO and the Burt Attitude Scales	151
31.	Correlations Between the CID-SO and the Four Fantasy Themes from the Appropriate Sexual Fantasies Scale	152
32.	Means and Standard Deviations for the Appropriate Sexual Fantasies Scale for the Total Sample and the Subgroups of the Sample	153

LIST OF FIGURES

1. Agreement Between Raters for Each CID-SO Item 154

ACKNOWLEDGMENTS

As always, my husband and my best friend, Kevin C. Yeasting, has been incredibly supportive and encouraging throughout this process. I am grateful that he has continuously reminded me of what is truly important in this world. Without him, I would not be who and where I am today. This is truly your dissertation as much as it is mine.

It is important for me to emphasize that this dissertation would not have been made possible without both Drs. Janet B. Bavelas and D. Richard Laws. I am privileged to have had the opportunity to work with these two amazing individuals in my lifetime.

Dr. Bavelas has not only been dedicated to this research, but she has always had more faith in me than I had myself. I want to thank her for her unwavering support throughout the creation and writing of this dissertation. I have enormously enjoyed and learned much from our many profound conversations.

Dr. Laws introduced me to an area of clinical practice in which he has always been knowledgeable and passionate. It is this passion that allowed me to find a research area that has since enamored my clinical interest. I greatly appreciate his "dead-honest" truth and his commitment to my education over these years.

I would like to give special thanks for the continued commitment of my dissertation committee and what they have contributed to this research: Dr. Robin Routledge, Dr. Bruce Monkhouse, and Professor Gerry Ferguson, and the external member, Dr. Stephen Hart. I would also like to acknowledge the prominent roles of the following individuals who assisted me in conducting this research and reviewing previous drafts: Ms. Meredith Allison, Dr. Karina Fuentes, Dr. James Geiwitz, Ms. Judith Hayes, Dr. Bruce Monkhouse, Dr. Don Salmon, Dr. Anton Schweighofer, and Dr. Heather Scott.

The positive regard and enthusiasm of so many friends and co-workers have truly made this a team effort to the end: Scott Bezeau, Meredith Allison, Karina Fuentes, Mark Slemko, John Price, Michael Gulayets, Cynthia Mills, and Teresa Lo.

This research was supported, in part, by the Sara Spencer Foundation Research Fellowship and by the Association for the Treatment of Sexual Abusers (Graduate Student Research Grant), and I gratefully acknowledge their support.

Lastly, family has always been tremendously important to me, and I give sincere thanks to my parents, Bing and Cindy Jang, for their unyielding support over the many years of my university studies. I also want to reserve heartfelt appreciation to my entire family: my siblings—Randy, Liz, Wendy, Trudy, and Dave, for always cracking me up when I needed it; Erika, Zachary, and Russell, for making this project that much more worthwhile; Brian and Angie, for being sources of constant support; and mom and dad (Lincoln and Katherine Yeasting), for your unconditional love.

I would like to give an extra-special thanks to my sister, Wendy. What you have contributed has been most invaluable to me—remember always that I will forever be in pursuit of the truth.

DEDICATION

This dissertation is dedicated to all survivors of sexual abuse.
Believe that the truth will conquer and your narrative will never be unheard.

CHAPTER ONE

INTRODUCTION

About two-thirds of sex offenders are unwilling or unable to admit that they have committed a crime, a phenomenon called denial (Haywood & Grossman, 1994; Marshall, 1994). As a result, they are often excluded from therapy, especially group therapy, and may not benefit even if they are allowed to participate. Without therapy, they are at risk of reoffending.

The study of denial among sex offenders is plagued by conceptual and definitional problems. Denial has long been considered an either-or action, but much evidence points to a complex, multifaceted act best conceptualized in terms of various forms or types with each type running on a dimension from full admission to complete denial. For instance, an offender may admit that he did sexually abuse the victim but claim that the victim was not harmed but rather benefited from the experience.

Even if the conceptual problems are clarified, the problem of assessment remains. Clinical measures of denial, such as the MMPI and numerous self-report inventories, have been used, but none has demonstrated adequate validity for use with sexual offenders. Without proper assessment, specification of treatment is unguided and research to resolve the conceptual controversies is severely hindered.

The goal of this dissertation is to develop a psychometrically sound instrument for measuring and defining denial in sexual offenders. In Chapter One, Introduction, I begin by asking why it is important to assess denial in offenders. Then we will examine current theories of offender denial, which define the conceptual issues, and current instruments for assessment. Finally, we shall summarize the criteria for a good measure of denial.

The Need for Valid Measures of Denial

The lack of appropriate and reliable measures for assessing denial among sex offenders has important implications for treatment and research.

Sex offender denial can make therapy difficult for several reasons. First, offenders who deny are often excluded from treatment. Most treatment programs require an admission of sexual offending by the offender. The reasoning behind this frequent choice is that so-called "innocent people" do not need treatment and therefore are purposely not invited to participate. The problem with this exclusion lies in the fact that a substantial number of incarcerated sexual offenders deny having committed an offense (Haywood & Grossman, 1994; Marshall, 1994), and similar numbers have been found in community-based settings (Grossman & Cavanaugh, 1990), leaving a substantial number of offenders untreated.

Second, if deniers are admitted into treatment, problems may emerge (Maletzky, 1993). One problem is that such offenders would not willingly discuss past offenses and sexually deviant interests. The importance of allowing information to emerge is presumed to be essential for successful therapy (Nelson & Jackson, 1989). For instance, the researchers of one study reported that men who minimized their child molesting did poorly in treatment because they failed to become actively engaged in the group (Gillies, Hashmall, Hilton & Webster, 1992). A second problem with including deniers is that they make therapy difficult for other members of the group and the atmosphere can become aversive and oppositional. For example, those who were partial deniers prior to entering group treatment may ally with complete deniers and further minimize their own offending. A third problem emerges from the way we often deal with these first two problems that is to simply remove them from the group. However, terminating an offender from a program because of a lack of disclosure or their

negative effect on other members would likely lead to the consequence of having yet another untreated offender (difficulties with this described earlier). Untreated offenders are often released into the community, and their probation terminates with no consequence of their lack of accountability and the unmet treatment conditions.

To summarize, denial can contribute to difficulties in the treatment of sex offenders but I would argue that denial should not be equated to untreatability. There tends to be an illusory relationship between denial and untreatability (Schlank & Shaw, 1997; Winn, 1996) and this is amply supported by several research reports that provide evidence that deniers can be treated effectively (Marshall, 1994; O'Donohue & Letourneau, 1993; Schlank & Shaw, 1997; Winn, 1996). I would further argue that understanding an offender's individual process of working through their denial is vital to make treatment successful. This begins with assessment. Barbaree (1991) pointed out that "denial and distortions compromise both the accurate assessment and the effective treatment of these offenders" (p. 30), suggesting that if denial is reliably measured, successful treatment is possible. In the broader scheme, finding a valid approach to assess denial and therefore engage deniers in treatment could have a significant impact on the community as saving even one potential victim can be of incalculable benefit.

The importance of developing a valid measure not only has implications for treatment, but also for research. Without a reliable and useful method of assessing denial, it is difficult to make generalizations regarding denial and theories that explain denial processes. For example, nonsignificant findings could reflect not only the possibility that the theory is wrong but also that the measure does not actually measure denial and is therefore poorly constructed.

To illustrate the importance of a valid measure for use in research, Hanson and Bussière (1998) reported that denial is not a good predictor of sexual recidivism (i.e.,

reoffending) based on their meta-analysis of risk factors in the literature. They assumed that their theory was supported (i.e., that denial does not predict reoffending) but failed to question the adequacy of the denial measures used in the studies that they included in meta-analysis. They were criticized for this absent detail by Lund (2000) who stated that "the underlying variability in the definition of denial and other potentially relevant factors that varied from study to study raise questions about how to interpret the overall lack of an observed effect" (p. 282, emphasis added). Hence, a carefully constructed measure is critical for testing hypotheses about any construct, including denial.

This discussion argues for a valid measure of denial because there are several implications for carrying out treatment and for conducting research. In the next section, conceptualizations of denial and extant assessment measures are explored.

Conceptualization and Assessment of Denial

For decades denial was considered a binary or categorical phenomenon in which the sex offender either is or is not in a state of denial (e.g., Baldwin & Roys, 1998; Barbaree & Marshall, 1988; Smith & Monastersky, 1986). This categorical way of defining denial often glosses over a more thorough explanation or exploration of the dimensions making up an individual's pattern of denial.

Salter (1988) described denial as "a complex, multifaceted phenomenon that must be examined carefully in order to assess offenders' progress accurately and to help them move towards full awareness of and responsibility for their behavior" (p. 110). She proposed that denial may be considered as a distribution on a spectrum rather than as categorical in nature. A sex offender's denial can slowly progress towards admission with guilt, but this may take several steps. Salter's scheme of sex offender denial is in the form of a matrix, as shown in Table 1, in that each step is characterized by the presence of certain components: admits the acts themselves, admits having fantasies

or having planned the offense, admits responsibility for the acts, admits the seriousness of the behaviour, admits feelings of guilt, and admits difficulty in changing abusive patterns. When an offender begins to accept responsibility for his offenses and the harm done to the victim(s), he proceeds to move along this continuum towards the last stage (i.e., full admission), which is characterized by the presence of all six components. Hence, denial and degrees of minimization can be quite varied and complex depending on how a sex offender presents his side of the story. If denial is a multifaceted phenomenon, it makes sense to examine the various facets of this characteristic in the sex offending population.

To date, a variety of measures have been used to assess sex offender denial. Some measures were not designed specifically either for assessing denial or for use with sex offenders only and are considered general psychological or physiological measures. Some measures were designed specifically for measuring sex offender denial and are completed either by questionnaire or through clinician's ratings.

With regard to general measures, the Minnesota Multiphasic Personality Inventory (MMPI; Lanyon & Lutz, 1984), Multiphasic Sex Inventory (MSI; Barbaree, 1991), 16 Personality Factors (16PF; Haywood, Grossman & Hardy, 1993), or the Eysenck Personality Questionnaire (EPQ; Kennedy & Grubin, 1992) have been used to determine an offender's level of denial. The difficulty with using these psychological measures is that these scales were not specifically designed for assessing levels of minimization among forensic populations. Another general measure used at times to detect denial or deception by parents accused of sexual abuse is the polygraph method (Blasingame, 1998; Lalumiere & Quinsey, 1991). Polygraphy usually involves several physiological measures, which record changes in respiration, skin conductance, blood

pressure, and pulse. Some researchers suggest that polygraphy has some utility for increasing disclosures among sex offenders (Abrams, 1989; Emerick & Dutton, 1993).

With regards to measures specific to sex offender denial, several self-rating measures have been developed. Eccles, Stringer, and Marshall (1997) created a self-report questionnaire for child molesters called the Denial and Minimization Scale (DAMS). The DAMS has established psychometric properties (e.g., high level of internal consistency and good test-retest reliability) and correlates with other measures assumed to also assess denial (e.g., Denial and Minimization Checklist, later described). Malloy (2000) developed a Denial Questionnaire (DQ), a 27-item, forced-choice, true/false self-report measure. However, there are no published studies suggesting that it is psychometrically sound or that it measures what it purports to measure (i.e., no validation studies are available). A third measure called the Sex Offender Acceptance of Responsibility Scale (SOARS) was developed by Peacock (2000). The SOARS assesses various levels of accepting responsibility for sexual offending and comprises six sub-scales, including the offender accepting that he did commit an offense, that he planned the offense, that he harmed the victim, that he is motivated for treatment, that he has deviant sexual interests, and that he had made justifications for his sexual offending. The SOARS has good internal consistency but no validity studies have been published. A fourth measure was introduced in a recent article that claimed that the measure reconceptualizes the role of denial in child molesters. Schneider and Wright (2001) developed the Facets of Sexual Offender Denial (FoSOD) questionnaire, which comprises six factors of denial: refutation of the offense, denial of extent, denial of intent, assertion of victim desire, denial of planning, and denial of risk of relapse. The FoSOD was shown to have related but distinct factors, and the factors and the total score revealed good internal consistency.

In addition to self-report measures, denial measures that are clinician-rated are also available. These measures go beyond self-report questionnaires by taking into account the clinician's decision-making, which can include both the verbal admission by the sex offender and the clinician's behavioural observations. One such measure is the Denial and Minimization Checklist (DMC), a clinician-rated checklist that can be repeatedly completed throughout a sex offender's participation in group treatment (Barbaree, 1991, 2000; Barbaree, Seto, & Maric, 1996). The DMC breaks denial and minimization down into three types each. These are listed in Table 2. Barbaree reported that there are no empirical studies that have evaluated the instrument's utility (Barbaree, personal communication, November 1, 2000). A second clinician-rated instrument was introduced by Kennedy and Grubin (1992). Their Denial Scales and Ratings measure has seven items each measure on a 3-point scale. It showed good interrater reliability, and cluster analysis produced three patterns of denial (they later added a fourth group called 'absolute denial'): denial of harm to victims, externalizers (i.e., blamed victim or others for their offense), and internalizers (i.e., attributed offense to temporary aberration of behaviour or mental state). These distinctive patterns of denial corresponded with significant differences on other variables, such as sex offense history and DSM-III-R criteria for paraphilias. A third clinical approach was suggested by Happel and Auffrey (1995). Although they did not develop a specific measure, they recommended that in institutional settings assessment of denial and amenability to treatment by a three-person review board of psychologists could be more effective than individual clinician ratings. However, it has been argued in the literature that resources are usually scarce and usually there are not enough licensed professionals available to conduct such a comprehensive evaluation (Wormith & Hanson, 1992). Therefore, it is

unlikely that most community outpatient centers and institutions can afford a team-centered approach.

For all intents and purposes, denial has been given increased attention in the recent years by researchers and clinicians. The next section provides a necessary critique and evaluation of these current views and approaches to conceptualizing and assessing denial.

Criteria for a Good Denial Measure

In spite of this increased attention to assessing denial among sex offenders in recent years, there still exists limitations in these extant approaches to determine an offender's level of denial and minimization. It is felt that these approaches provide a beginning point from which to develop criteria that should be considered in the development of a good reliable instrument.

A limitation of general measures (e.g., MMPI, polygraph) is that they were never specifically intended for use with the sex offender population. Also, many of the measures specific to sex offender denial (e.g., DAMS, FoSOD) were developed only for a particular type of sex offender, such as child molesters. Hence, the first criterion is that a good instrument should be designed for use with the sex offender population and should not be limited to any particular type of sex offender (e.g., exhibitionist vs. pedophile).

An obvious reason for why existing clinical personality measures and even self-report questionnaires not designed for sex offenders tend to be used in clinical practice is that they are convenient and simple to use. The problem with such measures is that they tend to assess offender attitudes or what the offender thinks is the appropriate attitude to endorse. Although denial has been seen as a psychological process (e.g., Salter, 1988; Schlank & Shaw, 1997), denial would likely be relayed behaviourally to an

observer. General or specific questionnaires are inadequate ways to assess denial as a behaviour. Therefore, a second criterion is that an appropriate method, such as an interview or an observational approach, would be more appropriate and suitable for such a task.

All of the general measures have been used to categorize offenders into deniers, partial deniers, and admitters (e.g., Haywood, Grossman & Hardy, 1993; Lanyon & Lutz, 1984) and demonstrate no utility in guiding therapy for individual sex offenders who are included in treatment. The efforts of researchers who have developed specific measures of sex offender denial are admirable in their avoidance of treating denial as an either-or state. For example, Kennedy and Grubin's Denial Scales and Ratings assesses denial as a multifaceted phenomenon. However, it is difficult to say that seven items can adequately measure denial. Such a limited scale heavily favours brevity to the detriment of comprehensiveness, which might limit the utility of the measure in addressing therapeutic intervention. Hence, a third criterion includes greater comprehensiveness of the measure to assess for distinct, dynamic areas that could be focused on in treatment.

As mentioned above, an interview would be an appropriate method to assess a behavioural phenomenon, such as denial. Given that the forensic population has a reputation for manipulation and conning behaviours, most clinicians would probably agree that one must have some degree of experience in working with such clients to provide such assessments (Laws, 2002). Such experience would enable a clinician to assess the entire picture of the circumstances surrounding the offense and the version of the offense as given by the sex offender through behavioural observation (e.g., apparent discomfort or unease in relaying his version of the events), consistency (i.e., whether what he says is consistent with what he has already said or with what is written

in the official police reports), and verbal discourse (i.e., his particular version of the story). Hence, a fourth criterion for a good measure is the consideration of a clinician's experience and judgment in assessing denial.

Given the above argument for an interview-based and clinician-guided approach to assess denial, it may also be argued that clinical judgment may be "too subjective" and lead to errors in measurement. In any measure, it is critical to have some form of structure to enhance objectivity and thereby increase the reliability of the instrument. A fifth criterion would include good interrater reliability of the measure.

Several of the measures described herein (e.g., MMPI, MSI) were either not intended to measure a specific and behavioural construct such as denial or not possess any empirical evidence to support the use of the instrument in assessing sex offender denial (e.g., polygraph, Barbaree's DMC). It is important for any measure to meet psychometric requirements of reliability and validity adequately. Therefore, the sixth criterion of a good measure is that the measure demonstrate sound psychometric properties.

These six criteria are important characteristics that a good measure of denial should possess. We will return to them later in Chapter Three when we introduce a new measure of denial that attempts to meet these criteria.

Summary

In summary, the measurement of sex offender denial is of importance when conducting both treatment and research in the field of sexual abuse. It is currently agreed in the literature that denial is a behaviour and a multifaceted phenomenon. Despite the numerous attempts to develop a reliable denial measure, existing measures do not meet all of the characteristics for a good measure. Hence, there still exists a

need for a comprehensive and valid measure suitable for measuring denial among sex offenders.

CHAPTER TWO

THEORIES OF SEX OFFENDER DENIAL

In addition to the clinical usefulness of a valid method for assessing denial, such an instrument is essential for any research into theories of denial. Chapter Two, Theories of Sex Offender Denial will outline three major theories to be found in the literature. As described in Chapters Three and Four, tests of these theories were part of the research design in order to show the potential research utility of the new measure.

Three particular theories have been applied to understanding denial and sex offending in the recent years. They attempt to explain the processes that contribute to the propensity of some sex offenders to maintain their denial. These theories essentially stem from a cognitive paradigm: cognitive capacity, cognitive deconstruction, and schema theory. Cognitive theorists have offered these frameworks to understand sexual offending and, more relevant to this dissertation, to understand why sex offenders deny. Only one study has empirically examined the first of the three theories and no published studies have investigated the validity of the latter two theories. The absence of a reliable and comprehensive method of assessing denial is a likely reason.

With the development of a measure to evaluate denial, which meets the criteria discussed in the previous chapter, conducting research to examine psychological theories can be pursued. Furthermore, such a measure would aid therapy as well as research by identifying the multifaceted components of denial to address through psychological intervention.

Cognitive Capacity

According to Baldwin and Roys' (1998) findings, deniers were seen to have lower levels of IQ (i.e., intelligence quotient) or fewer years of education than those who admitted the sexual charges against them. Furthermore, they added that intelligence

and education were also associated with response bias indicators on psychological measures, suggesting that more intelligent and more highly educated individuals were less likely to present themselves in a favourable manner (i.e., show a fake-good response bias on these measures). They concluded that deniers presented as less sophisticated than their admitting counterparts and cognitive capacity plays a role in the assessment of alleged sexual offenders such that it may require a greater degree of cognitive capacity to accept responsibility for one's behaviour. Interestingly, their findings run contrary to studies previously published. Other researchers have failed to find differences between admitters and deniers in IQ and in education (Grossman & Cavanaugh, 1989; Kennedy & Grubin, 1992; Langevin, 1988).

Cognitive Deconstruction

An early theory of self-destructive behaviours (e.g., suicide, alcoholism, binge eating) was developed by Baumeister (1990, 1991). In developing his theory of "escape from self," the concept of cognitive deconstruction played a major role, which is the immediate cognitive response to a psychologically aversive state (e.g., guilt, self-loathing). What happens in cognitive deconstruction is a subjective shift to less meaningful and less integrative forms of thought and awareness. For example, a feeling of failure (i.e., aversive state) leads to a shift in thinking that his or her decision on one question in the exam would have made a world of difference in the overall test results (i.e., lower levels of self-awareness), rather than thinking that he or she should have studied harder (i.e., higher levels of self-awareness). Another instance of cognitive deconstruction is someone who feels guilty thinks he should have just said sorry at the end. In order for this person to be self-aware, he would be thinking that he should not have hit his wife in the first place.

Deconstructed (i.e., low-level) awareness means being aware of self and action in concrete, short-term ways, focusing on movements and sensations, and thinking only of the “now” or proximal, immediate tasks and goals. The essence of cognitive deconstruction is the removal of higher meanings from awareness. Because negative affect can be a product of meaningful interpretations, deconstructing these interpretations removes affect. Through cognitive deconstruction, the person may still be self-aware, but only in a concrete, less meaningful way, so the aversiveness of full self-awareness is minimized (e.g., an offender feels better by acknowledging guilt due to a lack of an apology, rather than due to assaulting his wife). The deconstructed response is a refusal of insight and a denial of implications or contexts. According to Baumeister, sustaining a deconstructed state may be difficult. Hence, the optimal resolution is for the individual to cope by constructing and elaborating new, integrative meanings for the relevant circumstances in his or her life.

In brief, actions that are successful lead to a positive psychological state and tend to be identified at relatively high levels; actions that are unsuccessful are aversive and tend to drop to lower levels of meaning, becoming more specific. Ward, Hudson, and Marshall (1995) applied Baumeister’s theory of cognitive deconstruction to sexual offending. To illustrate, a convicted sex offender often gets through the police arrest, the court proceedings, and subsequent treatment by identifying the offense in a lower level of meaning. He may think to himself that he only touched his victim’s genitals once because he was curious at that moment in time of what a pre-pubescent girl looked like. In this example, he is able to avoid the full unpleasant implications of his actions. To become aware of his irrational thinking about the offense, he would have to identify the offense in a higher level of meaning and acknowledge that he was sexually aroused by

the young girl and wanted to gain sexual gratification by touching her private areas. In this latter case, he is likely to experience great discomfort and negative self-evaluation.

Deconstruction, therefore, implies denial. Sex offenders are always in danger of moving up to higher levels of meaning that would entail negative self- and external evaluation, hence, negative emotions. These offenders would be more likely to deny, minimize, and avoid discussing their offenses in order to avoid the negative implications of self-awareness and to escape from the effects of traumatic or particularly stressful experiences. This strategy may become entrenched as a way of dealing with ongoing stress. Once the offender is exposed to the dissonance in his beliefs (e.g., that sex offenders are bad and that he committed a sexual offense), it is likely that he will experience great discomfort in this self-awareness—the intense and distressing emotional experience that offenders often exhibit once engaged in therapy (Ward et al., 1995). Ward and his colleagues (1995) suggested that the appropriate approach to dealing with denial is "to bring the 'truth' into full awareness, exposing the small decisions and seemingly irrelevant decisions that underlie the chain of behavior leading to offending" (Ward et al., 1995, p. 79). The goal is to gradually move the offender out of a deconstructed state so that more complex cognitions are available and the incompatibility between the offensive behavior and the offender's self-standards is made clear.

Schema Theory

The third approach to understanding sex offending is offered through the social cognition paradigm. The dominant perspective in the social cognition literature is an information-processing model. The social cognition model casts individuals as "cognitive misers" who attempt to conserve their limited processing resources wherever possible (Fiske & Taylor, 1991). This is accomplished by using shortcuts in the form of schemas.

Schemas help us to remember and organize details, speed up processing time, fill in gaps in our knowledge, and interpret and evaluate information (Taylor, Peplau, & Sears, 2000). For example, if you have been asked to look after a friend's puppy, then you might rely on your existing schema for babysitting children. This schema tells you that you need to give the puppy water and food and to respond quickly when it whimpers or barks. Schemas allows us to conserve cognitive resources and take shortcuts when finding adequate resolutions to problems, because many of the associated thoughts and behaviours are already routinized.

However, according to this social cognitive approach, schemas can also be detrimental to how we perceive people and situations. Using schemas could lead to errors or biases in our decision-making, which cloud the way we view others. For example, if you have been asked to look after a neighbour's young child and you have had some experience babysitting your nephew, you might give her a hug to calm her down. This may cause the child to cry even more and experience a certain degree of fear because unlike your relationship with your nephew you do not have the same rapport with this child. Hence, assumptions based on existing schemas can be detrimental under some circumstances.

Social cognition theorists provide an alternate view of explaining both sexual offending and the denial of such behaviour and deviant interests. They suggest that sex offenders hold rigid, traditional, and inappropriate schemas within which they choose to view the world. Because these schemas are easily accessible, requiring few cognitive resources, offenders tend to resort to them rather than examining the alternatives and the potential consequences of their shortcut thinking. Johnston and Ward (1996) suggested that the negative aspects of using schemas to perceive people and situations may lead to errors in the thinking of sex offenders. Their distorted thinking can result in

maladaptive attitudes or beliefs about the legitimacy of sexualizing children or forcing sex on women. Given the heavy reliance sex offenders have on schemas, they tend to resort to ways of thinking that are comfortable or almost rote to them. In fact, a number of studies have shown that sex offenders tend to hold traditional, conservative attitudes toward women, to perceive children in sexual terms, and to endorse attitudes about male sexual entitlement (Abel, Gore, Holland, Camp, Becker, & Rathner, 1989; Marshall, 1997). The rationalizations and justifications presented by the offender may represent, in part, faulty interpretations of the situation rather than simply an attempt to avoid negative self-evaluation or social disapproval. These rationalizations result in attempts to deny or minimize the offenses. For instance, an offender who believes that affectionate women must find him sexually attractive may also erroneously use that schema when interacting with children. First, such schemas could lead to a sexual offense; in this example, the offender may interpret his friend's nine-year-old affectionate daughter as sexually attracted to him, leading him to victimize the girl. Second, schemas could lead to denial and minimization of the offense; the offender may later justify his offense by blaming the victim for being sexually seductive and "coming on" to him in the first place.

It is important to note that this is not to say that the sex offender does not have other options (i.e., that he has no control) but rather he chooses one cognitive course of action over the alternatives (i.e., that he does have control) (Fiske, 1989; Johnston & Ward, 1996). The premise of control underlies the emphasis in treatment programs on the management of one's own behaviour and thoughts (Hall, 1989; Ward, Hudson, & Keenan, 1998). Awareness and management of one's thoughts and behaviours requires effort and cognitive resources. Through cognitive-behavioural approaches, such as the relapse prevention model (Laws, 1989), sex offenders can effectively reduce

reoffending by recognizing ineffective schemas and replacing them with prosocial rational schemas and increase acceptance of responsibility (i.e., decrease denial).

Summary

In conclusion, it is important to reiterate that underlying mechanisms of sexual offending are not the focus of this dissertation; rather, I am interested in the relevance of psychological theories on how denial is exhibited. Theorists suggest that denial is associated with underlying mental processes: cognitive capacity, cognitive deconstruction, or schema theory. The first theory emphasizes that individuals with lower levels of cognitive capacity would express greater levels of denial. The second theory proposes that denial is the result of a need to reduce negative evaluations by maintaining low levels of meaning. The final theory emphasizes that denial is the result of cognitive distortions and faulty schemas. If we examine the validity of their theories, we are still left with the daunting task of measurement. Although the literature offers innumerable means to assess attitudes and beliefs, there are yet no measures that fully meet the criteria for assessing denial.

CHAPTER THREE

A NEW MEASURE OF DENIAL

This chapter will outline the development of a new instrument to measure denial in sex offenders.

Criteria for a Better Measure Revisited

The measurement of denial has been an area of interest in the literature over the past two decades. As previously discussed in Chapter One, although there have been advancements in developing a better measure of denial among sex offenders, none has yet met all of the criteria outlined, which are to:

1. Measure denial in all types of convicted sex offenders.
2. Measure both behavioural and communicative aspects of denial.
3. Assess multiple facets of denial.
4. Use judgments of experienced clinicians.
5. Demonstrate acceptable reliability.
6. Demonstrate acceptable validities.

These criteria can be further grouped into two areas: what we are measuring (criteria 1, 2, 3) and how we would use this measure (criteria 4, 5, 6). Let us examine the three criteria in the first area.

The first criterion refers to the population for whom the measure is intended. The measure should be specifically for use with convicted offenders. Measures, such as the MMPI, are intended for wider use, not limited to a criminal population. Also, the measure should be specifically designed for sex offenders rather than for the general offending population. There is a different presentation of denial by sex offenders than by other types of offenders. For example, nonsexual violent offenders (e.g., who assaulted an acquaintance) may minimize their offense by claiming that they reacted in self-

defense, whereas sex offenders would be less likely to use such an excuse to minimize their sexual offense. Finally, the measure should not be limited to a particular type of sex offender; instead, it should be applicable to all types of sex offenders. Several sex offender measures are solely intended for use with child molesters (e.g., FoSOD, Schneider & Wright, 2001), often excluding other paraphilic offenders (e.g., voyeurs, exhibitionists, fetish offenders). I propose that sex offenders, regardless of what sexual offense they committed, present similar excuses in order to minimize their offense.

The second criterion refers to the focus of measurement. The instrument should measure observable behavioural and communicative aspects of denial, rather than internal attitudes, that is, it should treat denial as a behaviour rather than as a mental state. Many sex offenders are proficient in using language to minimize their own responsibility for their sexual offending (Pollock & Hashmall, 1991; Scully & Marolla, 1984), and it is through this communicative route that sex offenders exhibit denial and through which the clinician must attempt to measure and assess denial.

Watzlawick, Bavelas, and Jackson (1967) emphasized that not only the verbal content of a behaviour should be taken into account, but also the metacommunicative aspects of behaviour—both what is said and how. For example, an offender could indicate on a self-report inventory that he feels bad and embarrassed for what happened (e.g., responds “true” to the statement, “I feel terrible about my offense”). One might conclude that he feels remorse and guilt for his offending behaviour; however, such a conclusion may be misconstrued as meaning something that the offender did not intend. If one questioned the same offender further, one might discover that the offender only felt bad about the consequences of the offense (e.g., being arrested, attending trial, receiving jail time) but not about committing the offense. This additional information would likely change one’s opinion of the offender’s attitude. A second aspect missing

from self-report approaches is how something is communicated. If we include our observations in the assessment of the same offender (e.g., from an interview), our conclusions might differ substantially. If he did not demonstrate any congruent behaviours (e.g., tearfulness and lack of eye contact), we might conclude that he is in fact not remorseful, embarrassed, or guilty about his sexual offenses.

Goffman (1959) elaborated on the importance of metacommunicative features in assessing social behaviour:

Knowing that the individual is likely to present himself in a light that is favorable to him, the others may divide what they witness into two parts; a part that is relatively easy for the individual to manipulate at will, being chiefly his verbal assertions, and [another] part in regard to which he seems to have little concern or control, being chiefly derived from the expressions he gives off. The others may then use what are considered to be the ungovernable aspects of his expressive behavior as a check upon the validity of what is conveyed by the governable aspects. In this a fundamental asymmetry is demonstrated in the communication process, the individual presumably being aware of only one stream of his communication, the witnesses of this stream and one other. (p. 7).

Hence, both the content of the verbal message and its metacommunicative attributes are crucial to fully understanding and assessing denial, which argues for an interview rather than a questionnaire measure, so that all of these aspects can be assessed.

The third criterion, comprehensiveness, has been absent from several of the extant measures. A good measure should be comprehensive enough to capture the multiple facets of denial described in the literature. These facets should also be assessed as dynamic, that is, as changeable behaviours that could be targeted in treatment (unlike static characteristics that are unchangeable; e.g., criminal record, past

substance abuse). Important facets of denial that are distinct as well as dynamic include denial of the sexual nature of the offense, denial of the need to be treated, minimization of responsibility, and minimization of harm to others. These behaviours cover the full breadth of denial and each could be a focus in treatment.

The above three criteria address the content of a measure of denial. The next three have to do with the means of assessment. The fourth criterion asserts the importance of allowing clinicians to use their experience and judgment in the assessment. If the approach to assessing denial restricts clinical judgment (e.g., self-report questionnaires or actuarial measures of risk), then it could miss capturing the whole picture. There are several advantages to an approach that takes into account clinicians' skills at conducting clinical interviews and their experience of working with sex offenders. The clinician is able to evaluate all of the data, not only the content from the interview, but also file information (e.g., police narrative for the offense, victim statement, previous criminal record, other reports), interview observations or impressions (e.g., whether the offender is cooperative, forthcoming, manipulative, or defensive), and collateral information (e.g., reports from family members, probation officer, and therapists). The information from all of these sources is important to assessing denial but could only be evaluated and integrated by an experienced clinician.

An obvious argument against using clinical judgment to guide decision-making is the potential subjectivity of such an assessment. However, clinical judgment and a lack of objectivity do not necessarily go hand in hand. A structured procedure to help guide the clinician's decisions is an appropriate start. For example, a manual with guidelines and prototypical examples could reduce subjectivity (e.g., manual for the SVR-20, Boer, Hart, Kropp, & Webster, 1997). Therefore, features that lead to demonstrated objectivity or interrater reliability are a fifth criterion for an improved measure of denial.

The sixth criterion for an improved measure is the adequacy of other psychometric properties, which are not limited to interrater reliability. In order for an instrument to be useful, proposed uses and interpretations of a measure's test scores should be clearly delineated and evidence that supports these uses should be obtained. Therefore, the validity of the intended uses and interpretations of test scores should be evaluated.

Comprehensive Inventory of Denial – Sex Offender Version

As reviewed in Chapter One, none of the existing measures of denial, either published or unpublished, adequately meets all six criteria described above. Therefore, for this dissertation, I was specifically guided by the above criteria to design a better measure of denial, called the Comprehensive Inventory of Denial – Sex Offender version (CID-SO). The CID-SO is an inventory checklist used by the interviewing clinician to assess and record various patterns of denial, which reflect a sex offender's acceptance or non-acceptance of responsibility. The CID-SO has 18 items, which are listed in Table 4. It is an inventory that is to be completed by a mental health worker after he or she has reviewed background information and interviewed the sex offender. Each item is rated by the clinician on a 3-point scale: 0 = not at all, 1 = maybe or in some respects, and 2 = yes. As shown in Table 4, each rating for each item has a fuller description on the inventory. For example, a rating of 0 for "denying difficulty of change" would apply to a person who acknowledges that offending is within his control and he is able to change with help.

To assess denial by using the CID-SO, the clinician must complete four steps. The first step involves the review of file information and collateral data. The offender's file information may include his criminal history, the police account of the current sexual offense, victim statements, and reports by other professionals (e.g., mental health,

probation). Collateral data about the offender could be obtained by interviewing the probation officer, the investigating police officer, and his family members or friends. The second step is a thorough intake assessment interview. Because the offender population has a reputation for manipulative and conning behaviours, reviewing file and collateral data is essential before interviewing the offender. Then, the extent to which the offender's version deviates from independent descriptions of his offense can be evaluated in the interview. Particular attention should be paid to any discrepancies between collateral or file information and the offender's interview responses, especially observable behavioural and communicative aspects. The third step is the review of the CID-SO manual, which has a thorough description of each item and how to decide each rating (see Appendix A). Fourth, the clinician rates all of the 18 items on the CID-SO for this offender.

The CID-SO's 18 items are clustered into four groups, shown in Table 5. These clusters were created conceptually, based on both my experience and the current literature (e.g., Kennedy & Grubin, 1992; Salter, 1988). The first cluster depicts offenders who deny sexually deviant behaviours and arousal. These offenders do not acknowledge that they have committed a sexual offense nor that they have committed sexual offenses in the past, despite file records that indicate otherwise. They minimize the sexual aspect of their offenses and deny they have any deviant sexual interests.

The second cluster refers to those offenders who deny the need for treatment or help with managing their offending. They either do not acknowledge having a problem that requires psychological attention or say that this was a "one time deal," which does not require lifetime management. They often become defensive or hostile to mental health professionals. Some offenders also say that a change in their behaviour is

"difficult" and that the focus should be on secondary and tertiary changes, such as reunification of the family or getting a job.

Offenders who deny responsibility fall under the third cluster. Such offenders are sometimes accusatory, blaming the victim for making up the offense or exaggerating the details of the offense. Often these offenders state that "it just happened" and that no planning preceded their offense. They may justify their offending with internal, psychological reasons, such as their mental status (e.g., depression, stress, anxiety) or cognitive deficits (e.g., impulsivity, memory deficits, disorientation). They tend to say that they are the real victims or that they are different people now. These offenders also justify their offending with external reasons, such as alcohol abuse, their own sexual abuse as a child, or their wife's lack of interest in sex. When alcohol abuse is described as a factor in their sexual offending, offenders may claim that they do not remember offending and therefore deny any responsibility for the offense.

The fourth cluster depicts offenders who minimize harm to their victims and show little remorse for their behaviour. They demonstrate a lack of empathy towards their victims and do not acknowledge the seriousness of the offense. They say that they have been treated unjustly for their offense or even that the offense should not be considered against the law.

Summary

The CID-SO was developed to meet the criteria that define a good measure of denial. First, the CID-SO was specifically designed for use with sex offenders rather than non-sexual offenders and was intended for assessing all types of sex offenders (e.g., pedophiles, rapists, exhibitionists, etc.). Second, the CID-SO assesses the behavioural and communicative aspects of denial through the interview and collateral information, rather than self-reported attitudes and beliefs. Third, the CID-SO has a

comprehensive inventory of 18 items, which captures multiple facets of denial missing in other available measures. Fourth, the clinicians' expertise plays a significant role in the decision-making process when rating items on the CID-SO. The final two criteria—reliability and validity—are the primary evaluative focus of this dissertation and are addressed in the next chapter, along with a description of the research design.

CHAPTER FOUR

DESIGN FOR EVALUATING RELIABILITY AND VALIDITY

The central goal of this dissertation was to develop a new measure of denial for use with sex offenders, called the Comprehensive Inventory of Denial – Sex Offender version (CID-SO). In this chapter, the design for evaluating the reliability of the CID-SO and the validity of its proposed uses is described.

Reliability

The reliability of a measure is of both psychometric and practical importance. There are potentially three different types of reliability—interrater, internal, and temporal (Anastasi & Urbina, 1997). Each addresses a different potential source of measurement error.

First, if an instrument depends in part on human judgment, one must determine the reliability of the judges' decisions (Anastasi & Urbina, 1997). This is done by having two or more individuals work independently, use the same data, and apply the same assessment procedure. If their ratings correlate highly, it would demonstrate that the instrument has good interrater reliability. In other words, the measure could be employed by different people and still produce similar ratings. Because the CID-SO is intended for clinicians' use and therefore uses human judgment, it is essential to establish interrater reliability.

Second, when an assessment procedure consists of many items sampled from what is intended to be a homogeneous domain, measurement error could exist in the actual items sampled. For example, some items might not represent that same domain. The degree of sampling error inherent in a measure, otherwise called the internal consistency of a measure, can be estimated by examining the average correlation among items within a measure or the correlation of each item with the total score

(Nunnally, 1967). However, given that I am assessing denial as a multifaceted phenomenon and expect that each item on the CID-SO would provide information that is unrelated to other items, internal consistency of the CID-SO is not a relevant or required kind of reliability. The CID-SO is intended to be fairly heterogeneous, not homogeneous.

Third, when an assessment procedure is intended to represent a relatively enduring trait, the scores it produces should remain relatively stable over an appropriate period of time (Nunnally, 1967). Temporal reliability is established by conducting the assessment at two different times. If the phenomenon being assessed is a stable characteristic or trait, then the two assessments should correlate highly, supporting the assessment as a temporally reliable measure. However, the phenomenon of interest in this study, denial, is defined as dynamic in nature (i.e., potentially changing over time) and therefore temporal reliability is not relevant in this investigation.

In sum, of the three kinds, only interrater reliability is relevant to the CID-SO. Next, we should consider the other fundamental requirement of a good measure, namely, validity.

Validity

In this dissertation, I depart from the older, traditional approach to measurement validation and use the current professional standards. The traditional approach implies that a test “has validity” or “is valid”, suggesting that the measure is valid in all situations and for all uses. This approach is misleading and often confusing. Today, it is recognized that we should be validating the proposed uses of the instrument (i.e., inferences that are made on the basis of test scores) rather than validating the instrument itself. In the following section, I will describe the traditional approach that we are more familiar with (American Educational Research Association (AERA), American Psychological Association (APA), & National Council on Measurement in Education

(NCME), 1985; Anastasi & Urbina, 1997; Bavelas, 1978) and then introduce and contrast the new approach to validation as defined in the sixth and most recent edition of the Standards for Educational and Psychological Testing (AERA, APA, & NCME, 1999; hereafter called the 1999 Standards). I will then apply this new perspective to the CID-SO and discuss the proposed uses and required evidence for each use.

The Traditional Approach to Establishing Validity

The traditional approach defined three types of validity—content, construct, and criterion (AERA, APA, & NCME, 1985; Goodwin, 2002; Huysamen, 2002; Kane, 2001). The first, content validity, refers to the systematic examination of the test content to determine whether it covers a representative sample of the behaviour domain of interest. In the case of the CID-SO, content validity would examine whether the 18 items are a representative sample of the domain of denial. To achieve content validity for the CID-SO, I would define the domain of denial and use an appropriate method for sampling and assessing this domain.

In contrast, construct validity is the extent to which the test may be said to measure a theoretical construct or trait. To illustrate, if the content validity of the CID-SO refers to the representative sampling of specific characteristics or behaviours of denial, then construct validity refers to whether the CID-SO truly measures the abstract, psychological construct of denial and whether it has relationships with other variables that one would expect, based on a theory of denial. Because I am proposing that denial is not a unitary construct but instead that many different forms of denial may exist, validation of this proposition would be achieved in part by demonstrating high internal consistency for each cluster and lower intercorrelations between clusters. With regard to the CID-SO's relationships with other variables, I would use the CID-SO to test hypotheses by making theoretical predictions about what the relationship of denial to

other psychological variables should be if the CID-SO were indeed a measure of the construct of denial. For example, the finding that higher ratings on the CID-SO were related to lower scores on an empathy scale could provide support for such a hypothesis.

The third form of validity, criteria validity, establishes whether a test relates to other, usually more practical, manifestations of the quality the test is supposed to measure. There are two approaches to criteria validity. The first, called predictive validity, establishes a test's capacity to make predictions about people's behaviour and therefore is relevant to tests employed for the prediction of future outcomes. For example, predictive validity would examine the extent to which the CID-SO could predict success in sex offender treatment. The second, called concurrent validity, concerns a test's capacity to correlate with another variable that was measured at the same time. It is often used when it is "impracticable to extend validation procedures over the times required for predictive validation" (Anastasi & Urbina, 1997, p. 119) or when considering whether a new test is a better alternative or substitute measure for a current procedure. For example, to assess the concurrent validity of the CID-SO, an existing measure of sex offenders' readiness for treatment could be correlated to the new alternative, the CID-SO.

The validation approach just described fits the traditional framework with which we are most familiar. However, the findings could potentially be misleading. To illustrate, if one were to find that the CID-SO has the capacity to make predictions about sex offenders' likelihood to comply with group treatment, one might say the CID-SO has predictive validity. Such an absolute statement could lead users of the measure to think that the CID-SO predicts all types of treatment success, including participation, completion, and maximal gains in any kind of treatment, although it may not. That is,

validity becomes a general property of the test, not specific to use or setting. Similar errors are liable to occur with the other two kinds of validity. There is an implicit assumption that the three kinds of validity are three potential properties that the test itself might have.

Goodwin (2002) summarized several problems with what she called the “holy trinity” view of validity:

Although this way of conceptualizing validity was useful to measurement theorists and practitioners for many years, it also caused some problems and confusion. It tended to compartmentalize thinking about validity, narrowing or limiting it to a checklist type of approach and it encouraged the misconception that validity is somehow a property of a test or measure per se, rather than a property of the scores obtained with a measure when used for a specific purpose and with a particular group of respondents [emphasis added]. (Goodwin, 2002, p. 101)

The section that follows will introduce the evolution of the meaning of measurement validity to one that has less chance of inviting confusion and is more appropriate and specific to establishing validity, including for the various uses of the CID-SO.

A New Perspective

In the 1999 Standards (AERA, APA, & NCME, 1999), a substantial change in perspective took place that put test uses in the forefront of validation and put validity categories (e.g., content validity) in the background. This evolved perspective defines validity as the degree to which evidence and theory support the interpretations of test scores entailed by proposed uses of tests (AERA, APA, & NCME, 1999). This definition differs from the traditional approach because it is no longer the test itself that is validated but rather the inferences and conclusions that the user reaches on the basis of test

scores (Eignor, 2001). Goodwin (2002) stated that the 1999 Standards emphasizes the “inappropriateness of saying such things as ‘this test is valid’ or referring to ‘the validity of this measure,’ as though validity were some sort of static property of a test or other measure” (p. 105). The newer approach will form the framework for validation in this dissertation.

In order to apply this framework, a test developer must be clear about the proposed uses and interpretations of test scores. These uses and interpretations should be explicitly described by elaborating on their scope and extent. This detailed description is termed the conceptual framework for the test, delineating the specific characteristics to be assessed and the suggested evidence:

The framework indicates how this representation of the construct is to be distinguished from other constructs and how it should relate to other variables.

The conceptual framework is partially shaped by the ways in which test scores will be used. For instance, a test of mathematics achievement might be used to place a student in an appropriate program of instruction, to endorse a high school diploma, or to inform a college admissions decision. Each of these uses implies a somewhat different interpretation of the mathematics achievement test scores: that a student will benefit from a particular instructional intervention, that a student has mastered a specified curriculum, or that a student is likely to be successful with college-level work. (AERA, APA, & NCME, 1999, p. 9)

Therefore, the test developer provides a conceptual framework that gives the rationale for the uses and interpretations of test scores:

Validation logically begins with an explicit statement of the proposed interpretation of test scores, along with a rationale for the relevance of the

interpretation to the proposed use. The proposed interpretation refers to the construct or concepts the test is intended to measure. (AERA, APA, & NCME, 1999, p. 9)

The clarity of a proposed interpretation is important in the process of validation:

In order to evaluate a proposed interpretation of test scores, it is necessary to have a clear and fairly complete statement of the claims included in the interpretation and the goals of any proposed test uses. Validation is difficult at best, but it is essentially impossible if the interpretation to be validated is unclear. (Kane, 2001, p. 329)

The next step is to examine the types of evidence that might be collected to evaluate the proposed use in light of the purposes of testing. The 1999 Standards reviews various strands of evidence that may serve to support the proposed uses of a measure. These include test content, response processes, internal structure, relations to other variables, and consequences of testing (AERA, APA, & NCME, 1999). It is important to note, however, that the types of evidence that are important for validation need to be clarified by developing a set of propositions that support each proposed use. Returning to the example in the 1999 Standards quoted earlier:

The decision about what types of evidence are important for validation in each instance can be clarified by developing a set of propositions that support the proposed interpretation for the particular purpose of testing. For instance, when a mathematics achievement test is used to assess readiness for an advanced course, evidence for the following propositions might be deemed necessary: (a) that certain skills are prerequisite for the advanced course; (b) that the content domain of the test is consistent with these prerequisite skills; (c) that test scores can be generalized across relevant sets of items; (d) that test scores are not

unduly influenced by ancillary variables, such as writing ability; (e) that success in the advanced course can be validly assessed; and (f) that examinees with high scores on the test will be more successful in the advanced course than examinees with low scores on the test. (AERA, APA, & NCME, 1999, p. 9-10).

As each of the propositions for each proposed use is articulated, evidence is gathered to evaluate its soundness:

When propositions have been identified that would support the proposed interpretation of test scores, validation can proceed by developing empirical evidence, examining relevant literature, and/or conducting logical analyses to evaluate each of these propositions. (AERA, APA, & NCME, 1999, p. 10)

Note, however, that because a validity argument usually depends on more than one proposition, it is important to seek evidence for all propositions and to understand that “strong evidence in support of one in no way diminishes the need for evidence to support others” (AERA, APA, & NCME, 1999, p. 10). Kane (2001) pointed out that it may not be feasible to examine all propositions at once, so he suggests to first “evaluate (empirically and/or logically) the most problematic assumptions in the interpretive argument” (p. 330). He further asserts that if propositions are not supported by empirical or logical evidence, then the “interpretive argument may be rejected, or it may be improved by adjusting the interpretation and/or the measurement procedure in order to correct any problems identified” (p. 330).

The 1999 Standards places the responsibility to validate a test’s proposed use on both the test developer and the test user:

The interpretation and uses of test scores, not the test itself, are evaluated for validity. Responsibility for validation belongs both to the test developer, who provides evidence in support of test use for a particular purpose, and to the test

user, who ultimately evaluates that evidence, other available data, and information gathered during the testing process to support interpretation of test scores. Test users have a particularly important role in evaluating validity evidence when the test is used for purposes different from those investigated by the test developer. (Turner, DeMers, Fox, & Reed, 2001, p. 1101)

Although it is likely that it will take time for the new way of thinking about validity to become commonplace, this evolved process of validation eliminates the old “trinity” view of validity (Goodwin, 2002) and instead emphasizes both the uses of the instrument and the varied types of validity evidence to support each proposed use:

Validation can be viewed as developing a scientifically sound validity argument to support the intended interpretation of test scores and their relevance to the proposed use. The conceptual framework points to the kinds of evidence that might be collected to evaluate the proposed interpretation in light of the purposes of testing. As validation proceeds, and new evidence about the meaning of a test’s scores becomes available, revisions may be needed in the test, in the conceptual framework that shapes it, and even in the construct underlying the test. (AERA, APA, & NCME, 1999, p. 9).

Validating the Uses of the CID-SO

In the following sections, the conceptual framework for developing the CID-SO and the proposed uses and interpretations will be delineated. Then the various types of evidence needed for each proposed use will be described.

Conceptual Framework

The conceptual framework behind the development of the CID-SO was shaped by my clinical experience working with sex offenders. Although the following discussion

is a review of earlier chapters, it is important to provide an overview of my original conception of denial.

To begin, I propose that denial is not assessable by traditional self-report measures. As mentioned in Chapter One, the problem with self-report measures is that they tend to assess offender attitudes or what the offender thinks would be an appropriate attitude to endorse. In my experience, denial is a behavioural phenomenon that can only be assessed through behavioural and communicative means. Therefore, denial should be assessed by both an interview and a thorough review of collateral information, such as the police's narrative of the offense and a criminal record. Because denial is a behavioural phenomenon, the assessor should have clinical expertise in working with sex offenders and therefore be capable of detecting the manipulative and deceptive nature of many offenders.

Of equal importance, I also propose that the construct of denial was neither a binary concept (e.g., a sex offender either is a denier or an admitter; e.g., Barbaree & Marshall, 1988) nor a phenomenon that could be measured on a single continuum (e.g., denial ranging on a Likert scale from 0 to 10; e.g., Denial Questionnaire, Malloy, 2000). Rather, my experience treating sex offenders made clear that there were various patterns of sex offender denial. My approach is most similar to Salter's (1988) conceptualization of denial as a multifaceted phenomenon. Moreover, in my view, denial should be treated as a phenomenon that is specific to sex offenders rather than to the general population. Therefore, broader psychological measures, such as the MMPI or the polygraph, would not be suitable to assess sex offender denial. As a corollary, a measure of denial for sex offenders should also be applicable to all types of sex offenders rather than only one type. Often, specific types of sex offenders are not clearly defined by researchers and therefore not always useful. For example, the

FoSOD (Schneider & Wright, 2001) measure only assesses child molesters, but it is not clear how one would define a child molester (e.g., would sex offenders who use child pornography or who expose themselves to children be placed in the same category as those who sexually assault children?). It is also important to note that I propose that denial is not static but rather a dynamic, changing phenomenon that is affected by societal, social, and psychological variables (e.g., consequences, peer pressure, treatment). As such, denial should not be equated with untreatability (i.e., that sex offenders who deny are not treatable). In a similar vein, denial should not be equated with social desirability, educational level, or intelligence. Denial should be independent of these variables.

This conceptual framework set the stage for my development of the CID-SO. However, two other related but practical additions to this framework emerged during its development. The first addition refers to the finding that denial inhibits treatment (Barbaree, 1991). Therefore, denial should be assessed as it may relate to treatment needs and treatment outcomes. This broad statement implies that an offender's presentation of denial is associated with his readiness for treatment, his likelihood to gain from treatment (therefore decreasing his risk to reoffend), his treatment prognosis, and his specific treatment needs. Hence, various treatment-related areas are an important component of the role denial plays among sex offenders.

The second addition refers to the fact that testing any theoretical hypotheses about denial is impossible without an adequate measure of denial (Lund, 2000). An adequate measure of denial could allow researchers to empirically examine theories of denial, specifically those discussed in Chapter Two regarding a sex offender's cognitive capacity, cognitive deconstruction, and the schema theory. With such a measure, I could test existing theories proposed by other researchers.

Proposed Uses

As required by the 1999 Standards, Table 6 lists the intended uses of the CID-SO, and this section will elaborate on each use. The first group of uses of the CID-SO ratings is methodological and has several defining features:

- a. The ratings can be used to combine several sources of data required to assess denial, including verbal, behavioural, and collateral information (e.g., legal records, victim's report).
- b. The CID-SO can be used to capture expert clinical judgment (e.g., unlike self-report inventories).
- c. The CID-SO can be interpreted as reliable, that is, as ratings on which clinicians can agree.

The second group of uses for the CID-SO ratings refers to the conceptualization of denial. The CID-SO ratings are defined by several uses:

- a. The CID-SO ratings can be used as a direct measure of denial as it presents specifically in sex offenders (as opposed to broader or more general measures of denial, such as the lie scale on the MMPI or the polygraph, but in all kinds of sex offenders (e.g., not just child molesters)).
- b. The ratings can be used to assess denial as a dynamic, potentially changing characteristic, as opposed to a static trait.
- c. The CID-SO ratings can be interpreted as distinct from social desirability, educational level, and intelligence.
- d. The ratings can be interpreted as a behavioural and communicative assessment of denial, as opposed to an attitude or mental process.
- e. The ratings can be used to identify specific patterns or types of denial, rather than rating denial on a continuum (e.g., as a degree of denial with overall

rating from 0 to 100) or as a dichotomous construct (e.g., the offender is either a denier or an admitter). Specifically, the proposed four patterns are (i) denying sexually deviant behaviours or arousal, (ii) denying the need for treatment or help with managing their sexually offensive behaviour, (iii) denying responsibility for their offense, and (iv) minimizing the harm to the victims.

These first two groups of uses for the CID-SO ratings are essential uses; therefore, they must be demonstrated first. The next two uses for the CID-SO ratings are practical and clinical in nature.

A third use for the CID-SO ratings is for assessing treatment variables. Treatment variables could include the offenders' treatment needs; for example, one could use the CID-SO ratings to determine whether an individual would benefit most from individual or group therapy. Another variable might be treatment prognosis and therefore the CID-SO ratings could be used to determine a sex offender's maximal gain from treatment. Yet another variable might be treatment progress. As mentioned earlier, denial could be a target of treatment and therefore the CID-SO ratings could be used to assess the change in an individual's pattern of denial throughout treatment.

The fourth proposed use for the CID-SO ratings is for theoretical research, to empirically test existing hypotheses about sex offender denial. For example, the CID-SO ratings could be used to examine the relationship between denial and other variables, such as self-esteem and cognitive distortions.

There may be many other uses that are important but validation of these uses would be outside the scope of the present dissertation and may likely be the subject of future investigations. One such example is the potential use of the CID-SO ratings to predict future offending behaviour. In this example, the CID-SO ratings might be used to

provide information that would help clinicians predict a sex offender's risk for reoffending. As such, the CID-SO ratings would be expected to correlate with future offending as well as pre-offending behaviours, such as engaging in inappropriate conduct while under supervision either in the community or in an institution (e.g., not attending probation appointments, committing other non-sexual crimes, misconduct in an institution).

In sum, these four proposed uses for the CID-SO ratings are clearly delineated here in order to outline the procedures for validating CID-SO within the conceptual framework behind its development. They may not represent an exhaustive list of possibilities for using the ratings from the CID-SO; however, they are seen as important reasons for why a denial measure is needed in the field of sexual offending.

Evidence Required

According to the 1999 Standards (AERA, APA, & NCME, 1999), once the proposed uses and interpretations for a measure are delineated, "the conceptual framework points to the kinds of evidence that might be collected to evaluate the proposed interpretation" (p. 9). There are several forms of evidence that may be relevant to support each use:

A sound validity argument integrates various strands of evidence into a coherent account of the degree to which existing evidence and theory support the intended interpretation of test scores for specific uses. It encompasses evidence gathered from new studies and evidence available from earlier reported research. The validity argument may indicate the need for refining the definition of the construct, may suggest revisions in the test or other aspects of the testing process, and may indicate areas needing further study. (AERA, APA, & NCME, 1999, p. 17).

What matters most is the quality and relevance of each strand of supporting evidence:

No type of evidence is inherently preferable to others; rather, the quality and relevance of the evidence to the intended test use determine the value of a particular kind of evidence. (AERA, APA, & NCME, 1999, p. 17).

Returning to the five proposed uses for the CID-SO ratings, the following section will examine the types of relevant evidence needed to proceed with validation and these required evidence for each proposed use is summarized on Table 6. The required evidence discussed below has been gathered for this dissertation unless otherwise stated. The evidence gathered is summarized separately on Table 7.

Recall that the first proposed group of uses was methodological in nature and was characterized by three defining uses that include the use of a measure that has the capacity to combine several sources of data and not just the sex offender's self-report (1a), that captures clinical judgment and experience (1b), and that has demonstrated interrater reliability (1c). The most relevant form of evidence for the first two uses would be a logical analysis of the assessment process. Such evidence should demonstrate that the rating procedure includes the use of various sources of information, including interview and file review, and that the clinician's expertise would be used in the process of rating CID-SO items. Regarding the third use, interrater reliability coefficients would be a means of demonstrating the reliability of the CID-SO ratings for different raters.

The second group of uses of the CID-SO is conceptual. Several forms of evidence are needed to support these uses.

The first conceptual use for the CID-SO is both to measure sex offender denial and to assess denial for all types of sex offenders (2a). With regard to measuring sex offender denial rather than general denial, logical analyses could provide evidence that is based on test content. For example, if one examines the individual items on the CID-SO and finds they are specific to sex offenders, then there would be supporting evidence

for this use. With regards to assessing denial for all types of sex offenders, the type of evidence that is relevant might include evidence that is based on validity generalization, which allows one to generalize the findings to all types of sex offenders (e.g., exhibitionists, child molesters, etc.) in any setting (e.g., jail, community). To illustrate, empirical support for this aspect might demonstrate that the presentation of denial would not differ between a child molester and a rapist.

The second conceptual use is to assess denial as a dynamic or changeable variable (2b). Logical analyses of the CID-SO items should provide evidence that the measure is truly measuring a dynamic phenomenon. The CID-SO items should be rated on the basis of a sex offender's present behaviour and should be written in present tense (e.g., denies sex offending history, blames the victim). Another method would be to examine whether the item ratings for an offender changes with therapy. For example, it would be expected that treated and untreated offenders would differ in their CID-SO ratings.

The third conceptual use of the CID-SO is to assess denial as a behavioural and communicative phenomenon (2c). A logical analysis of the assessment process should provide evidence that the measure is assessing a behaviour. Use of observation, interviews, and past history are methods of behavioural assessment. To complete CID-SO ratings for any individual, one would include all of these forms of assessment.

The fourth conceptual use is to measure denial as distinctly different from social desirability, intelligence, or educational level (2d). This use could be examined by searching for evidence that is characterized by relationships to other variables (or lack thereof). These could be empirically supported through correlational studies to examine the relationship between denial and such ancillary (or irrelevant) variables. For instance,

a non-significant correlation with intelligence would provide discriminant evidence (i.e., support demonstrating that a variable is not related to a second variable).

The fifth and final conceptual use within this group is to identify specific patterns of denial (2e; see Tables 6 and 7). Any relevant literature that supports a multi-faceted definition of denial (rather than a dichotomous definition) would be relevant evidence. Furthermore, evidence that is based on test content and on the internal structure would also be deemed appropriate. Evidence that is based on test content would be a logical analysis of the relationship between the content of the CID-SO and the behaviour that the CID-SO is intended to measure. Evidence that is based on internal structure refers to the degree to which the relationships among test items and test components conform to the construct that the measure assesses. A relevant form of evidence might include finding adequate internal consistency for each CID-SO cluster. Another type of evidence may be to find low intercorrelations between the four clusters.

The third use of the CID-SO refers to the clinical or practical use of the measure to assess or predict treatment variables. Supportive evidence for this proposed use is important because often when a clinical measure is used it has implications for an individual. For example, he may be deemed ineligible to enter treatment or he may be considered a poor candidate and subsequently be treated differently by therapists. The 1999 Standards (AERA, APA, & NCME, 1999) calls this “evidence based on consequences of testing” (p. 16). To illustrate, if there is a significant correlation between treatment failure and denial, then one might use the CID-SO to recommend that some sex offenders not be given treatment as a result of their level of denial. However, this decision would be unacceptable if treatment failure and denial were unrelated or if their relationship were due only to a characteristic of the individual, that is, intelligence was found to be related to both treatment and denial. One form of evidence

that would be relevant to support this clinical use is “evidence of the relation of the test scores to a relevant criterion” (AERA, APA, & NCME, 1999, p. 14). If this dissertation empirically demonstrates that there are differences in denial as measured by the CID-SO between treated and untreated sex offenders, then support would be found for this use. A further approach, which is outside the scope of this dissertation, may be to examine the correlation between the CID-SO and other measures of readiness for treatment.

The fourth use is theoretical in nature, namely, to use the CID-SO to test hypotheses regarding denial currently in the literature. Evidence that would provide support for this use would include support that is based on the CID-SO’s relationship to other variables. These would be expected to be in the form of empirical findings. Because one of the uses for the CID-SO is to test several theories about denial that are of interest for me (as reviewed in Chapter Two), hypothesis testing was included in this dissertation. To date, there have been no empirical studies that have specifically examined the theoretical underpinnings of sex offender denial. As quoted earlier, Lund (2000) pointed out that “the underlying variability in the definition of denial” (p. 282) makes it difficult to test hypotheses at this time. However, with the development of a comprehensive measure of denial as in this dissertation, the theories proposed by Baldwin and Roys (1998) and Ward and his colleagues (Ward et al., 1995; Johnston & Ward, 1996) can be examined as described below.

First, Baldwin and Roys (1998) have suggested that only highly intelligent and educated offenders would exhibit lower levels of denial because it requires a greater degree of cognitive capacity to accept responsibility for one’s behaviour. This theory proposes that the following:

H₁ The offenders' estimated intelligence and educational level would correlate negatively with their level of denial for each cluster and the total score for the entire sample.

Second, according to the cognitive deconstructionist approach (Ward et al., 1995), sex offending and the maintenance of excuses and justifications that minimize offending are caused by one's need to reduce the cognitive dissonance associated with accepting responsibility. A sex offender often maintains some degree of denial to escape self-evaluation and evaluation by others. This theory therefore suggests the following hypothesis:

H₂ Personality measures of social desirability, self-monitoring, and self-esteem would correlate (positively for social desirability and self-monitoring and negatively for self-esteem) with various patterns of denial for all sex offenders (regardless of whether they offended against children or adults).

Third, according to schema theory (Johnston & Ward, 1996), everyone uses schemas to make interpretations about social behaviour. However, sex offenders have maladaptive attitudes or beliefs (i.e., schemas) about the legitimacy of sexualizing children or raping women. When a sex offender uses schemas to make interpretations about their offenses, he often makes errors in his thinking as a result of maladaptive schemas (e.g., that children are capable of consenting to sex). These schemas shape the way sex offenders view things and may lead to disastrous actions. This theory hypothesizes that, depending on the offense, maladaptive attitudes and beliefs would have different relationships to two patterns of denial—Denying the Need for Treatment/Management of Sexual Offending and Minimizing Harm. These relationships would emerge as follows:

- H₃ For child molesters, measures of distorted cognitions and attitudes about sexualizing children would correlate positively with Denying the Need for Treatment/Management of Sexual Offending and Minimizing Harm (i.e., Clusters B and D).
- H₄ For those who offended against adult females, measures of distorted cognitions and attitudes about forcing sex on women and gender roles would correlate positively with Denying the Need for Treatment/Management of Sexual Offending and Minimizing Harm (i.e., Clusters B and D).
- H₅ For all sex offenders, Denying the Need for Treatment/Management of Sexual Offending and Minimizing Harm (i.e., Clusters B and D) would correlate positively with measures of attitudes towards impersonal, exploratory, and sado-masochistic deviant sexual fantasies.

Summary

The CID-SO meets four criteria that define a good measure as shown in Chapter Three. But in order to establish a measure's reliability or to evaluate the validity of a measure's intended uses, one must gather multiple strands of evidence. This chapter provided a description of the overall research design. First, it is essential to evaluate the CID-SO's interrater reliability. This chapter also introduced the current perspective on validity (i.e., the 1999 Standards), presented four groups of intended uses of the CID-SO (methodological, conceptual, practical, and theoretical), and described the types of evidence required to evaluate the validity of each use. In the following two chapters, the method of gathering empirical evidence to evaluate the reliability of the CID-SO and the validity of its uses is described in Chapter Five and the overall results of this evaluation is provided in Chapter Six.

CHAPTER FIVE

METHOD

The goal of this dissertation is to develop a psychometrically sound instrument, the CID-SO, for defining and measuring denial in sexual offenders. This chapter will describe the method for gathering the evidence required for evaluating the reliability of the CID-SO and the validity of its proposed uses, as these uses were outlined in the previous chapter.

Participants

Fifty-two males who had been charged, convicted, and sentenced for a sexual offense participated in this study. The mean age of participants was 44.8 years old ($SD = 12.80$; range = 20.6 - 75.9 years); 40 were of Caucasian descent, and 12 were Aboriginal. Of these 52 offenders, 32 were serving a provincial sentence (i.e., they either received sentences to be served in the community or sentences of less than 2 years in jail). The other 20 offenders were serving a federal sentence (i.e., they received a sentence of incarceration for 2 years or more).

The sample included offenders who had and had not completed sex offender treatment because the instrument is intended for use with sex offenders at different stages of their treatment and because denial is seen as potentially changeable. Thirty-seven offenders had completed a sex offender program either in the community or in prison, 10 offenders had never entered such a program, and 5 offenders were going through a program at the time of participation. At the time of participation, 37 offenders were serving a community sentence, and 15 offenders were in a prison. Tables 8 and 9 summarize demographic, adjudication, offense, and treatment information.

Materials

Ten measures were used in this dissertation. Reasons for their inclusion, descriptive information about each measure, and psychometric properties of each measure are described in each sub-section. All psychometric information regarding the measures were from non-forensic samples, unless otherwise stated.

Comprehensive Inventory of Denial - Sex Offender Version

As described in Chapter Three, the Comprehensive Inventory of Denial - Sex Offender version (CID-SO, see Table 4) is an inventory that I developed to assess four distinct clusters of denial among sex offenders a. To use the CID-SO, an experienced clinician is expected to complete four steps: (1) review background information (e.g., file information, victim impact statements, police reports), (2) conduct a thorough assessment interview, (3) review the CID-SO manual, and (4) rate the 18 items on the CID-SO. The full Rating Guide (provided as Appendix A) contains a thorough description of each CID-SO item and criteria for each rating. The measure was developed specifically for this dissertation and therefore there was no previous psychometric data available.

Shipley Institute of Living Scale

The Shipley Institute of Living Scale (SILS; see Appendix B) was designed to assess general intellectual functioning in adults and adolescents (Harnish, Beatty, Nixon, & Parsons, 1994; Zachary, 1991). Baldwin and Roys (1998) proposed that lower levels of intelligence may correlate with higher levels of denial, which suggests that higher levels of intelligence should correlate with greater insight into their offense (and accepting more responsibility). The SILS was included to examine whether such a relationship exists. However, intelligence is considered by others to be a contaminant or artifact in personality tests, because it can produce spurious relationships with third

variables (e.g., Bavelas, 1978, pp. 101-102). So the SILS was included to sort out these contradictory hypotheses.

The SILS is a self-administered measure of intelligence that can be given either individually or in groups. The scale assesses overall intelligence by incorporating two components of intelligence, as measured by two separate subtests: a 40-item vocabulary test and a 20-item test of abstract thinking. In the Vocabulary subtest, the participants choose which of four possible words "means the same or nearly the same" as the given target word. In the Abstraction subtest, the participants are given a logical sequence and then fill in the numbers or letters that best complete the sequence. The total administration time for the test is 20 minutes, with 10 minutes allotted to each subtest.

Zachary (1991) examined various aspects of reliability in the SILS. The SILS had good internal consistency; Zachary found values from 0.84 to 0.92 for split-half reliability using the Spearman-Brown formula. He also demonstrated that the SILS has adequate temporal reliability: For the Vocabulary subtest, test-retest analyses with an interval of 2 weeks generated reliability coefficients of 0.31 to 0.77 (median $r(10) = .60$). For the Abstraction subtest, test-retest analyses with an interval of 2 weeks produced reliability coefficients of 0.47 to 0.88 (median $r(15) = .69$). For the Total Estimated IQ, temporal reliability with an interval from 2 to 16 weeks was 0.62 to 0.82 (median $r(15) = .78$). Because the subtests measure two different aspects of intelligence, correlations between them are expected to be high but not perfect. Zachary also found correlations between the Vocabulary and Abstraction subtests in the range of 0.31 to 0.60 (median $r(288) = .48$, $p < .001$). These values suggest that the subtests are assessing two different but related areas of intelligence.

Other studies have shown that the SILS correlates significantly with other measures of overall intelligence: Wechsler intelligence scales, $r_s = 0.73$ to 0.90 (e.g., median $r(288) = 0.78$, $p < .001$; Paulson & Lin, 1970), Raven's Progressive Matrices, $r(98) = 0.72$, $p < .001$ (Eisenthal & Hartford, 1971), Wide Range Vocabulary Test, $r(48) = 0.73$, $p < .001$ (Martin, Blair, & Vickers, 1979), and Kaufman Brief Intelligence Test, $r(48) = 0.83$, $p < .001$ (Bowers & Pantle, 1998; Zachary, 1991).

Personality Variables

According to the cognitive deconstructionist approach (Ward et al., 1995), denial and minimization are caused by one's need to reduce the cognitive dissonance associated with accepting responsibility for one's actions. This need may be represented by several personality characteristics. The three instruments described below were included in this dissertation in order to measure the extent to which the participants respond in a socially desirable fashion (presumably untruthfully), the extent to which the participants monitor their behaviour and adjust it to the situation, and the participants' self-esteem. These measures were expected, according to Ward's model, to correlate positively with denial (recall H_2 of Chapter Three). Although Ward and his colleagues propose that personality variables, such as social desirability, would correlate with denial, I have previously mentioned that a criterion of a good measure is usually that it does not correlate with social desirability. It is important to note and test these contradictory predictions.

Balanced Inventory of Desirable Responding

The Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1984; see Appendix C) is a 40-item questionnaire with 7-point Likert-type scales for each item. The BIDR was designed to assess two components of socially desirable responding: Self-Deception and Impression Management. The first factor, Self-Deception, measures

the extent to which the respondent actually believes his or her positive self-reports while the second factor, Impression Management, measures the extent to which the respondent consciously portrays him- or herself as socially desirable (Paulhus, 1984).

Research has demonstrated that the instrument has good internal consistency. For example, Kroner and Weekes's study (1996) produced an alpha coefficient of 0.74 for the self-deception factor and 0.84 for the impression management factor ($N = 539$). Nugent and Kroner (1996) found further support for a two-factor model of social desirability; both factors were significantly but moderately correlated with one another, $r(96) = 0.58, p < .001$. No studies have examined the temporal stability of the instrument.

Several studies have investigated the relationship between the BIDR factors and other measures purported to assess social desirability. The self-deception factor correlated significantly with the defensiveness scale on the Basic Personality Inventory both for child molesters, $r(47) = 0.49, p < .01$, and for rapists, $r(47) = 0.58, p < .001$ (Nugent & Kroner, 1996), with the Marlowe-Crowne Scale, $r(423) = 0.29, p < .001$, and with the Lie Scale of the Minnesota Multiphasic Personality Inventory, $r(423) = 0.31, p < .001$ (Paulhus, 1984). The impression management factor correlated significantly with the defensiveness scale on the Basic Personality Inventory both for child molesters, $r(47) = 0.58, p < .01$, and for rapists, $r(47) = 0.68, p < .001$ (Nugent & Kroner, 1996), with the Marlowe-Crowne Scale, $r(423) = 0.50, p < .001$, and with the Lie Scale of the Minnesota Multiphasic Personality Inventory, $r(423) = 0.39, p < .001$ (Paulhus, 1984). Furthermore, Kroner and Weekes (1996) found that the self-deception factor correlated significantly with the "grandiose sense of self" item of the Psychopathy Checklist, $r(77) = 0.33, p < .001$, and Holden, Starzyk, McLeod, and Edwards (2000) found that the BIDR

scores could correctly classify over two-thirds of test responders either as responding honestly or as faking.

Self-Monitoring Scale

Snyder (1974, 1987; Snyder & Gangestad, 1986) developed the Self-Monitoring Scale (SMS; see Appendix D), which purports to measure the extent to which participants monitor and regulate their expressive behaviour and self-presentation. High self-monitors are inclined to adjust their behavior to the situation, whereas low self-monitors are more likely to respond consistently across situations. The SMS is an 18-item questionnaire.

The SMS has been shown to have good internal consistency with reliability coefficients ranging from 0.70 to 0.75 (Ahmed, Garg, & Braimoh, 1986; Snyder, 1974). Factor analytic studies, however, have been less than consistent. For example, Ahmed et al. (1986) found that three factors account for 66% of the variance, but Gabrenya and Arkin (1980) found up to nine factors. Snyder (1974) found that the SMS has good temporal stability, $r(81) = 0.83$, $p < .001$ (one month interval) and correlates with peer ratings of self-monitoring, $r(14) = 0.45$, $p < .05$. The SMS did not correlate with peer ratings of ingratiation or likeability (Snyder, 1974). In the same study, the peers of high self-monitors described their friends as good at learning what is socially appropriate in new situations, as having good self-control of their emotional expression, and as effective in their use of this ability to create the impressions that they want to create (Snyder, 1974).

DeBono (1987; DeBono & Edmonds, 1989) has shown that self-monitoring is related to the experience of dissonance. For example, high self-monitors only reduce their dissonance when their behaviours are in disagreement with the values of their peer group but not when in disagreement with their self-concept. On the other hand, low self-

monitors only reduce their dissonance when their behaviours are in disagreement with their own values but not with their peers. According to the cognitive deconstructionist model, high self-monitoring sex offenders would be expected to deny or minimize their offending. It is therefore relevant to examine whether a person's level of self-monitoring is related to their pattern of denial.

Rosenberg Self-Esteem Scale

The Rosenberg Self-Esteem Scale (RSES; see Appendix E) is a measure of general feelings of self-worth (Rosenberg, 1965, 1979). The RSES assesses a person's overall evaluation of himself across time and situations. Individuals with high RSES scores would likely respect, accept, and positively evaluate themselves. In contrast, respondents with low RSES scores will likely evaluate themselves negatively. The RSES is a 10-item questionnaire, and each item is scored on a 4-point scale, ranging from strongly agree to strongly disagree.

Research suggests that the RSES has good internal consistency (alphas = 0.59 to 0.88; Fleming & Courtney, 1984; Francis & Wilcox, 1995; McCarthy & Hoge, 1982), and the scores from the RSES are temporally stable, with correlation coefficients ranging from 0.82 to 0.85 over a two-week test-retest period (all p s < .001; N s = 44 to 259; Fleming & Courtney, 1984; Rosenberg, 1979; Silber & Tippett, 1965). In addition, the scores on the RSES have been shown to correlate positively with scores on other self-esteem measures, such as the Lerner Self-esteem Scale ($r(10) = 0.72$, $p < .01$; Savin-Williams & Jaquish, 1981) and the global self-worth subscale of Harter's Self-Perception Profile for Adolescents ($r(73) = 0.75$, $p < .001$; Hagborg, 1993). RSES correlates negatively with scores on the Coopersmith Self-esteem Inventory, on which low scores indicate high self-esteem and high scores indicate low self-esteem (for boys, $r(312) = -0.47$, $p < .001$, and for girls, $r(486) = -0.54$, $p < .001$; Francis & Wilcox, 1995). The

RSES has also been shown to be unrelated to other variables that would not be expected to correlate with global self-esteem, such as stability of perceptual speed (Silber & Tippett, 1965), depression and anxiety (Fleming & Courtney, 1984), and grade point average in school (Fleming & Courtney, 1984). However, there seems to be a lack of correlation between the RSES and behavioural methods of assessing self-esteem, such as observer ratings, $r(33) = 0.01$, ns, and peer ratings, $r(33) = -0.17$, ns (Savin-Williams & Jaquish, 1981). This lack of significant findings may not be surprising because self-report measures are often not correlated to behavioural measures (Pervin, 1994).

Murphy and Page (2000) proposed that low self-esteem is associated with feelings of powerlessness and a “poor me” stance often taken by an offender. The inclusion of the RSES may help to assess the relationship, if any, between self-esteem and the minimization of sexual offending.

Deviant Attitudes

Several measures that assess deviant attitudes towards sexual offending and deviant sexual interests are described in the next three sub-sections.

Measures of Attitudes about Child-Adult Relations

The following instruments measure the extent to which offenders endorse maladaptive attitudes or beliefs about the legitimacy of sexualizing children. Recall Johnston and Ward's (1996) theoretical proposition that sex offenders may use erroneous schemas in their thinking in order to make re-interpretations about their offenses; these attitudinal measures were included in order to examine their relationship to the expression of denial.

Revised Cognition Scale. The Revised Cognition Scale (RCS; Laws, 1994) is an adaptation of the Sex with Children Scale (SCS; Marshall, 1989) and assesses the

endorsement of problematic attitudes that are supportive of adult-child sexual relations (see Appendix F). The RCS has 40 items, and each item is a statement related to child molestation (e.g., "Having any sexual experience with a child is always wrong"), which offers five comments about the content of the statement. The respondent is to choose one of the five comments that most closely matches his own reaction to that statement. The scores are tallied for each of the five comments, which represent specific categories.

The first category measures the respondent's endorsement of attitudinal statements that are conservative in nature and deny any child sexuality (e.g., "Sex with children is against the law, and that is all there is to it"). The second category includes statements that are neither sexual nor deviant in nature (e.g., "Many children have experiences they could do without"). The third category refers to statements that may be sexual in nature but not deviant (e.g., "Sexual experience is something that should occur naturally with peers when a child is growing up"). The fourth category measures the endorsement of statements about children and sex that are both deviant and sexual in nature (e.g., "If an adult is seduced into a sexual relationship by a willing, enthusiastic child, he can hardly be blamed for that"). The fifth category measures the endorsement of statements that are directly supportive of adult sex with children (e.g., "Some children encourage sex with adults because they know that they need the experience"). These categories are mutually exclusive and the total of all scores on the five categories add up to 40. It is important to note that this instrument has never been field tested. Statistical data pertaining to the psychometric properties of this scale are not yet available. The absence of reliability findings may, in part, be due to the difficulty with calculating the internal consistency of the RCS. Because the response choices are mutually exclusive (i.e., the five choices are not independent of the others; e.g., if one chose category A for

an item, that would mean categories B, C, D, and E would receive a zero) and the scales are intra-item (i.e., certain choices within each item were totaled across all items) rather than inter-item (i.e., certain items total to one subscale), traditional approaches of calculating reliability would be inappropriate (e.g., Nunnally, 1967). In the RCS, there are five categories for each item:

1. Conservative/denial of child sexuality category
2. Nonsexual/nondeviant category
3. Nondeviant/sexual category
4. Deviant/sexual category
5. Category which directly supports adult-child sexual relations.

Hence, in attempt to calculate the internal consistency of this instrument, the scoring of the items was conducted differently than the scoring proposed by the developer of the instrument (Laws, 1994). Each choice within an item was assigned a value from 1 to 5. One (1) referring to the most conservative of the choices (i.e., conservative/denial of child sexuality) and five (5) to the most deviant choice (i.e., statements which directly support adult/child sex). The responses of participants who refused to choose only one category for an item were not included in the internal consistency analyses, reducing the total sample from 52 to 39.

MOLEST Scale. The MOLEST Scale (Bumby, 1996; Appendix G) purports to measure the cognitive distortions that sex offenders may hold regarding the sexual molestation of children. A limited number of items from this scale were derivations of items from the Abel and Becker Cognition Scale (Abel et al., 1989), although none was identical (i.e., some items were taken from the Burt scale, re-worded, and included in the MOLEST Scale). The scale is a 38-item questionnaire that uses a 4-point Likert-type scale that ranges from "strongly disagree" to "strongly agree".

Bumby's research (1996) indicated that the MOLEST Scale has good internal consistency with an alpha coefficient of 0.97 and good test-retest reliability with an $r(87) = 0.84$, $p < .001$, over a two-week period ($N = 89$). Bumby (1996) has also shown that the scale correlated with similar cognition scales, such as the Abel Cognition Scale ($r(87) = -0.54$, $p < .001$), as well as the Cognitive Distortions/Immaturity subscale, ($r(87) = 0.47$, $p < .001$), and the Lie Scale: Child Molest subscale of the Multiphasic Sex Inventory ($r(87) = -0.51$, $p < .001$). The MOLEST Scale was shown not to correlate with social desirability as measured by the Marlowe-Crowne Scale ($r(87) = -0.01$, ns ; Bumby, 1996).

Measures of Attitudes Towards Women

The following instruments measure either the extent to which offenders endorse maladaptive attitudes or beliefs about the legitimacy of raping women or their attitudes about the female sex role. Johnston and Ward (1996) proposed that these attitudes may cloud the way offenders view events, especially their offenses; therefore, these attitudinal measures were included to examine their relationship to the expression of denial.

RAPE Scale. The RAPE Scale (Bumby, 1996; Appendix H) measures a respondent's endorsement of rape myths (i.e., beliefs that condone sexually assaultive behaviours) that are commonly reported by sexual offenders. A limited number of items in this scale are derivations of the items from the Burt Rape Myth Acceptance Scale (Burt, 1980), although none was identical. The RAPE Scale is a 36-item questionnaire in which each item is scored on a 4-point Likert-type scale, ranging from strongly disagree to strongly agree.

Bumby (1996) found that the RAPE scale has good internal consistency with an alpha coefficient of 0.97 and good temporal stability over two weeks, $r(87) = 0.86$, $p <$

.001 ($N = 89$). Although the scale did not correlate with the Burt Rape Myth Acceptance Scale ($r(87) = 0.12$, ns) or the Multiphasic Sex Inventory's Lie Scale: Rape ($r(87) = -0.04$, ns), it did correlate moderately with two other attitudinal subscales from the Multiphasic Sex Inventory, the Cognitive Distortions/Immaturity subscale ($r(87) = 0.33$, $p < .05$) and the Justifications subscale ($r(87) = 0.34$, $p < .05$). As was found with the MOLEST Scale, the RAPE Scale did not correlate with social desirability, as measured by the Marlowe-Crowne scale ($r(87) = -0.02$, ns; Bumby, 1996).

Burt Attitude Scales. Three of the five Burt Attitude Scales were used to assess stereotypic and adversarial attitudes about women (Burt, 1980; see Appendix I). The first scale, Sex Role Stereotyping (SRS) measures the extent to which respondents endorse traditional sex roles in familial, work, or social settings and includes nine questions. The second scale, Adversarial Sexual Beliefs (ASB), measures the extent to which respondents endorse the attitude that sexual relationships are fundamentally exploitive and has nine questions. The third scale, Sexual Conservatism (SC), assesses a respondent's attitudes about the restrictions regarding the appropriateness of sexual partners, of sexual acts, and of circumstances under which sex should occur. The SC scale has ten questions. Respondents answer each question on a 7-point scale, ranging from strongly agree to strongly disagree. Each of the three scales is totalled separately.

Burt (1980, 1983) has found that the SRS, the ASB, and the SC have good internal consistency (Cronbach's alphas = 0.80, 0.80, and 0.81, respectively; $N = 598$). No studies have examined the temporal stability of the scales. All three scales correlated significantly with the Burt Rape Myth Acceptance Scale ($r(596) = 0.48$, 0.40, and 0.39, all $ps < .001$, respectively; $N = 598$). These findings were from a non-forensic sample.

Measure of Attitudes about Sexual Fantasies

A scale was specifically designed for the present study, called the Appropriate Sexual Fantasies Scale (ASFS; see Appendix J). Although some of the items on the ASFS were taken from the Wilson Sexual Fantasy Questionnaire (WSFQ; Wilson, 1978), the ASFS asks a different question; the WSFQ asks respondents how many times they have had a particular fantasy, whereas the ASFS asks respondents how appropriate would it be for someone to have such a fantasy. Therefore, the scale used in this dissertation measured the extent to which offenders endorse certain sexual fantasies as appropriate. The reason for the amendment to Wilson's original scale (1978) was because, according to Johnston and Ward's theory (1996), attitudes may cloud the way offenders view events; therefore, I was looking for a measure that would assess a respondent's attitudes about certain types of sexual fantasies rather than a respondent's reported practice of sexual activities.

Given the theoretical proposition that the endorsement of deviant sexual fantasies may affect how sex offenders interpret situations and perceive people (Johnston & Ward, 1996), this questionnaire is included to examine the relationship between attitudes about types of sexual fantasies and the exhibition of denial. The ASFS has 40 items that are grouped into four themes: intimate, exploratory, impersonal, and sado-masochistic. Participants rate each item on a 7-point scale, ranging from extremely inappropriate to extremely appropriate.

Because the ASFS was developed for this dissertation, no psychometric data is available. However, some research is available on Wilson's original scale, the WSFQ. Wilson and Lang's study (1981) employed a factor analysis, which produced four types of fantasies. These four fantasy themes were positively correlated, and all were more commonly reported by men, with the exception of the intimate theme. Wilson (1988)

also found that high levels of sexual activity and libido were associated with a greater amount of fantasy, as measured by the WSFQ. The WSFQ was shown to be able to distinguish between “variant” men (i.e., men belonging to various clubs that cater for unusual sexual interests) and a control group (i.e., men from the general public) with the former scoring higher on sado-masochistic, impersonal, and exploratory fantasies; the groups did not differ on intimate fantasies (Gosselin & Wilson, 1980; Gosselin, Wilson, & Barrett, 1991). A recent study by Baumgartner, Scalor, and Huss (2002) showed that child molesters had higher scores on the exploratory and intimate fantasy factors than nonsexual offenders. There have been no studies examining temporal stability.

Procedure

Prior to recruiting participants, I obtained approval from the University of Victoria's Human Research and Ethics Committee (Appendix K), the Forensic Psychiatric Services Commission (Appendix L), and the Correctional Service of Canada (Appendix M). I fully informed each participant about the nature of the study and what would be involved in their participation. After participants gave signed consent to participate in the study and to allow me to review their institutional or forensic files (see Appendix N), I began by reviewing the background information in their files and by documenting their demographic information (e.g., gender, age, educational level). A session was subsequently scheduled to interview each participant and to have them complete the paper-and-pencil questionnaires.

Because I had a Master's degree in Clinical Psychology and three years' experience in clinical interviewing at the time I started collecting data, I assessed and interviewed each participant. The interview for the CID-SO was semi-structured and included a series of standard questions aimed at whether the participant had minimized any part of his offending or his deviant sexual arousal (see Appendix O for an outline of

the interview protocol). These interviews ranged from 35 minutes to 1.5 hours. I subsequently reviewed the CID-SO manual each time and completed a CID-SO rating sheet for each participant. A second clinician who also has a Master's degree in Clinical Psychology attended 11 of my 52 interviews. This second clinician independently reviewed file information and completed the CID-SO in order to establish inter-rater reliability.

Based on the interview and collateral information (e.g., file review, police reports, any victim statements, past psychological reports), I assessed and rated each participant on the CID-SO. Because of the reputation that forensic and institutional participants have for "conning" (Scully & Marolla, 1984), it was also necessary to establish the extent to which their responses deviated from independent descriptions of their crimes. To do so, the second clinician and I used the same technique that others have used in offender research: comparing the offender's version of the offenses with documented information, such as details of the crime obtained from police, victim, and pre-sentence reports. This procedure allowed us to identify any discrepancies between the offenders' accounts and the victims' or the police's versions of the crime.

Following each interview, participants were administered the Shipley Institute for Living Scale, which usually took 10 to 20 minutes. Each participant then completed the battery of questionnaires described above (i.e., BIDR, SMS, RSES, RCS, MOLEST Scale, RAPE Scale, SRS, ASB, SC, and ASFS). The participants spent approximately 45 minutes to 2 hours completing these questionnaires. Afterwards, I fully debriefed each participant about the study (see Appendix P for Debriefing).

CHAPTER SIX

EVALUATION OF RELIABILITY AND THE VALIDITIES FOR METHODOLOGICAL,
CONCEPTUAL, AND PRACTICAL USES

This chapter will report the reliability of the CID-SO and the validation findings for the methodological, conceptual, and practical uses and interpretations of the CID-SO. Chapter Seven will report the findings for the validity of the hypothesis testing use. All empirical analyses used an alpha of .05 as the level of significance. Although most predictions were specific in terms of direction, two-tailed tests were used to provide a correction for the multiple analyses conducted on the data.

Reliability

Because measurement error is an important issue, investigations of reliability are essential when new measures are developed. For an instrument to be useful, it must produce consistent results across different raters. This is called interrater reliability and is particularly pertinent for measures that are based on (potentially) subjective ratings, such as the CID-SO.

Both I (rater 1) and another clinician (rater 2) independently completed the CID-SO for 11 participants. The mean CID-SO total score of this sub-sample of sex offenders was 17.00 (SD = 11.76) for me and 15.00 (SD = 12.88) for the second clinician, which did not differ statistically ($p > .05$). For both raters, the range of total scores fell between 4 and 34. For the 11 participants, means and standard deviations for each item by each rater are listed in Table 10. Means and standard deviations for the CID-SO clusters and total CID-SO score by each rater are listed in Table 11.

Table 12 presents the interrater reliability, which was assessed using three different statistics. Percentage agreement was calculated for each CID-SO item. The sample was divided into the number of cases (out of 11) in which there was (a) complete

agreement (i.e., both persons rated an item exactly the same), (b) 1-point disagreement (i.e., rater 1 and rater 2 scored an item differently but their ratings differed by one point only), and (c) complete disagreement (i.e., 2-points off, where one person rated an item 0 and the other rated the same item a 2). Figure 1 shows the level of agreement for each item. Across all items, complete agreement ranged from 7 to 11 cases. That is, for every item, the two raters were in complete agreement for at least 7 of the 11 participants and often for all 11 of them. Complete disagreement was infrequent, that is, the raters differed by the maximum 2 points only on six items. Hence, the percentage agreement values revealed that interrater reliability was adequate for the interview-based CID-SO.

Kappa is a statistic indicating the proportion of agreements between raters after chance agreement has been removed; it is a conservative reliability measurement used with ordered scales (Cohen, 1960; Rosenthal & Rosnow 1991). Because the individual items on the CID-SO are rated from 0 to 2, the kappa statistic could be used to examine the reliability of each item. There were five items (items 2, 10, 12, 14, 18) for which meaningful kappa values could not be obtained due to low score variability (e.g., ratings of 0 or 1 were given for that item but not a rating of 2). All other kappa values were significant (range = 0.44 to 0.95, $ps < .05$).

Pearson correlation coefficients were calculated for the clusters because there was sufficient variability within each cluster (i.e., a composite of items that could range from 0 to 8 or 10), and for the overall total score (i.e., a composite of all item ratings, potentially ranging from 0 to 36; ranges of variability are listed in Table 11). The Pearson correlation coefficient is sensitive to the degree to which the raters agreed or disagreed (Keppel, Sautley, & Tokunaga, 1992). For example, if one person rated items within a cluster so as to yield a total of 6 and the other person rated items in that cluster

to a total of 3, this level of disagreement would be greater than if the first person had arrived at a total of 6 and the other at 5. The Pearson correlation coefficients for all four clusters and the total score were greater than 0.90, and all were significant (p s < .001). Correlations ranged from 0.91 (Cluster C: Denying Responsibility) to 0.95 (Cluster B: Denying Need for Treatment/Management of Sexual Offending).

In summary, interrater reliability was found to be moderate to good for most items on the CID-SO and excellent for each cluster and the overall total CID-SO rating.

Although the 11 offenders were assessed by both me and the second clinician, only my ratings (rater 1) were used in the validity analyses below.

Validity

Recall from Chapter Four that the Standards for Educational and Psychological Testing (AERA, APA, & NCME, 1999) were substantially changed in 1999 to place test uses (as defined by a conceptual framework) in the forefront of validation and to move validity categories (e.g., content validity) to the background. As a result, the remainder of this chapter and all of Chapter Seven focus on the validation findings for the four groups of proposed uses of the CID-SO as previously listed in Table 7. The following three sections will evaluate the first three groups of uses of the CID-SO.

Validity 1: Methodological Use of the CID-SO

The first group of uses of the CID-SO is methodological. These methodological uses include the use of a measure that has the capacity to combine several sources of data and not just the sex offender's self-report (1a), that captures clinical judgment and experience (1b), and that has demonstrated interrater reliability (1c). The evidence gathered to support these uses is evaluated and described in the following sections.

Use of Several Sources of Data (1a)

The first methodological use for the CID-SO is to rate sex offender denial by combining several sources of data, including verbal, behavioural, and collateral information. A logical analysis can assess this methodological use. As outlined in Chapter Three, the assessment procedure requires that these sources of data are reviewed before the interview. The first step is the review of file and collateral information, such as the criminal history, the police account of the offense, and interviews with parole/probation officers, family, or friends. The second step is the completion of a thorough intake assessment interview, focused on the degree to which the offender's version of his offense deviates from independent descriptions of his offense. The advantages of the interview format (versus a written statement) are that the clinician is able to pay attention to behavioural and communicative aspects of the offender's responses and also to probe and clarify when necessary. The third and fourth steps include a review of the CID-SO manual and the rating of all 18 CID-SO items, respectively. These mandatory steps in the CID-SO assessment procedure make use of multiple sources of data.

Expert Clinical Judgment (1b)

The second methodological use for the CID-SO is to measure sex offender denial by using expert clinical judgment, rather than using self-report inventories. As for the methodological use described above, a logical analysis of the assessment process is the appropriate way to evaluate this use. Recall from Chapter Three that the assessment process requires that the clinician have experience working with sex offenders and conducting clinical interviews. In this dissertation, two clinicians with Master's degrees in Clinical Psychology who were experienced with sex offenders and with clinical interviewing completed the CID-SO forms. The CID-SO manual clearly

indicates that “completing the items on the CID-SO requires that the practitioner has had some experience in the provision of psychological services within a forensic or correctional setting to sexual offenders” (see Appendix A). Hence, the completion of the CID-SO items requires clinical judgment and experience.

Reliable Assessment (1c)

The third methodological use refers to demonstrating that the CID-SO has good interrater reliability for the expert’s clinical judgment. Adequate interrater reliability coefficients would provide the strongest support for this methodological use. As discussed in the Reliability section of this chapter, two clinicians independently completed the CID-SO for 11 participants, and our ratings were analyzed using three different statistics—percentage agreement for each CID-SO item, kappa statistic for each item, and Pearson correlation coefficients for the clusters and overall total score. The findings revealed that interrater reliability was moderate to good for most items on the CID-SO and excellent for each cluster and the overall total CID-SO rating.

Validity 2: Conceptual Use of the CID-SO

The second group of uses of the CID-SO is conceptual and includes its use to measure denial for all types of sex offenders, to assess denial as a dynamic variable, to assess denial as a behavioural and communicative phenomenon, to measure denial as distinctly different from other variables, and to identify specific patterns of denial.

Specific Use with Sex Offenders and All Kinds of Sex Offenders (2a)

The first conceptual use for the CID-SO is to measure sex offender denial and to assess denial for all types of sex offenders. Three forms of evidence to support this use are described and evaluated below.

Test Content. As discussed in Chapter Three, I specifically designed the CID-SO to assess denial among sex offenders. The items included in the inventory were

based both on my experience working with sex offenders and on the literature on denial. The items sample characteristics of the behavioural phenomenon of denial that are potentially seen among sex offenders and not the general population of offenders. Several items are specific to sexual offending. For example, items 4, 12, and 13 focus on sexual arousal associated with the crime, which would be absent from other types of nonsexual offenses (e.g., domestic violence, armed robbery). If the other items were read in the abstract, they could be applied to other non-sexual crimes, but the topic in the interview is the sexual offense.

Furthermore, the CID-SO is applicable to all types of sex offenders, such as child molesters, exhibitionists, and rapists. The items are phrased in such a way as to avoid the specifics of their offense (e.g., “denies sexual arousal during current offense”). This level of generality allows each item to apply to all sex offenders. For example, item 4, “focuses on acceptable or nonsexual behaviours”, could apply to an exhibitionist who may claim that he was just urinating in the bush and not exposing himself and to a child molester who may claim that he was checking for sores or mosquito bites and that he did not touch the victim in a sexual manner. Hence, a logical analysis of the CID-SO’s content demonstrates support for its specific use with sex offenders and for its use with all types of sex offenders.

Broad Sample. The sample of 52 males included a broad range of sex offenders with varying characteristics as summarized earlier, in Table 9. This included offenders who were given provincial or federal sentences, who committed various sexual offenses (e.g., child molestation, voyeurism, rape), who offended against child or adult victims, who targeted male or female victims, and who were either in the community or in a prison. It is this broad range of characteristics that provides further support for the CID-SO’s use with all types of sex offenders.

Differences Between Categories of Offenders. To examine whether the CID-SO could be used with different types of offenders, I focused on two bases for categorizing offenders: the age of the victim (child vs. adult) and the type of sentence that the offender was given (provincial vs. federal sentence).

We would expect, first, that if a measure should not be used with a group, then items in that measure would not cohere and therefore internal consistency for one group would be poor. Lack of consistency within a measure seriously interferes with that measure's utility in applied assessment situations. Internal consistency is determined by calculating Cronbach's alpha, which provides the upper limit for this kind of reliability:

If it proves to be very low, either the test is too short or the items have very little in common [emphasis added]. In that case there is no need to make other estimates of reliability, because they will prove to be even lower. If, for example, coefficient alpha is only .30 for a 40-item test, the experimenter should reconsider his measurement problem and begin test construction anew. (p. 210, Nunnally, 1967)

The internal consistencies of the CID-SO clusters and total rating were calculated for each subgroup and for the total sample. Table 13 lists Cronbach's alphas for each cluster and CID-SO total by each subgroup. Internal consistencies of the total CID-SO rating were found to be good for all subgroups (range = 0.93 to 0.97). If one examines the internal consistencies of the clusters, the items within each cluster appear to cohere adequately for all subgroups.

Second, I also compared CID-SO scores for child versus adult victim offender groups and for provincially versus federally sentenced offenders. Often, if a measure produces arbitrarily different scores for different groups, one would then assume that it should not be used with that particular group. However, it is also possible that the

measure may be valid for both groups and reveal genuine differences between groups. The means and standard deviations for each cluster and for the CID-SO total are listed in Table 14 for the full sample and for the sub-samples.

Analysis by t -test revealed that total CID-SO ratings did not differ significantly between child molesters and adult offenders and between provincial and federal offenders (all p s > .05). Moreover, there were no significant differences between provincial and federal offenders for any of the four clusters (all p s > .05). There were also no differences between child molesters and adult offenders for Clusters A and C (all p s > .05). However, significant differences were found for the age of the victim on Clusters B and D. Adult offenders exhibited greater denial for the need for treatment or management of sexual offending (Cluster B), $t(50) = 2.05$, $p < .05$, and greater minimization of harm to their victims than child molesters (Cluster D), $t(50) = 2.16$, $p < .05$.

These differences in denial patterns (denying need for treatment/management and minimizing harm) may be genuine differences between child molesters and adult offenders and may not necessarily lessen the validity of using the CID-SO with all kinds of sex offenders, including child molesters and adult offenders. For example, Nugent and Kroner (1996) found that rapists were more likely to partially deny their offense than child molesters, and they attributed this difference to the type of denial used by offenders:

The difference in admission between child molesters and rapists can be attributed to the greater number of partial deniers among rapists (23 vs. 13 child molesters). Furthermore, the type of partial denial was different between rapists and child molesters. Child molesters tended to deny the extent of the offense, whereas rapists denied the degree of force. (p. 482).

Nugent and Kroner's findings are consistent with my results, indicating that there are real differences in denial patterns between child molesters and adult offenders (e.g., rapists). Therefore, the differences found in this dissertation are likely a reflection of real group differences and not a result of poor validity for the conceptual use for the CID-SO as an instrument for all kinds of sex offenders.

Summary. The test content, the broad sampling used in this research, the good internal consistencies of the CID-SO clusters and total rating for two categories of offenders, and the lack of difference between provincial and federal offenders help support the contention that the CID-SO measures sex offender denial among all types of sex offenders. The pattern of significant differences between child and adult offenders suggests that these are likely to be real differences and not due to differential applicability of the CID-SO to the two groups.

Dynamic Characteristic (2b)

The second conceptual use for the CID-SO is to assess denial as a dynamic or changeable variable. Two forms of evidence that were gathered to support this use are reported below.

Test Content. Examining the procedure and item content of the CID-SO should provide evidence that the measure is truly measuring a dynamic phenomenon. Three aspects of the CID-SO support this contention.

First, I developed the CID-SO to treat denial as a behaviour rather than as a fixed mental state. The clinician is expected to review file information and then interview the sex offender and observe the communicative aspects of the offender's expression of accepting responsibility. The intent behind this procedure, unlike other measures (e.g., FoSOD, SOARS, DAMS), is to compare and contrast the file information about the offense and to evaluate the sex offender's expression of responsibility in light of the file

information. This communicative expression of the offense by the offender is by nature behavioural rather than a fixed attitude, because it may change the next time he is interviewed.

Second, the content of the CID-SO measures behavioural phenomena that are influenced by various factors. As was seen in Table 4, the items refer to a person's level of admission or denial at the time of the assessment. For example, item 12, "denies deviant arousal and fantasies", does not ask whether or not the offender has deviant arousal and fantasies, but rather it asks if, in this interview, the offender admits, partially or fully, or denies that he has such deviant interests. The offender could change what he says about himself and about his deviant interests during another assessment at another time.

Third, each item on the CID-SO (e.g., "lacks feelings of guilt and embarrassment") as well as each point for that item (e.g., "feels guilt and embarrassment for committing the offense(s)") are written in present tense. Items written in the present tense remind clinicians that any rating given to a particular offender on the CID-SO is intended to assess his pattern of denial at this time rather than to provide a global and stable assessment of denial.

This logical analysis of the procedure and the CID-SO's content provide some support for its use to measure denial as a changeable variable.

Difference Between Treated and Untreated Offenders. Another method of gathering evidence to support the use of the CID-SO for assessing denial as a dynamic or changeable variable is to compare the item ratings between treated and untreated offenders. First, I would expect that treated and untreated sex offenders would differ in their CID-SO rating, specifically, that untreated offenders would deny to a greater degree than treated offenders. The means and standard deviations for each cluster and for the

CID-SO total are listed in Table 15 for the full sample and for the treated and untreated sub-samples. As expected, untreated participants had higher means for denying overall (total CID-SO rating), $t(50) = 2.67$, $p < .01$. Furthermore, untreated participants also had higher means for each cluster (Cluster A, $t(50) = 2.52$, $p < .05$; Cluster B, $t(50) = 2.78$, $p < .01$; Cluster C, $t(50) = 2.03$, $p < .05$; Cluster D, $t(50) = 2.54$, $p < .05$).

Second, if a measure should not be used with different groups, such as treated and untreated sex offenders, we would expect that the internal consistency would be poor for one or both groups. As seen in Table 16, internal consistencies were adequate for both treated and untreated sex offenders (Cronbach alphas = 0.77 to 0.95 for treated offenders, 0.57 to 0.93 for untreated offenders).

In light of the consistent differences found between treated and untreated offenders and the adequate internal consistencies for both groups, the CID-SO appears to measure denial as a dynamic phenomenon that could be influenced by treatment.

Summary. The content of the CID-SO and the means comparisons between treated and untreated offenders provide support for the conceptual use of the CID-SO to measure denial as a dynamic characteristic.

Behavioural and Communicative Assessment (2c)

The third use for the CID-SO is to assess denial as a behavioural and communicative phenomenon because denial is a communicative behaviour. This use was examined through a logical analysis of the assessment process. As discussed in Chapter Five, to use the CID-SO, an experienced clinician is expected to review background information and to conduct a thorough assessment interview. Prior to rating the 18 items on the CID-SO, the clinician should make behavioural and communicative observation of the offender and compare and contrast the file information about the offense and the observations from the interview. Most importantly, in an interview, a

clinician is given the opportunity to observe and to listen to an offender, thereby accessing both metacommunicative attributes of the verbal message and the content of the message (Goffman, 1959). Only two other denial measures, the Denial and Minimization Checklist (DMC; Barbaree, 1991) and the Denial Scales and Ratings measure (Kennedy & Grubin, 1992), include both file information and behavioural observations in their assessment of denial, although there is no psychometric data on the DMC. By gathering information about an offender through interviews and collateral information, a clinician is able to thoroughly assess an offender's expression of denial. In this way, denial is treated as a behaviour rather than as an attitude or belief (i.e., a cognitive construct).

Distinct from Other Variables (2d)

The fourth conceptual use for the CID-SO is to measure denial as distinctly different from social desirability, intelligence, or educational level. As discussed in Chapter Four, this use can be evaluated by gathering empirical evidence, specifically correlational analyses, to examine the relationship between denial and each of these three variables. Social desirability was assessed using the Self-Deceptive Enhancement (SDE) and the Impression Management (IM) scales of the Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1984). Intelligence was assessed with the Shipley Institute for Living Scale (SILS; Zachary, 1991), and educational level was measured by the years of education completed.

Correlational analyses confirmed that there was no significant relationship between the CID-SO and Self-Deceptive Enhancement (all p s > .05); correlation coefficients are listed in Table 17. Similar non-significant results were found between three of the four clusters (i.e., Clusters A, C, and D) and the IM scale and between the total CID-SO rating and IM scale (all p s > .05). A small positive correlation emerged

between Cluster B (i.e., denying the need for treatment or management of sexual offenders) and Impression Management, $r(50) = 0.28$, $p < .05$, suggesting that those concerned with impression management tended to deny the need for treatment or management of their sexual offending. As shown in Table 17, no significant relationships emerged between the CID-SO clusters and intelligence or between the CID-SO total score and intelligence (all $ps > .05$). Similarly, no significant correlations were found between education and the CID-SO clusters or between education and the CID-SO total score (all $ps > .05$; see Table 17).

Table 18 lists the descriptive statistics for the SDE and IM scales of the BIDR, for intelligence, and for education. Psychometric analysis of this sample revealed that the SDE scale had adequate reliability (Cronbach's alpha = 0.71). Similarly, the IM scale showed very good reliability (Cronbach's alpha = 0.83). The two subscales correlated significantly with one another, $r(50) = 0.51$, $p < .001$. For the SDE and IM scales, no significant differences emerged between child molesters and those who offended against adults, between provincial and federal offenders, or between treated and untreated offenders (all $ps > .05$). Similarly, means comparisons revealed no differences in intelligence between these same categories (all $ps > .05$). With regard to education, no differences emerged between provincial and federal offenders or between treated and untreated offenders (all $ps > .05$). However, a significant difference in education emerged between child molesters and adult offenders, $t(50) = 2.71$, $p < .01$; those who offended against children had significantly fewer years of education (on average they had a grade 10 education) than those who offended against adults (on average they had a grade 12 education).

Hence, the lack of relationship between most of the CID-SO clusters and the CID-SO total score with social desirability, intelligence, and education provides support

that the CID-SO assesses denial as distinctly different from other confounding variables. The only significant correlation that emerged—between denial of need for treatment or management and impression management—was small and may be indicative of a real relationship that exists between the desire to impress someone and the defensive action of not wanting help. Thus, this finding may not call into question the validity of the measure itself.

Patterns (2e)

The fifth and final conceptual use for the CID-SO is to identify specific patterns of denial. Three forms of evidence to support this use are described below.

Previous Literature. Historically, denial has been characterized as a dichotomous phenomenon. More recently, several published works have appeared in the literature proposing a multi-faceted definition of denial (as opposed to a dichotomous definition). Theoretical contributors to the literature, such as Ann Salter and Richard Laws, posit that denial is a “complex, multifaceted phenomenon” (Salter, 1988, p. 110) and that denial is “distributed along a continuum from categorical denial to full admission...between these poles lies a graded continuum containing various degrees of minimization and other self-protective statements” (Laws, 2002, p. 2). Moreover, empirical research that examines sex offender denial are beginning to use multi-faceted rather than dichotomous measures of denial. Several researchers have attempted to construct measures with multiple facets that were either clinician-rated or self-rated. An early attempt to design such a measure was Barbaree’s clinician-rated Denial and Minimization Checklist (DMC; Barbaree, 1991, 2000). The DMC divided denial into three types and minimization into three types, listed earlier in Table 2. Kennedy and Grubin (1992) developed a seven-item measure of denial, which could identify three patterns of denial: denial of harm to victims, externalizers, and internalizers (see Table

3). More recent attempts to measure denial include self-rating measures, such as the Denial and Minimization Scale (DAMS; Eccles, Stringer, and Marshall, 1997), Sex Offender Acceptance of Responsibility Scale (SOARS; Peacock, 2000), and Facets of Sexual Offender Denial (FoSOD; Schneider & Wright, 2001)—all of which measure multiple patterns of denial. Hence, the literature appears to support a multi-faceted definition of denial.

Test Content. Based on my clinical experience working with sex offenders and on the previous literature on sex offender denial, I created 18 items that were intended to assess denial comprehensively. Then, based on previous research (especially Barbaree, 1991; Kennedy & Grubin, 1992; Salter, 1988) and my clinical experience, I sorted these items into four different patterns, as shown in Table 5, namely,

- ❖ Cluster A – Denying Sexually Deviant Behaviours and Arousal
- ❖ Cluster B – Denying Need for Treatment or Management of Sexual Offending
- ❖ Cluster C – Denying Responsibility for the Offense
- ❖ Cluster D – Minimizing Harm Done by the Offense

The development and inclusion of these clusters provide initial support for the conceptual use of the CID-SO to measure patterns of sex offender denial.

Internal Structure. To explore whether the CID-SO identifies specific patterns of denial, evidence should also include empirical support for the internal structure of the measure. Specifically, one should investigate the degree to which the relationships among test items and test components conform to the hypothesized cluster. One requirement would be to find high correlations among items within each cluster (i.e., internal consistency for each CID-SO cluster). Another requirement would be to find lower correlations between the clusters. Both requirements are deemed relevant, and the findings are described here.

The internal consistency of the total CID-SO score was 0.95, so the CID-SO has excellent internal consistency. Within each cluster, the alpha values, as listed in Table 19, indicated that the clusters have good internal consistency as well. Coefficients ranged from 0.73 to 0.91.

Intercorrelations were also calculated among the four clusters of the CID-SO and the total CID-SO rating. The findings revealed extremely high correlations among the clusters, on the order of their internal consistencies, suggesting that the clusters were not distinct or independent of one another, that is, did not capture distinct patterns of denial within the CID-SO measure, as I had originally hoped. Intercorrelation coefficients are listed in Table 19.

Items for each cluster had been conceptually grouped to assess a particular pattern of denial. However, based on the a priori analysis, this conceptual use was not supported; their intercorrelations were too high. Kane (2001) recommended that if proposed uses are not supported by empirical or logical evidence, then the “interpretive argument...may be improved by adjusting the interpretation and/or the measurement procedure” (p. 330). Therefore, the four clusters of denial were subsequently further analyzed.

The a priori analyses (the values in Table 19) included all participants from the study. I noted that several of these participants either completely denied having even been present at the incident, or they admitted to being present but denied committing the sexual offense. I hypothesized that this group of offenders could be affecting the data. To illustrate, the first type of full denier could be represented by Andrew, a 61-year-old male who has a lengthy history of voyeuristic behaviour in women’s public bathrooms. During the interview, Andrew denied his recent offense, which was peeping in women’s bathrooms at a local shopping center, and his previous sexual offenses, which included

peeping into women's stalls on the university campus. He completely denied having ever been present at the scene of these crimes, so that (according to him) he could not have committed any of the offenses for which he had been charged and convicted. Andrew denied 17 of the 18 CID-SO items, with the exception of item 14 (i.e., "shows defensive or excessive hostility") and received a CID-SO rating of 34.

The second type of full denier could be represented by Brad, a 27-year-old male convicted for sexually touching his younger half-sister. Brad admitted to being alone with his sister and playing non-sexual games, such as board games, but completely denied ever touching her. He focused entirely on non-sexual activities, emphasizing that he had "never [been] interested in children" and that the charge is "completely made up." He also denied 16 items on the CID-SO, with the exception of items 2 (i.e., denies sex offending history") and 14 (i.e., "shows defensive or excessive hostility"), and received a CID-SO rating of 32.

These two types of full deniers would obviously have high ratings on the CID-SO (i.e., 32 and above) and may represent a distinct cluster of deniers. Although they are not necessarily outliers—many who have worked with sexual abusers would say that these individuals are common among their sex offending clientele—they may have skewed the correlations, that is, they would consistently have high scores on all items and clusters. Such consistently high scores would greatly influence the correlations among clusters. Therefore, it would make sense to re-analyze the intercorrelations within and between the clusters without these full deniers.

Nine participants with CID-SO ratings of 32 and above were considered full deniers and were removed. New internal consistencies and intercorrelations between clusters were calculated (see Table 20). When the full-deniers are removed from the sample, the intercorrelation coefficients now fall within a reasonable range (between

0.24 to 0.60), supporting the notion that each cluster may be a distinct entity. However, the internal consistencies for Clusters A, B, and C also dropped substantially (from 0.73—0.82 to 0.41—0.50). In contrast, only Cluster D remained high (dropping only from 0.91 to 0.84) and still met the criterion of higher internal consistency correlations than between-cluster correlations. This effect is probably due to curtailment of range, and the difference between Cluster D and the other clusters permits us to test whether the cause is indeed likely to be curtailment of range. As shown in Table 21, the standard deviations for all four clusters become smaller when the full-deniers are excluded, which demonstrates that there is indeed curtailment of range. However, Cluster D is distinct in three respects: The range is unchanged (0-8); the ratio of the restricted standard deviation to the unrestricted standard deviation is highest for this cluster (0.77); and the absolute value of the restricted standard deviation is still high (2.41). In other words, it appears that some of the remaining participants also minimized harm to their victims to the same degree as the full-deniers did. As a result, there was still sufficient variation in the remaining sample that curtailment did not reduce the correlations to the same degree as for Clusters A, B, and C. This internal evidence strongly supports the interpretation that the failure to validate all four clusters empirically is due to the presence of full deniers and their unique effect on Clusters A, B, and C.

Having demonstrated the cause of the problem, the question becomes what to do about it? One possibility would be to leave the full deniers out of the sample, that is, to use their total CID-SO score only to identify them and then proceed to further analyses with the remainder of the sample. However, considering the above evidence, it was concluded that it is not appropriate to exclude the full deniers from the sample for two reasons. First, the curtailment of range would be severe, as shown in Table 22, and would affect all future correlations. Second and more important, they are a legitimate

and essential part of the sample in any measure of denial. They are necessary to meet the standard that the CID-SO applies to all sex offenders. To illustrate by an analogy, eliminating the highest values would be like eliminating all high (or low) IQ's from the validation of a wide-range intelligence test. Therefore, they must be included and their inevitable effects understood. As a result, at present, there can be only logical but not empirical evidence for three of the four clusters.

On the positive side, the CID-SO can detect all levels of denial, from minimizing to full denial. Also, there will be an effect of full deniers on relationships within the CID-SO, but there is no reason to expect an effect on the relationship of the CID-SO to other variables. That is, there is no artifactual reason for the full deniers to respond as a group on any other variable—unless there is a real relationship. Furthermore, leaving out the full deniers would both severely limit the possibility of finding any relationship with other variables, again because of curtailment of range, and it would produce a skewed and unrepresentative sample of the population of offenders with regard to denial.

Summary. The literature and the test content provided support for the four clusters, but it was disconcerting that empirical analyses did not support three of the four clusters. Although high correlations emerged among items within each cluster, equally high correlations emerged among the clusters. It was shown that the full deniers influenced these correlations among clusters. However, the removal of these participants led to a curtailment of range. Furthermore, the intention behind developing the CID-SO was to assess all patterns of denial, including complete denial of having even been present at the offense and denial of committing the offense. Hence, it was not feasible to remove these complete deniers from the sample. Despite the lack of empirical evidence to support the three clusters, A, B, and C, the 18 items of the CID-SO can themselves be used to conceptualize the comprehensive nature of sex offender

denial, and the three logically supported clusters and the empirically-supported cluster D can identify multifaceted expressions of denial.

Validity 3: Use for Assessing Treatment Variables

The third use of the CID-SO is to assess treatment variables, such as treatment progress or outcome. A relevant form of evidence to support this practical use of the CID-SO is whether there is a demonstrated difference in denial between treated and untreated sex offenders. In an earlier section of this chapter, a comparison between treated and untreated sex offenders showed that untreated offenders had both higher means for all four clusters (all $t_s(50) > 2.0$) and higher overall total CID-SO rating ($t(50) > 2.0$) than treated offenders; see Table 15. Hence, the results lend support to the practical use of the CID-SO to assess treatment variables.

Summary

This chapter reported the reliability of the CID-SO and the validity of three of its four proposed uses. The findings supported the interrater reliability of the CID-SO. The logical and empirical evidence gathered also supported the group of methodological uses to combine several sources of data, to capture clinical judgment and experience, and to give reliable ratings among different raters. Four of the five conceptual uses of the CID-SO were supported by the evidence; however, the internal structure of three of the four CID-SO clusters did not meet the criterion of higher internal consistency correlations than between-cluster correlations. Nonetheless, the CID-SO demonstrated that it can detect all levels of denial. Furthermore, the evidence supported the practical use of the CID-SO to assessment treatment progress. The following chapter will report the validity findings of the use for hypothesis testing.

CHAPTER SEVEN

EVALUATION OF VALIDITY: USE OF CID-SO FOR HYPOTHESIS TESTING

This chapter will continue the validation findings for the proposed uses and interpretations of the CID-SO, specifically, the uses of the CID-SO to test hypotheses.

Validity 4: Use for Hypothesis Testing

The fourth and final proposed use of the CID-SO is to test hypotheses about denial that are currently found in the literature. Three theories of denial were described in Chapter Two: cognitive capacity, cognitive deconstruction, and the schema theory. To test these theories, the following sections evaluate each hypothesis (H_1 to H_5) and also include psychometric data as well as correlations among other relevant measures.

Cognitive Capacity (H_1)

The first theory of denial examined in this dissertation proposes that denial is associated with lower intelligence and fewer years of education (Baldwin & Roys, 1998). This theory predicted that denial, in its various forms, would correlate negatively with intelligence and education. As shown in Table 17, there were no significant relationships between the CID-SO clusters or total score and the estimated IQ or the years of education; all p s > .05.

As described in Chapter Five, Table 18 shows the means and standard deviations of the IQ's as estimated by the Shipley Institute for Living Scale (Zachary, 1991) and of the years of education, for the whole sample and by the age of the victim, by the severity of adjudication, and by the treatment status.

The first two lines of Table 22 show the relationship of these two variables with each other and with all other measures. As one would expect, intelligence and education were correlated significantly and positively with one another, $r(46) = 0.42$, $p < .01$. They also correlated significantly with the same two attitudinal questionnaires; the

RAPE Scale and the MOLEST Scale were correlated negatively both to intelligence and to education. Less educated offenders or those with lower estimated IQ's tended to endorse sexually deviant attitudes about rape and child molestation.

Cognitive Deconstruction (H₂)

The second theory of denial is the cognitive deconstructionist approach (Ward et al., 1995). These researchers proposed that the pressure to accept responsibility for the offending behaviours causes cognitive dissonance, which can be resolved by the use of excuses and justifications. This suggests that denial, in any form, would be positively associated with personality characteristics that enable one to escape the discomforts of self-evaluation and evaluation by others. These personality characteristics include a high need to appear socially desirable, high self-esteem, and high self-monitoring.

Social Desirability

The tendency to respond in a socially desirable manner was assessed by two questionnaires, the Self-Deceptive Enhancement (SDE) and the Impression Management (IM) scales of the Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1984). The cognitive deconstructionist approach predicts that social desirability would correlate positively with all patterns of denial. This prediction was not supported, as shown in the correlations listed in Table 17; most p s > .05. The only significant relationship that emerged was a small positive correlation between IM and Cluster B (i.e., denying the need for treatment or management of sexual offending), $r(50) = 0.28$, $p < .05$. Offenders who reported a greater concern with impression management tended to deny the need for treatment or management of sexual offending.

Table 18 lists the descriptive statistics for the BIDR. Psychometric analysis revealed that the SDE scale had adequate reliability (Cronbach's alpha = 0.71). Similarly, the IM scale showed good reliability (Cronbach's alpha = 0.83). The two

subscales correlated significantly with one another, $r(50) = 0.51$, $p < .001$. There were no significant differences among subgroups: between child molesters and those who offended against adults; between provincial and federal offenders; or between treated and untreated offenders; all $ps > .05$.

Correlations between the social desirability scales and all other measures are listed on lines 3 and 4 of Table 22. The SDE scale correlated positively with RSES and the conservative category of the RCS; those with tendencies to self-deceive were more likely to have higher self-esteem and conservative views of child sexuality. The SDE scale also correlated negatively and significantly with three other categories of the RCS: nondeviant and sexual views of child sexuality, deviant and sexual views, and directly supportive views on adult-child sexual relations. These results suggest that individuals who were more self-deceptive were less likely to endorse adult-child sexual relations. Another negative and significant correlation emerged between the SDE scale and the Adversarial Sexual Beliefs scale, suggesting that individuals who were more self-deceptive were less likely to report that they expected sexual relationships to be characteristically exploitive. The IM scale correlated negatively with the SMS, implying that persons who had greater tendencies to consciously appear socially desirable (i.e., manage their impression) were less likely to adjust their behaviour to the situation (i.e., self-monitor).

Self-Monitoring

Self-monitoring was assessed using the Self-Monitoring Scale (Snyder, 1974). As shown in Table 23, the expected positive correlation between the CID-SO clusters or the total score and the self-monitoring questionnaire did not emerge; all rs were nonsignificant.

The internal consistency of the Self-Monitoring Scale (SMS) was adequate (Cronbach's alpha = 0.78). Descriptive statistics are presented in Table 24. No significant differences emerged between subgroups by victim age, by severity of adjudication, or by treatment status; all $ps > .05$.

Correlational analyses of the SMS and other measures are listed on line 5 of Table 22 and show that the SMS correlated negatively and significantly with three other measures: the IM scale of the BIDR, the RAPE scale, and the SC scale (i.e., sexual conservatism). These correlations suggest that, surprisingly, individuals who tended to self-monitor were less concerned with impression management; they also endorsed fewer deviant rape attitudes, and were less conservative towards sex.

Self-Esteem

The Rosenberg's Self-Esteem Scale (RSES) was employed to assess the offender's self-esteem (Rosenberg, 1979). As with the previous two personality variables, the cognitive deconstructionist approach predicted a negative correlation with the CID-SO. However, no significant correlations emerged in support of this prediction, as shown in Table 23.

The RSES had good internal consistency (Cronbach's alpha = 0.86). Descriptive statistics are shown in Table 24; there were no significant differences in self-esteem between child molesters and those offenders against adult victims, between provincial and federal offenders, or between treated and untreated sex offenders; all $ps > .05$.

The RSES did correlate significantly with several other measures; see line 6 of Table 22. The RSES correlated positively with the SDE scale of the BIDR and negatively with measures assessing deviant attitudes, including the RAPE scale, the ASB scale, the SC scale, deviant and sexual attitudes about sexualizing children as measured on the RCS, and the MOLEST Scale. Hence, individuals with high self-

esteem tended to be more self-deceptive but had fewer deviant attitudes that endorsed rape and child molestation and were less sexually conservative.

Schema Theory: Child Molestation and Cognitive Distortions (H₃)

This section and the following two sections examine the third theory, the schema theory, which proposes that a sex offender holds deviant, maladaptive beliefs that legitimize sexual offending (Johnston & Ward, 1996). According to the schema theory, these beliefs may lead to attempts to deny or minimize offending by justifying or rationalizing the behaviour. The theory would therefore predict that two forms of denial, downplaying one's need for treatment (Cluster B) and minimizing any harm to the victim(s) (Cluster D), would be associated with greater endorsements of distorted cognitions and attitudes about sexualizing children, about forcing sex on women, and about engaging in deviant sexual fantasies. In this section, two attitudinal measures designed to assess deviant cognitions about the legitimacy of sexualizing children were included. These measures were included in order to examine the prediction that sex offenders, particularly child molesters who exhibit certain patterns of denial (i.e., Cluster B and D), would endorse distorted cognitions and attitudes about sexualizing children.

Revised Cognition Scale

The Revised Cognition Scale (RCS) assesses problematic attitudes that support adult-child sexual relations (Laws, 1994). The first hypothesis, as would be predicted by the schema theory, proposed that Clusters B (i.e., denying the need for the treatment or management of sexual offending) and D (i.e., minimizing harm) would correlate positively with the latter three cognitively distorted categories, nondeviant and sexual, deviant and sexual, and directly supportive of adult/child sex.

For the total sample of sex offenders, this prediction was not supported; all $ps > .05$. Correlation coefficients are listed in Table 25. However, unexpected findings were

found for the subgroup of child molesters; the second category of the RCS, nonsexual and nondeviant, correlated positively to Clusters C and D, suggesting that child molesters who denied responsibility or minimized harm were more likely to endorse nondeviant and nonsexual statements regarding child-adult relations (e.g., "Many children have experiences they could do without"). Furthermore, the same nonsexual and nondeviant category of the RCS and the total CID-SO score correlated positively. The remaining four of the five RCS categories were not significantly correlated to CID-SO clusters or to the total score.

Psychometric analysis of the RCS revealed that the internal consistency of the instrument (calculated as described in Chapter Five) was adequate (Cronbach's alpha = 0.78). Intercorrelations are listed on lines 7 through 11 of Table 22. The conservative/denial of child sexuality category correlated negatively with the nondeviant/nonsexual category, $r(37) = -0.79$, $p < .001$, and the nondeviant/sexual category, $r(37) = -0.75$, $p < .001$. As expected, the deviant/sexual category positively correlated with the category that directly supports child sexual abuse, $r(37) = 0.47$, $p < .01$. Means and standard deviations for each category are listed in Table 26. The t-tests revealed no differences for any of the five categories between child molesters and those who offended against adult women, despite the fact that the instrument was intended to identify deviant attitudes of child molesters; all $ps > .05$. Nor were there significant differences between subgroups by type of adjudication (provincial vs. federal) or by treatment completion (treated vs. untreated); all $ps > .05$.

Correlational analyses between the RCS categories and all other measures in this study are shown on lines 7 to 11 of Table 22. The first category, conservative views that deny any child sexuality, correlated positively with the SDE scale of the BIDR and negatively with the exploratory category of the ASFS, suggesting that those who had

conservative views that did not support child-adult sexual relations were more likely to attempt appearing socially desirable and were also less likely to have had fantasies with exploratory themes. The second category, nonsexual and nondeviant, did not significantly correlate with any of the other measures (all p s > .05).

The third category, nondeviant and sexual, correlated positively to the intimate category and the exploratory category of the ASFS and the SRS scale and negatively with the SDE scale of the BIDR. The fourth category, deviant and sexual, correlated positively with the RAPE scale, the MOLEST scale, and the ASB scale (i.e., adversarial sexual beliefs) and negatively with the SDE scale of the BIDR and the RSES. Finally, the category with items that support child-adult sexual relations correlated positively with the MOLEST scale and negatively with the SDE scale of the BIDR, suggesting that those who supported sexualizing children were more likely to endorse deviant attitudes about child molestation and were less likely to be self-deceptive.

MOLEST Scale

The MOLEST scale assesses deviant attitudes that condone sexualizing children (Bumby, 1996). Based on the schema theory, I predicted that Clusters B and D would positively correlate with the MOLEST scale; however, this hypothesis was not fully supported. No significant correlations emerged between the CID-SO and the MOLEST scale for the total sample as shown in Table 27; all p s > .05. However, partial support was found among the subsample of child molesters. Of the CID-SO clusters and the total score, only Cluster D correlated positively with the MOLEST scale, $r(34) = 0.36$, $p < .05$. Child molesters who minimized the harm to their victim were likely to have attitudes that supported child molestation.

The internal consistency of the MOLEST scale was shown to be very good (Cronbach's $\alpha = 0.94$). The descriptive data from this study's sample are listed on

the bottom line of Table 26. The t-tests revealed no group differences on the MOLEST scale by victim age, by severity of adjudication, and by treatment completion; all p s < .05.

Correlations with other measures are presented on line 12 of Table 22. The MOLEST scale correlated positively with the RAPE scale, with two RCS categories supporting child-adult sexual relations, with the ASB scale, and with the SC scale. Those who endorsed attitudes towards sexualizing children were more likely to endorse attitudes that legitimize rape, child-adult sexual relations, sexually exploitive relationships, and sexual conservatism. The MOLEST scale also correlated negatively with the SDE scale of the BIDR, the RSES, intelligence, and level of education, suggesting that offenders who supported sexualizing children were less inclined to self-deception, and tended to have higher intellect and education and to have high self-esteem.

Schema Theory: Offenders Against Adults and Cognitive Distortions (H₄)

This section also reports evidence to examine the Schema Theory but with a focus on deviant cognitions and attitudes about rape and adult women. I will also discuss the relationship between deviant cognitions and certain patterns of denial (specifically, Clusters B and D).

RAPE Scale

The RAPE scale assesses attitudes about rape (i.e., beliefs that condone sexually assaultive behaviours; Bumby, 1996). The original hypothesis that Clusters B and D of the CID-SO would be positively correlated to the RAPE scale was partially supported, as shown in Table 28. For the total sample, the RAPE scale correlated positively with Cluster A, $r(50) = 0.32$, $p < .05$, Cluster C, $r(50) = 0.42$, $p < .01$, Cluster D, $r(50) = 0.30$, $p < .05$, and the total CID-SO score, $r(50) = 0.35$, $p < .05$, but not with

Cluster B, $p > .05$. Hence, offenders who denied committing sexually deviant behaviours (Cluster A), denied responsibility (Cluster C), minimized harm (Cluster D), and overall denied (total CID-SO score) were likely to have beliefs that endorsed sexually assaultive behaviours. Contrary to prediction, for the subgroup of offenders who victimized adult women, the RAPE scale did not correlate significantly with denial; all $ps > .05$.

Psychometric analysis showed that the RAPE scale is a reliable measure (Cronbach's alpha = 0.95). As seen in Table 29, no significant differences on this scale emerged between child molesters and offenders against adult women, between provincial and federal offenders, and between treated and untreated offenders; all $ps < .05$. Bumby (1996) also found that rapists (i.e., offenders against adults) do not significantly differ in their rape beliefs from child molesters.

As seen on line 13 of Table 22, the RAPE scale correlated positively to the MOLEST scale, the deviant and sexual category of the RCS, the Adversarial Sexual Beliefs scale, and the Sexual Conservatism scale. Those who endorsed rape attitudes were more likely to endorse child molestation attitudes and exploitive and conservative sexual relationships. The RAPE scale also correlated negatively with the Self Deception Enhancement scale of the BIDR, the Self Monitoring Scale, the Rosenberg Self-Esteem Scale, the intimate category of the Appropriate Sexual Fantasy Scale, intelligence, and level of education. Hence, those who endorsed rape attitudes tended to have lower intelligence, less education, and lowered self-esteem. They also were less inclined to self-deception, to self-monitor, and to report intimate-type fantasies.

Burt Attitude Scales

Three of Burt's attitudinal scales (1980) were included in this study: Sex Role Stereotyping (SRS), which measures attitudes about traditional sex roles; Adversarial Sexual Beliefs (ASB), which assesses attitudes about exploitive relationships, and

Sexual Conservatism (SC), which assesses conservative attitudes about sex. Based on the schema theory, my prediction was that for the total sample and for the subsample of offenders who victimized adults Clusters B and D of the CID-SO would correlate positively with the SRS and ASB scales and correlate negatively with the SC scale (given the direction of the scale; i.e., higher scores on the SC scale suggest greater sexual conservatism and therefore less distorted views of sex). Only one significant correlation emerged from the 30 coefficients calculated (see Table 30). The ASB scale correlated positively and significantly with Cluster C of the CID-SO, suggesting that those who denied responsibility for their sexual offending tended to endorse the expectation that sexual relationships are fundamentally exploitive; $r(50) = 0.32, p < .05$.

The internal consistency of the SRS and SC scales was low (Cronbach's alpha = 0.56 and 0.63, respectively). The internal consistency of the Adversarial Sexual Beliefs (ASB) scale was high (Cronbach's alpha = 0.86). Comparisons of means revealed that child molesters tended to have more conservative views of sex roles than offenders against adult victims; $t(50) = 2.01, p < .05$. The ASB and SC scores did not differ significantly by victim age, by severity of adjudication, or by completion of treatment (all $ps > .05$). For all three attitudinal scales no significant differences were found between provincial and federal offenders and between treated and untreated offenders (all $ps < .05$). Means and standard deviations are listed in Table 29.

Correlations of Burt's attitudinal scales with other measures are listed in Table 22. On line 14 of Table 22, the SRS scale correlated positively with the nondeviant and sexual category of the RCS, suggesting that those with traditional views of sex roles are more likely to carry nondeviant and sexual attitudes toward child-adult sexual relations. On line 15 of Table 22, the ASB scale correlated positively with the SC scale, the MOLEST scale, the RAPE scale, and the deviant and sexual category of the RCS. It

also correlated negatively with the SDE scale of the BIDR and the RSES. These findings suggest that individuals who endorsed exploitive sexual relationships also endorsed attitudes that support child molestation and rape but they were less inclined to self-deception and more inclined to have low self-esteem. Similar to the pattern seen with the ASB scale, the SC scale correlated positively with the ASB scale, the MOLEST scale, the RAPE scale, and the deviant and sexual category of the RCS (as seen on line 16 of Table 22). The SC scale also correlated negatively with the SMS and the RSES.

Schema Theory: Deviant Sexual Fantasies (H₅)

A measure of one's attitudes towards particular types of fantasies was developed for this dissertation and called the Appropriate Sexual Fantasy Scale (ASFS). My hypotheses that Clusters B and D would correlate significantly with the impersonal and exploratory fantasy themes and not with intimate or sado-masochistic themes were not supported; correlation coefficients are listed in Table 31. The sado-masochistic fantasy theme correlated negatively with Cluster B, denying the need for treatment or management of sexual offending, suggesting that the less likely the offenders were to endorse the appropriateness of sado-masochistic fantasies, the more they denied the need for treatment, $r(50) = -0.31$, $p < .05$. For all other comparisons, $ps > .05$. However, the intimate, impersonal, and exploratory fantasy themes did not significantly correlate with the clusters or the total score of the CID-SO.

The internal consistencies of all fantasy factors were good (Cronbach's alphas for intimate theme = 0.90, impersonal theme = 0.71, exploratory theme = 0.76, sado-masochistic theme = 0.78). All fantasy factors were correlated positively with each other as seen on lines 17 to 20 of Table 22. Means and standard deviations for the four fantasy themes of the ASFS are provided in Table 32, where the data are divided into subgroups according to victim age, adjudication, and treatment status. When factor

scores were compared between subgroups, only the sado-masochistic fantasy factor differed significantly between child molesters and offenders against adult victims. Child molesters endorsed the appropriateness of having sado-masochistic fantasies more than those who offended against adults; $t(50) = 3.27, p < .01$.

Returning to lines 17 to 20 of Table 22, the intimate fantasy theme correlated positively with the SRS scale and the nondeviant/sexual category of the RCS and negatively with the RAPE scale. Those who endorsed relatively normal or intimate fantasies were more likely to endorse traditional sex role stereotypes and sexual/nondeviant views of child-adult sexual relations but they were less likely to endorse attitudes that legitimize rape.

Both the impersonal and sadomasochistic fantasy factors correlated positively with the SRS scale, thereby suggesting that those who endorsed impersonal fantasies (e.g., sex with strangers) or sado-masochistic fantasies (e.g., bondage) would endorse more traditional sex role stereotypes. The exploratory fantasy factor correlated positively with the SRS and the nondeviant and sexual category of the RCS and negatively to the conservative category of the RCS.

Summary

Three theories proposed in the current literature were outlined in Chapter Two, and five hypotheses derived from them were evaluated in this chapter. The first hypothesis (H_1), derived from the cognitive capacity theory, proposed that offenders' estimated intelligence and educational level would correlate negatively with their level of denial for each cluster and the total score for the entire sample. This hypothesis was not supported by the findings. It appears that sex offender denial functions independently from intelligence and education. The second hypothesis (H_2), from the cognitive deconstructionist theory, proposed that personality variables, social desirability, self-

monitoring, and self-esteem, would correlate with patterns of sex offender denial. Only one correlation was significant.

Schema theory yielded three hypotheses. One hypothesis (H_3) proposed that, for child molesters, measures of distorted cognitions and attitudes about sexualizing children would correlate positively with denying the need for treatment and minimizing harm. Only one correlation emerged significant for one of the two measures used. Another hypothesis (H_4) proposed that, for those who offended against adult females, measures of distorted cognitions and attitudes about women would correlate positively with denying the need for treatment and minimizing harm. The empirical findings did not support this hypothesis. The last hypothesis (H_5) proposed that, for all sex offenders, denying the need for treatment and minimizing harm would correlate positively with measures of attitudes towards impersonal, exploratory, and sado-masochistic deviant sexual fantasies. Only limited support (for sado-masochistic deviant sexual fantasies) emerged from the results.

Within these theories, the overt behaviour of denial is attributed to cognitive capacity, personality characteristics, or cognitive distortions, which have been traditionally assessed through self-report measures. However, previous research suggests that sexual offenders carry cognitive distortions that inhibit them from having insight into their behaviours; that is, they either are unable to acknowledge or are unaware of their own behaviours (Cortoni & Marshall, 2001; Jenkins-Hall & Marlatt, 1989). Hence, self-report measures may not provide useful information about their behaviours, particularly the behavioural aspects of denial, and this explains, in part, the lack of correlations between behavioural measures, such as the CID-SO, and self-report measures.

In sum, the fourth proposed use of the CID-SO is hypothesis testing, and it appears that it can be used this way. The finding that the cognitive theories examined in this dissertation were minimally supported may reflect the complex and somewhat illusory relationship between cognition and behaviour. Alternatively, the results may simply reflect a lack of empirical support for the hypotheses themselves. The next and final chapter will elaborate on and discuss the implications of the methodological, conceptual, practical, and hypothesis testing uses of the CID-SO.

CHAPTER EIGHT

DISCUSSION

The primary focus of this dissertation was the development and evaluation of a new clinically-relevant measure of sex offender denial. Conceptually derived, the Comprehensive Inventory of Denial – Sex Offender version (CID-SO) included several criteria that were not fully met by other extant measures of denial. This dissertation also evaluated the reliability of the CID-SO and the validity of its uses and interpretations. This chapter will summarize the development of the CID-SO and the reliability and validity findings and then consider limitations of this dissertation, clinical implications, and future directions.

Development and Evaluation of the CID-SO

My conceptualization of denial is as a multifaceted, behavioural phenomenon that includes the way in which a sex offender denies sexually deviant behaviours and arousal, denies the need for treatment, denies responsibility, and minimizes the harm done to his victim. In recent decades, the sex offender literature has evolved from a dichotomous view of sex offender denial as present or absent to a multifaceted view. This change is reflected in some of the most recent measures of sex offender denial (e.g., FoSOD; Schneider & Wright, 2001). However, many of these extant measures are self-report questionnaires that assess denial as an attitude rather than focusing on the communicative and behavioural aspects of denial. I have proposed that denial is ultimately manifested behaviourally and therefore our assessment of denial should include both the content of the spontaneous verbal message and its metacommunicative attributes (e.g., tearfulness, tone of voice). Few measures exist that employ an interview approach to assessment, and those that do exist are either not empirically validated

(e.g., DMC; Barbaree, 2000) or are not comprehensive enough to assess denial as a multifaceted phenomenon (e.g., Denial Scales and Ratings; Kennedy & Grubin, 1992).

In addition to developing the CID-SO interview, I also constructed a comprehensive assessment procedure, in which clinicians review file and collateral information, conduct a thorough interview, review the CID-SO manual (Appendix A), and then rate the 18 items on the CID-SO. Specifically, I included six criteria in my design of the CID-SO. A new and better measure of denial should measure denial in all types of convicted sex offenders, measure both behavioural and communicative aspects of denial, assess multiple facets of denial, use judgments of experienced clinicians, have acceptable reliability levels, and have acceptable validities. The remainder of my dissertation focused on evaluating the reliability of the CID-SO and the validity of its uses—many of which address the criteria listed.

First, the reliability analyses provided strong support for the interrater reliability of the CID-SO. Second, validity analyses focused on four groups of proposed uses of the CID-SO: methodological, conceptual, practical, and hypothesis-testing uses. Logical and empirical evidence provided support for the three methodological uses: to rate denial by combining several sources (1a); to measure denial by using expert clinical judgment (1b); and to assess denial reliably (1c). Five conceptual uses of the CID-SO were also evaluated. Evidence was found supporting four of the five uses. These included the use of the CID-SO to measure sex offender denial and to assess denial for all types of sex offenders (2a), to assess denial as a dynamic or changeable variable (2b), to assess denial as a behavioural and communicative phenomenon (2c), and to measure denial as distinctly different from other variables (2d). However, only logical evidence (i.e., previous literature and test content) provided support for the fifth conceptual use of the CID-SO to identify specific patterns of denial (2e). Probably

because of the effect of “total deniers”, there was a lack of empirical evidence to support three of the four conceptual patterns (denying sexually deviant behaviours and arousal, denying need for treatment or management of sexual offending, and denying responsibility for the offense). For the practical use of the CID-SO to assess treatment variables, empirical evidence supported the use of the CID-SO to assess differences between treated and untreated sex offenders.

The fourth use of the CID-SO was to test hypotheses about denial. Cognitive capacity, cognitive deconstruction, and schema theories were found in the literature (Baldwin & Roys, 1998; Johnston & Ward, 1996; Ward et al., 1995) and were tested using CID-SO. Five hypotheses were derived from these theories and tested. No support emerged for the cognitive capacity prediction that better education and higher intelligence would be related to admissions of responsibility (H_1). Minimal evidence was found to support theories of cognitive deconstruction, which propose that denial is associated with one’s need to reduce negative self-evaluations by maintaining low levels of meaning (H_2). Mixed support emerged for the third theory, schema theory. Schema theory proposes that because sex offenders use schemas to make interpretations about their offenses, they often make errors in their thinking as a result of maladaptive schemas. Hence, faulty offense-specific schemas (e.g., about child-adult sexual relations) were expected to lead to denial. Support emerged for faulty schemas about molesting children (H_3) and about sado-masochistic deviant sexual fantasies (H_5), but no support was found for schemas about rape (H_4). Although it appears that the CID-SO can be used to test hypotheses, mixed support was found for two of the three theories investigated in this dissertation (see below).

In brief, support was found for the reliability of the CID-SO and also found for three of four groups of proposed uses for the measure.

Limitations

Like all research, this dissertation is not without its limitations, and it is important to acknowledge them here. The lack of support for the three theories tested (in the validation of the fourth proposed use of the CID-SO) may be a reflection of the limitations of available methodology. The use of measures that attempt to assess social variables by non-social means (i.e., by self-report questionnaires rather than behavioural observations and verbal discourse) may have precluded the possibility of finding significant results and may not have adequately tested the hypotheses. Two of the three relevant theories seek to infer an underlying mechanism (a cognitive process) from the observable behaviour (a social process). For example, in cognitive deconstruction theory, the overt statements made by a sex offender are treated as an indication of his cognitive level of meaning (e.g., low vs. high level of action identification). Similarly, in schema theory, an offender's irrational statement about sexual offending is seen as an indication of an underlying attitude or belief. Both of these theories assume that there are underlying cognitive reasons for an offender's denial of his sexual offenses.

Although both theories may be useful in attempting to explain the mental processes underlying sexual offending by inferring them from social events, inferential approaches to understanding human behaviour have limitations. Cognitive processes occur inside the mind; they do not require the presence of another person and are not directly observable. Cognitive processes may be inferred from social behaviours, but they are not observable behaviours themselves. For example, cognitions may lead to social behaviour (i.e., thoughts may lead to actions), but the cognitions are still distinct from those behaviours. Social events, on the other hand, are observable acts, behaviours, or situations. Social events occur in the presence of others and include communication with other people; they are influenced by social processes. The linkage

between cognition and social behaviours is tenuous, at best. An examination of cognitions may not lead to a detailed understanding of overt denial.

To illustrate, an alternative interpersonal view uses the concept of the “black box.” Watzlawick, Bavelas, and Jackson (1967) proposed that it is impossible to see the mind (i.e., black box) at work and that it cannot be opened for study. Even if the box were opened, we would only be capable of making inferences about what really goes on inside the box. The authors argued that “this knowledge is not essential for the study of the function of the device in the greater system of which it is a part” (p. 44). Similarly, it may not be necessary to know why an offender denies (i.e., his cognitive process); rather, it may be more relevant to understand how he displays it. That is, the metacommunicative and communicative aspects of denial may be more relevant. Although the interpersonal approach was not an original focus of this dissertation, it is presented here to illustrate that the existing, cognitive theories in the sex offender literature are limited. In addition, the interpersonal approach provides an alternative explanation for the lack of positive findings in one area.

The attitude-behaviour inconsistency was recognized as early as the 1930s, when LaPiere wrote his article, “Attitude and actions” (1934). This inconsistency has also been supported by the extant literature, which has shown sizable gaps in the relationship between one’s attitude and one’s behaviour (e.g., Bem & Allen, 1974; Kirk-Smith, 1998; Segrin, 1998; Wicker, 1969). Hence, attitude-behaviour inconsistency may well be the rule rather than the exception. Perhaps the lack of relationship between attitude and behaviour may lead to a reduced tendency to use questionnaires (Kirk-Smith, 1998) and an increased need to develop behavioural measures to assess theories (Segrin, 1998). However, the paucity of behavioral measures often leads to

over-use of questionnaires or the inclusion of unstructured clinical interviews (e.g., self-esteem measures, see Glaus, 1999)

In light of this limitation, it is difficult to ascertain the validity of the CID-SO's use for hypothesis testing at this time without appropriate social or behavioural measures to assess certain variables that are typically measured by questionnaires. Without behavioural measures to assess variables like those indicated in the cognitive deconstruction and schema theories (e.g., self-esteem, self-monitoring, distorted beliefs), the difficulty remains in assessing the connection between certain variables and actual behaviours.

Clinical Implications

The CID-SO was constructed and developed with the intention of providing a measure that would have clinical implications for both the assessment and treatment of sex offenders. I initially searched for an existing measure of denial; however, the literature offered few adequate alternatives. In this section, several clinical implications of the CID-SO are discussed. The CID-SO can be used as a measure of clinical characteristics associated with denial, as an assessment tool for treatment eligibility and readiness for treatment, as a tool to determine the appropriate treatment approaches, and finally as a tool to assess treatment progress.

During criminal proceedings, the criminal justice system may require a forensic psychological and psychiatric evaluation. Clinicians are often faced with numerous concerns. For example, many clinicians have very specific questions regarding relevant clinical characteristics (e.g., empathy, insight) about an offender. For many of these characteristics, there are no directly relevant measures available. However, clinicians may question whether the offender has insight into his problem, whether he is suitable for treatment, whether he accepts responsibility for his behaviour, and whether he is

remorseful or understands victim impact. Therefore, the first clinical implication of using the CID-SO is that the CID-SO offers a standardized procedure to comprehensively assess sex offender denial and these associated clinical characteristics. Ultimately, denial is important because of its potential relationship with all of the factors listed above (i.e., recognition of a problem behaviour, amenability for treatment, acceptance of responsibility, and victim empathy; Baldwin & Roys, 1998; Barbaree, 1991; Maletzky, 1993; Marshall & Barbaree, 1990). Often, the judiciary uses these aspects of a forensic report to make decisions regarding sentencing (e.g., incarceration or community supervision), treatment options, and restrictive conditions.

A second clinical implication of the CID-SO is that clinicians may become more open to including denying offenders into treatment by simply assessing denial more thoroughly. Denial of any kind is often considered an exclusionary factor when contemplating treatment eligibility. Many clinicians believe that treatment is a privilege that should only be offered to offenders willing to meet certain conditions; one of these conditions may be that the offender must admit, to some degree, that he committed the offense for which he was convicted. However, denial is usually measured as a dichotomous variable, suggesting an offender is either in or not in a state of denial. In both clinical practice and research, denial should be considered multifaceted. Dichotomizing denial limits the ability of the clinicians to include certain offenders and to subsequently treat them. Including full deniers who say they did not commit the offense at all in group therapy settings can be challenging and, at times, disruptive to the functioning of the group. Their continued inclusion may hinder the progress of other, motivated sex offenders in treatment. In contrast, the inclusion of offenders with a different denial pattern (e.g., denial of harm to the victim) is appropriate and may be helpful to these offenders because the treatment may encourage motivation and

acceptance of responsibility by the modeling of prosocial behaviours by offenders who admit responsibility. The use of the CID-SO allows clinicians to identify the pattern of denial that an offender exhibits, to avoid the pitfall of categorizing him simply as a denier, and to include him in treatment despite some tendencies to deny aspects of his offending.

The CID-SO is also useful as a procedure for evaluating treatment readiness. Recall that one of the four patterns of denial assessed by the CID-SO is the denial of the need for treatment or management of sexual offending (Cluster B). The items under this pattern specifically assess those offenders who deny the possibility of a future offense, who show defensive or excessive hostility, who acknowledge no possibility of change through treatment, and who express no desire or need for help. This cluster or denial pattern allows the clinician to easily identify those offenders who are ready to engage in treatment. Often, clinicians attempt to have a mixed group of offenders in therapy sessions. The inclusion of offenders with varied levels of treatment readiness increases general engagement and involvement by having “ready” offenders model engaged behaviour to others.

A third clinical use of the CID-SO could be to determine the most appropriate treatment approach for an individual offender. By identifying patterns of denial and minimization, clinicians may be better equipped to develop relevant treatment approaches that would suit individual needs in therapy. For example, if an offender denies that there was an impact on his victim but acknowledges that he committed a sexual offense, clinicians could place a greater emphasis on victim empathy, such as long-term effects of sexual abuse, for that offender. Therapy could be tailored to each offender in individual sessions, and specific material could be included that is directly relevant to certain offenders in group sessions.

Lastly, the CID-SO offers a procedure that assesses denial as a dynamic, potentially changing behaviour. Although limited research has focused on adequate dynamic measures of treatment progress (Hanson & Harris, 2001), the CID-SO could potentially assess an offender's progress in treatment. That is, the clinician would be able to measure whether or not the offender was making gains in therapy. Often the focus of sex offender treatment is to improve an offender's insight into his problem, to increase his acceptance of responsibility, and to increase victim empathy (Laws, 1989)—all of these issues are related to denial and can be assessed with the CID-SO.

In the previous chapters, the CID-SO was shown to demonstrate reliability and validity of several proposed uses. This section also proposes that the CID-SO may have other uses for clinicians who assess and treat sex offenders. With appropriate research, the CID-SO could be used to assess relevant clinical characteristics, to assess treatment eligibility and readiness, to determine suitable treatment approaches, and to measure treatment progress.

Future Directions

The process of test development is never complete. Recall that “as validation proceeds, and new evidence about the meaning of a test's scores becomes available, revisions may be needed in the test” (AERA, APA, & NCME, 1999, p. 9). This section will discuss the next stages in the development and evaluation of the CID-SO. The next stages include revision of the current CID-SO manual and collection of evidence for evaluating the use of the CID-SO both to assess the phenomenon of denial, as measured by the other existing instruments, and to assess treatment progress in a longitudinal study (rather than a cross-sectional approach as used in this dissertation).

The first step is to develop the CID-SO further, and this process involves a significant revision to the existing manual in light of the findings from this dissertation.

The manual should be revised so that it includes the normative data from my dissertation sample, the reliability findings, and the validation evidence for the methodological, conceptual, practical, and hypothesis testing uses. Furthermore, a discussion of the paucity of empirical support for the four clusters should be included in the manual. This would emphasize that the four CID-SO clusters are conceptually derived and logically supported but also discuss the problems that arise for empirical support.

The second step involves continued evaluation of the CID-SO as a measure of denial. Further empirical validation of the first conceptual use, that is, to measure sex offender denial and to assess denial for all types of sex offenders, would be another important step in evaluating the CID-SO. This step could be achieved by examining the relationship between the CID-SO and other extant measures of denial, despite the limitations of the extant measures, discussed in Chapter One (e.g., poor or no psychometric findings, non-behavioural approaches, specificity to certain types of offenders). I would rate denial for sex offenders by the CID-SO and other clinician-rated denial measures (e.g., Denial and Minimization Scale; Eccles, Stringer, and Marshall, 1997) and also by administering self-report denial questionnaires. Then I would conduct correlational analyses to examine the CID-SO's relationship with these extant measures of denial.

A third step of test development should address, in part, the clinical implications discussed in the previous section. Further examination of the utility of the CID-SO for clinical uses, particularly to assess treatment progress, would best be accomplished using a longitudinal design. Rather than using a cross-sectional approach as employed in this dissertation, a longitudinal study assessing a group of offenders prior to treatment and again following treatment would eliminate the weaknesses of cross-sectional

designs. In addition, a longitudinal study would also provide support for the CID-SO's use as a measure of treatment progress.

These steps for further development and evaluation of the CID-SO are only a few of my responsibilities as the test developer:

Responsibility for validation belongs both to the test developer, who provides evidence in support of test use for a particular purpose, and to the test user, who ultimately evaluates that evidence, other available data, and information gathered during the testing process to support interpretation of test scores. (Turner et al., 2001, p. 1101)

The task of development is an ongoing process, and the work in this dissertation is only the beginning of a larger process.

Summary

In this dissertation, I developed a new measure of sex offender denial called the Comprehensive Inventory of Denial – Sex Offender version (CID-SO) and evaluated its reliability and the validity of its proposed uses. The CID-SO has good inter-rater reliability and validity for three of the four proposed uses. Although there are some limitations of this dissertation, the CID-SO has demonstrated utility as a clinical instrument.

The CID-SO is a valuable contribution to the field of treating sexual abusers because it provides clinical guidelines for the identification of the behavioural attributes of denial. Assessing denial behaviourally may help the clinician to assess offenders prior to entering treatment, to target what needs to be addressed through treatment, and to evaluate treatment effectiveness. The CID-SO may ultimately benefit both the client and the community.

REFERENCES

- Abel, G. G., Gore, D. K., Holland, C. L., Camp, N., Becker, J. V., & Rathner, J. (1989). The measurement of cognitive distortions of child molesters. *Annals of Sex Research, 2*, 135-152.
- Abrams, S. (1989). *The complete polygraph handbook*. Toronto: Lexington Books.
- Ahmed, S. M. S., Garg, R., & Braimoh, G. (1986). Psychometric properties of Snyder's self-monitoring of expressive behavior scale. *Perceptual and Motor Skills, 63*, 495-500.
- American Educational Research Association (AERA), American Psychological Association (APA), & National Council on Measurement in Education (NCME). (1985). *Standards for educational and psychological testing*. Washington, DC: American Educational Research Association.
- American Educational Research Association (AERA), American Psychological Association (APA), & National Council on Measurement in Education (NCME). (1999). *Standards for educational and psychological testing*. Washington, DC: American Educational Research Association.
- Anastasi, A., & Urbina, S. (1997). *Psychological testing*. Upper Saddle River, NJ: Prentice Hall.
- Baldwin, K., & Roys, D. T. (1998). Factors associated with denial in a sample of alleged adult sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 10*, 211-226.
- Barbaree, H. E. (1991). Denial and minimization among sex offenders: Assessment and treatment outcome. *Forum on Corrections Research, 3*, 30-33.
- Barbaree, H. E. (2000). Denial and Minimization Checklist. Unpublished clinical measure.

- Barbaree, H. E., & Marshall, W. L. (1988). Deviant sexual arousal, offense history and demographic variables as predictors of reoffense among child molesters. *Behavioral Sciences and the Law, 6*, 267-280.
- 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*. Toronto, ON: Forensic Division, Clarke Institute of Psychiatry
- Baumeister, R. F. (1991). *Escaping the self*. New York, NY: Basic Books.
- Baumeister, R. F. (1990). Suicide as escape from self. *Psychological Review, 97*, 90-113.
- Baumgartner, J. V., Scalora, M. J., & Huss, M. T. (2002). Assessment of the Wilson Sex Fantasy Questionnaire Among Child Molesters and Nonsexual Forensic Offenders. *Sexual Abuse: A Journal of Research Treatment, 14*, 19-30.
- Bavelas, J. B. (1978). *Personality: Current theory and research*. Monterey, CA: Wadsworth.
- Bem, D. J., & Allen, A. (1974). On predicting some of the people some of the time: The search for cross situational consistencies in behavior. *Psychological Review, 81*, 506-520.
- Blasingame, G. D. (1998). Suggested Clinical Uses of Polygraphy in community-based sexual offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment, 10*, 37-45.
- Boer, D. P., Hart, S. D., Kropp, P. R., & Webster, C. D. (1997). *Manual for the Sexual Violence Risk – 20: Professional guidelines for assessing risk for sexual violence*. Vancouver, BC: British Columbia Institute Against Family Violence, Simon Fraser University.

- Bornstein, R. F., Rossner, S. C., Hill, E. L., & Stepanian, M. L. (1994). Face validity and fakability of objective and projective measures of dependency. *Journal of Personality Assessment, 63*, 363-386.
- 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 Treatment, 8*, 37-54.
- Burt, M. R. (1980). Cultural myths and supports for rape. *Journal of Personality and Social Psychology, 38*, 217-230.
- Burt, M. R. (1983). Justifying personal violence: A comparison of rapists and the general public. *Victimology: An International Journal, 8*, 131-150.
- Bowers, T. L., & Pantle, M. L. (1998). Shipley Institute for Living Scale and the Kaufman Brief Intelligence Test as screening instruments for intelligence. *Assessment, 5* (2), 187-195.
- 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 Treatment, 8*, 37-54.
- Burt, M. R. (1980). Cultural myths and supports for rape. *Journal of Personality and Social Psychology, 38*, 217-230.
- Burt, M. R. (1983). Justifying personal violence: A comparison of rapists and the general public. *Victimology: An International Journal, 8*, 131-150.
- Campbell, D. T., & Fiske, D. W. (1959). Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychological Bulletin, 56*, 81-105.
- Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement, 20*, 37-46.

- Cortoni & Marshall, W. L. (2001). Sex as a coping strategy and its relationship to juvenile sexual history and intimacy in sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 13*, 27-44.
- Crowne, D. P., & Marlowe, D. (1964). *The approval motive: Studies in evaluative dependence*. New York: John Wiley.
- DeBono, K. G. (1987). Investigating the social-adjustive and value-expressive functions of attitudes: Implications for persuasion processes. *Journal of Personality and Social Psychology, 52*, 279-287.
- DeBono, K. G., & Edmonds, A. E. (1989). Cognitive dissonance and self-monitoring: A matter of context? *Motivation and Emotion, 13*, 259-269.
- Eccles, T., Stringer, A., & Marshall, W. L. (1997, October). *Denial and minimization in sexual offenders: A self-report measure*. Paper presented at the annual meeting of the Association for the Treatment of Sexual Abusers, Arlington, VA.
- Eignor, D. R. (2001). Standard for the development and use of tests: The Standards for Educational and Psychological Testing. *European Journal of Psychological Assessment, 17*, 157-163.
- Eisenthal, S., & Hartford, T. (1971). Correlation between the Raven Progressive Matrices Scale and the Shipley Institute of Living Scale. *Journal of Clinical Psychology, 27*, 213-215.
- Emerick, R. L., & Dutton, W. A. (1993). The effect of polygraphy on the self report of adolescent sex offenders: Implications for risk assessment. *Annals of Sex Research, 6*, 83-103.
- Fiske, S. T. (1989). Examining the role of intent: Toward understanding its role in stereotyping and prejudice. In J. S. Uleman, & J. A. Bargh (Ed.), *Unintended*

- thought: The limits of awareness, intention and control* (pp. 153-283). New York: Guilford Press.
- Fiske, S. T., & Taylor, S. E. (1991). *Social cognition* (2nd Ed.). New York: McGraw-Hill.
- Fleming, J. S., & Courtney, B. E. (1984). The dimensionality of self-esteem: II. Hierarchical facet model for revised measurement scales. *Journal of Personality & Social Psychology*, 46, 404-421.
- Francis, L. J., & Wilcox, C. (1995). Self-esteem: Coopersmith and Rosenberg compared. *Psychological Reports*, 76, 1050.
- Gabrenya, W. K., & Arkin, R. M. (1980). Self-Monitoring Scale: Factor structure and correlates. *Personality & Social Psychology Bulletin*, 6, 13-22.
- Garfield, S. L., & Fey, W. F. (1948). A comparison of the Wechsler-Bellevue and Shipley-Hartford Scales as measures of mental impairment. *Journal of Consulting Psychology*, 12, 259-264.
- Gibbons, P., de Volder, J., & Casey, P. (2003). Patterns of denial in sex offenders: a replication study. *The Journal of the American Academy of Psychiatry and the Law*, 31, 336-344.
- Gillies, L. A., Hashmall, J. M., Hilton, N. Z., & Webster, C. D. (1992). Relapse prevention in pedophiles: Clinical issues and program development. *Canadian Psychology*, 33, 199-210.
- Glaus, K. (1999). Measuring self-esteem. In C. J. Carlock (Ed.), *Enhancing self-esteem* (3rd Ed.) (pp. 457-475). Philadelphia, PA: Accelerated Development, Inc.
- Goffman, E. (1959). *The presentation of self in everyday life*. Garden City, NY: Doubleday.

- Goodman, J. T., Streiner, D. L., & Woodward, C. A. (1974). Test-retest reliability of the Shipley Institute of Living Scale: Practice effects on random variation. *Psychological Reports, 35*, 351-354.
- Goodwin, L. D. (2002). Changing conceptions of measurement validity: An update on the new standards. *Journal of Nursing Education, 41*, 100-106.
- Gosselin, C. C., & Wilson, G. D. (1980). *Sexual variations: fetishism, transvestism, and sadomasochism*. London: Faber and Faber.
- Gosselin, C. C., Wilson, G. D., & Barrett, P. T. (1991). The personality and sexual preferences of sadomasochistic women. *Personality & Individual Differences, 12*, 11-15.
- Grossman, L. S., & Cavanaugh, J. L., Jr. (1990). Psychopathology and denial in alleged sex offenders. *The Journal of Nervous and Mental Disease, 178*, 739-744.
- Goodwin, L. D., & Leech, N. L. (2003). The meaning of validity in the new standards for educational and psychological testing: Implications for measurement courses. *Measurement and Evaluation in Counseling and Development, 36*, 181-191.
- Grossman, L. S., & Cavanaugh, J. L. (1989). Do sex offenders minimize psychiatric symptoms? *Journal of Forensic Sciences, 34*, 881-886.
- Hagborg, W. J. (1993). The Rosenberg Self-Esteem Scale and Harter's Self-Perception Profile for Adolescents: A concurrent validity study. *Psychology in the Schools, 30*, 132-136.
- Hall, R. L. (1989). Self-efficacy ratings. In D. R. Laws (Ed.), *Relapse prevention with sex offenders* (pp. 137-146). New York, NY: The Guilford Press.

- Hanson, R. K., & Harris, A. J. R. (2001). A structural approach to evaluating change among sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 13*, 105-122.
- Hanson, K., & Bussière, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66*, 348-362.
- Happel, R. M., & Auffrey, J. J. (1995). Sex offender assessment: Interrupting the dance of denial. *American Journal of Forensic Psychology, 13*, 5-22.
- Harnish, M. J., Beatty, W. W., Nixon, S. J., & Parsons, O. A. (1994). Performance by normal subjects on the Shipley Institute of Living Scale. *Journal of Clinical Psychology, 50* (6), 881-883.
- Haywood, T. W., & Grossman, L. S. (1994). Denial of deviant sexual arousal and psychopathology in child molesters. *Behavior Therapy, 25*, 327-340.
- Haywood, T. W., Grossman, L. S., & Hardy, D. W. (1993). Denial and social desirability in clinical evaluations of alleged sex offenders. *The Journal of Nervous and Mental Disease, 181*, 183-188.
- Holden, R. R., Starzyk, K. B., McLeod, L. D., & Edwards, M. J. (2000). Comparisons among the Holden Psychological Screening Inventory (HPSI), the Brief Symptom Inventory (BSI), and the Balanced Inventory of Desirable Responding (BIDR). *Assessment, 7*, 163-175.
- Huysaman, G. K. (2002). The relevance of the new APA standards for educational and psychological testing for employment testing in South Africa. *South African Journal of Psychology, 32*, 26-33.

- Jenkins-Hall, K. D., & Marlatt, G. A. (1989). Apparently irrelevant decisions in the relapse process. In D. R. Laws (Ed.), *Relapse prevention with sex offenders* (pp. 47-55). New York, NY: The Guilford Press.
- Johnston, L., & Ward, T. (1996). Social cognition and sexual offending: A theoretical framework. *Sexual Abuse: A Journal of Research and Treatment, 8*, 55-80.
- Kane, M. T. (2001). Current concerns in validity theory. *Journal of Educational Measurement, 38*, 319-342.
- Kennedy, H. G., & Grubin, D. H. (1992). Patterns of denial in sex offenders. *Psychological Medicine, 22*, 191-196.
- Keppel, G., Sautley, W. H., Jr., & Tokunage, H. (1992). *Introduction to design & analysis: A student's handbook* (2nd Ed.). New York: W. H. Freeman.
- Kirk-Smith, M. (1998). Psychological issues in questionnaire-based research. *International Journal of Market Research, 40*, 223-236.
- Kroner, D. G., & Weekes, J. R. (1996). Balanced Inventory of Desirable Responding: Factor structure, reliability, and validity with an offender sample. *Personality and Individual Differences, 21*, 323-333.
- Lalumiere, M. L., & Quinsey, V. L. (1991). Polygraph testing of child molesters: Are we ready? *Violence Update, 1*, 3, 9, 11; (12), 6-7.
- Langevin, R. (1988). Defensiveness in sex offenders. In R. Rogers (Ed.), *Clinical assessment of malingering and deception* (pp. 269-290). New York: Guilford.
- Lanyon, R. I., & Lutz, R. W. (1984). MMPI discrimination of defensive and nondefensive felony sex offenders. *Journal of Consulting and Clinical Psychology, 52*, 841-843.
- LaPiere, R. T. (1934). Attitude and actions. *Social Forces, 13*, 230-237.
- Laws, D. R. (1989). *Relapse prevention with sex offenders*. New York: Guilford.

- Laws, D. R. (1994). *Revised Cognition Scale*. Unpublished manuscript.
- Laws, D. R. (2002). Owing your own data: The management of denial. In M. McMurrin (Ed.), *Motivating offenders to change: A guide to enhancing engagement in therapy* (pp. 173-191). Chichester, UK: John Wiley.
- Lund, C. A. (2000). Predictors of sexual recidivism: Did meta-analysis clarify the role and relevance of denial? *Sexual Abuse: A Journal of Research and Treatment*, *12*, 275-287.
- Maletzky, B. M. (1993). Factors associated with success and failure in the behavioral and cognitive treatment of sexual offenders. *Annals of Sex Research*, *6*, 241-258.
- Malloy, C. (2000). *Denial Questionnaire*. Unpublished doctoral dissertation. MCP Hahnemann University, Philadelphia, PA.
- Marshall, W. L. (1989). *Sex with Children Scale*. Kingston, ON: Kingston Sexual Behaviour Clinic.
- Marshall, W. L. (1994). Treatment effects on denial and minimization in incarcerated sex offenders. *Behavioral Research and Therapy*, *32*, 559-564.
- Marshall, W. L. (1997). Pedophilia: Psychopathology and theory. In D. R. Laws, & W. O'Donohue (Eds.), *Sexual deviance: Theory, assessment, and treatment* (pp. 152-174). New York: The Guilford Press.
- Marshall, W. L., & Barbaree, H. E. (1990). Outcome of comprehensive cognitive-behavioral treatment programs. In W. L. Marshall, D. R. Laws, & H. E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories, and treatment of the offender* (pp. 363-385). New York: Plenum.

- Martin, J. D., Blair, G. E., & Vickers, D. M. (1979). Correlation of the Quick Word Test and the Wide Range Vocabulary Test with the Shipley Institute of Living Scale. *Educational and Psychological Measurement, 39*, 935-937.
- McCarthy, J. D., & Hoge, D. R. (1982). Analysis of age effects in longitudinal studies of adolescent self-esteem. *Developmental Psychology, 18*, 372-379
- McNemar, Q. (1969). *Psychological statistics* (4th Ed.). New York: John Wiley.
- Murphy, W. D., & Page, I. J. (2000). Relapse prevention with adolescent sex offenders. In D. R. Laws, S. M. Hudson, & T. Ward (Eds.), *Remaking relapse prevention with sex offenders: A sourcebook* (pp. 353-368). Thousand Oaks: Sage.
- Nelson, C., & Jackson, P. (1989). High-risk recognition: The cognitive-behavioral chain. In D. R. Laws (Eds.), *Relapse prevention with sex offenders* (pp. 167-177). New York, NY: The Guilford Press.
- 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.
- Nunnally, J. C. (1967). *Psychometric theory*. New York: McGraw-Hill.
- O'Donohue, W., & Letourneau, E. (1993). A brief group treatment for the modification of denial in child sexual abusers: Outcome and follow-up. *Child Abuse and Neglect, 17*, 299-304.
- Paulhus, D. L. (1984). Two-component models of socially desirable responding. *Journal of Personality and Social Psychology, 46*, 598-609.
- Paulhus, D. L. (1986). Self-deception and impression management in test responses. In A. Angleitner & J. S. Wiggins (Eds.), *Personality assessment via questionnaires: Current issues in theory and measurement* (pp. 143-165). Berlin: Springer-Verlag.

- Paulhus, D. L., & Reid, D. B. (1991). Enhancement and denial in socially desirable responding. *Journal of Personality and Social Psychology, 60*, 307-317.
- Paulson, M. J., & Lin, T. (1970). Predicting WAIS IQ from Shipley-Hartford scores. *Journal of Clinical Psychology, 26*, 453-461.
- Peacock, E. J. (2000, November). *Measuring readiness for sex offender treatment*. Poster presented at the 19th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, San Diego, CA.
- Pervin, L. A. (1994). A critical analysis of current trait theory. *Psychological Inquiry, 5*, 103-113.
- Pollock, N. L., & Hashmall, J. M. (1991). The excuses of child molesters. *Behavioral Sciences and the Law, 9*, 53-59.
- Rosenberg, M. J. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.
- Rosenberg, M. J. (1979). *Conceiving the self*. New York: Basic Books.
- Rosenthal, R., & Rosnow, R. L. (1991). *Essentials of behavioral research: Methods and data analysis* (2nd Ed.). New York: McGraw-Hill.
- Salter, A. (1988). *Treating child sex offenders and victims: A practical guide*. Newbury Park, CA: Sage.
- Savin-Williams, R. C., & Jaquish, G. A. (1981). The assessment of adolescent self-esteem: A comparison of methods. *Journal of Personality, 49*, 324-336.
- Schlank, A. M., & Shaw, T. (1997). Treating sexual offenders who deny -- a review. In B. K. Schwartz, & H. R. Cellini (Eds.), *The sex offender: New insights, treatment innovations and legal developments* (pp. 6-1 - 6-7). Kingston, NJ: Civic Research Institute.

- Schneider, S. L., & Wright, R. C. (2001). The FoSOD: A measurement tool for reconceptualizing the role of denial in child molesters. *Journal of Interpersonal Violence, 16*, 545-564.
- Scully, D., & Marolla, J. (1984). Convicted rapists' vocabulary of motive: Excuses and justifications. *Social Problems, 31*, 530-544.
- Segal, Z. V., & Marshall, W. L. (1985). Self-report and behavioral assertion in two groups of sexual offenders. *Journal of Behavior Therapy and Experimental Psychiatry, 16*, 223-229.
- Segrin, C. (1998). The impact of assessment procedures on the relationship between paper and pencil and behavioral indicators of social skill. *Journal of Nonverbal Behavior, 22*, 229-251.
- Silber, E., & Tippett, J. S. (1965). Self-esteem: Clinical assessment and measurement validation. *Psychological Reports, 16*, 1017-1071.
- Smith, W. R., & Monastersky, C. (1986). Assessing juvenile sexual offenders' risk for reoffending. *Criminal Justice and Behaviour, 13*, 115-140.
- Snyder, M. (1974). The self-monitoring of expressive behavior. *Journal of Personality and Social Psychology, 30*, 526-537.
- Snyder, M. (1987). *Public appearances/Private realities*. New York: W. H. Freeman.
- Snyder, M., & Gangestad, S. (1986). On the nature of self-monitoring: Matters of assessment, matters of validity. *Journal of Personality and Social Psychology, 51*, 125-139.
- Taylor, S. E., Peplau, L. A., & Sears, D. O. (2000). *Social psychology* (10th Ed.). Upper Saddle River, NJ: Prentice Hall.
- Turner, S. M., DeMers, S. T., Fox, H. R., & Reed, G. M. (2001). APA's Guidelines for Test User Qualifications. *American Psychologist, 56*, 1099-1113.

- Ward, T., Hudson, S. M., & Keenan, T. (1998). A self-regulation model of the sexual offense process. *Sexual Abuse: A Journal of Research and Treatment, 10*, 141-157.
- Ward, T., Hudson, S. M., & Marshall, W. L. (1995). Cognitive distortions and affective deficits in sex offenders: A cognitive deconstructionist interpretation. *Sexual Abuse: A Journal of Research and Treatment, 7*, 67-83.
- Watzlawick, P., Bavelas, J. B., & Jackson, D. D. (1967). *Pragmatics of human communication: A study of interactional patterns, pathologies, and paradoxes*. New York: Norton.
- Wicker, A. W. (1969). Attitudes versus actions: The relationship of verbal and overt behavioral responses to attitude objects. *Journal of Social Issues, 25*, 41-78.
- Wilson, G. (1978). *The secrets of sexual fantasy*. London, England: J.M. Dent & Sons.
- Wilson, G. D. (1988). Measurement of sex fantasy. *Sexual and Marital Therapy, 3*, 45-55.
- Wilson, G. D., & Lang, R. J. (1981). Sex differences in sexual fantasy patterns. *Personality and Individual Differences, 2*, 343-346.
- Winn, M. E. (1996). The strategic and systemic management of denial in the cognitive/behavioral treatment of sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 8*, 25-36.
- Wormith, J. S., & Hanson, R. K. (1992). The treatment of sexual offenders in Canada: An update. *Canadian Psychology, 33*, 180-198.
- Zachary, R. A. (1991). *Shipley Institute of Living Scale - Revised Manual*. Los Angeles, CA: Western Psychological Services.

Table 1

Degrees of Denial

Components of Denial	Admission with Justification	Denial of Behavior			Denial of Seriousness of Behavior and Need for Treatment	Denial of Responsibility for Behavior	Full Admission W/ Responsibility and Guilt
		Physical Denial With or Without Family Denial	Psychological Denial	Minimizes Extent of Behavior			
Admits he committed the acts?	yes	no	no	partially	yes	yes	yes
Describes Fantasy and Planning?	yes or no	no	no	no	no	no	yes
Accepts responsibility?	yes or no	no	no	minimizes	no	no	yes
Accepts Seriousness of Behaviors	yes or no	no event, no consequences	no event, no consequences	minimizes	no	yes	yes
Feels Guilty or Shame Over Discovery?	neither	neither	neither	shame	shame	shame	guilt
Difficulty in Changing Abusive Patterns?	no desire to	no reason to	no reason to	easy	easy	easy	difficult

Taken from p. 98 of Salter (1988).

Table 2

The Denial and Minimization Checklist

For each of the categories below, check those circumstances that apply to the offender's explanation of the offense on the target date. First, check one of either denial, minimization, or none. Then, go through each of the other categories, and check any which, in your opinion, applies to the offender's explanation. Finally, at the bottom of the checklist, add a narrative description of any additional categories which you believe are important for this offender which are not reflected in the list given below:

- I. DENIAL
 - A. Deny that he had any interaction with victim
 1. Victim out to get him for some reason
 - B. Deny that the interaction he had was sexual in nature
 1. He was angry and committed a non-sexual assault
 2. Was touching for some legitimate reason
 - C. Deny that the sexual interaction was an offense
 1. Victim did not resist
 2. Victim consented
 3. Victim said she was older than she was
 4. Victim benefitted from interaction
 - a. Sex Education
 - b. Affectional-Serving the victim's emotional needs
- 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. Stress circumstances
 - c. Social pressure
 - d. Provocation
 3. He absolves himself of blame w. irresponsible internal attributions
 - a. Emotional or mental disorder or disturbance
 - b. Hormonal imbalance
 - c. Bad experiences during childhood
 - d. Past victimizations
 - B. Of Extent
 1. He minimizes the frequency of his past offenses
 2. He minimizes the number of his past victims
 3. He minimizes the degree of force he used
 4. He minimizes the intrusiveness of the sexual 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
- III. NO DENIAL OR MINIMIZATION

From Barbaree (2000).

Table 3

Denial Scales and Ratings

Offence	0	Fully admits offence as charged
	1	Partial denial, e.g. claims victim consented
	2	Denies offence completely
Responsibility	0	Accepts full responsibility
	1	Accepts partial responsibility only, e.g. says was led on by victim, or under peer pressures
	2	Denies responsibility completely
Internal attribution	0	Accepts internal responsibility: no mitigating internal factors
	1	Claims offence out of character
	2	Denial of internal responsibility, e.g. drunk, under stress, depressed
External attribution	0	No blame of third parties
	1	Blames remote factors, e.g. upbringing
	2	Blames proximate factors, e.g. wife, employer
Preference	0	Says offence arose from sexual preferences
	1	Admits paraphilic interest, but denies relevance to offence
	2	Denies any deviant preferences
Effect	0	Acknowledges harm to victim
	1	Denies harm to victim
	2	Claims to have helped victim
Social Sanction	0	Regards offence as deserving sentence like that received
	1	Believes sentences generally too harsh for type of offence
	2	Believes type of offence should not be against law

Taken from p. 196 of Kennedy & Grubin (1992).

Table 4

Comprehensive Inventory of Denial – Sex Offender Version (CID-SO)

1. Denies Current Specific Offense
 - 0 Fully admits current offense as charged
 - 1 Partially denies the current specific offense
 - 2 Denies the current offense completely
2. Denies Sex Offending History
 - 0 Fully admits committing offenses at other times, both as recorded and unrecorded
 - 1 Partly admits offenses at other times; some not all recorded offenses
 - 2 Denies previous offenses completely
3. Lacks Feelings of Guilt and Embarrassment
 - 0 Feels guilt and embarrassment for committing the offense(s)
 - 1 Feels embarrassed over the offending, but feels minimal guilt for the offense itself
 - 2 Lacks any guilty or embarrassment associated with the actual offense
4. Focuses on Acceptable or Nonsexual Behaviours
 - 0 Fully focuses on sexual nature of the offense
 - 1 Able to focus on sexual nature of offense, but emphasizes other nonsexual behaviours
 - 2 Focuses on other aspects of his behaviour; usually more "acceptable" or "nonsexual" aspects
5. Minimizes the Seriousness of the Offense
 - 0 Accepts seriousness of his behaviours
 - 1 Accepts, in part, seriousness of offense
 - 2 Denies the offense was serious in nature; belittles the sex offense
6. Minimizes Harm to Victim
 - 0 Acknowledges harm to victim; not applicable
 - 1 Minimizes the harm to victim; difficulty acknowledging harm to victim
 - 2 Denies any harm was done to the victim; or claims to have helped the victim
7. Blames the Victim
 - 0 Acknowledges offending is a result of his own behaviour
 - 1 Partly acknowledges offending is a result of his behaviour, but also to the victim's ill-will or exaggeration
 - 2 Blames the victim for the offending and/or the consequences of the charges
8. Qualifies or Justifies with Internal Attribution
 - 0 Accepts internal responsibility; no mitigating internal factors
 - 1 Claims there were mitigating internal factors, but accepts responsibility for committing the offense
 - 2 Denies internal responsibility; claims offense was out of character
9. Qualifies or Justifies with External Attribution
 - 0 No blame of third parties
 - 1 Claims there were mitigating external factors, but accepts responsibility for committing the offense
 - 2 Blames remote and proximate factors
10. Denies Possibility of Future Behaviour
 - 0 Acknowledges cannot predict future and identifies that future offending is likely; contends will not commit further offenses, if he or she uses strategies learned (Tx only)
 - 1 Partly denies possibility of committing similar offenses in the future
 - 2 Denies possibility of committing similar offenses in the future
11. Denies Any Intent, Planning, or Premeditation
 - 0 Fully acknowledges offense was planned
 - 1 Partially admits there were elements that were planned
 - 2 Completely denies offense was planned
12. Denies Deviant Arousal and Fantasies
 - 0 Fully acknowledges he has, or has had, deviant sexual interests and fantasies
 - 1 Partly admits having fantasies and deviant interest; qualifies this by emphasizing 'normal' interests
 - 2 Claims sexual offending occurred only this once; there is no deviant sexual interest or fantasies
13. Denies Sexual Arousal During Current Offense
 - 0 Admits being sexually aroused during offense
 - 1 Partially admits he was sexually aroused
 - 2 Fully denies any sexual arousal
14. Shows Defensive or Excessive Hostility
 - 0 Fully compliant; may initially be defensive, but diminishes partway through the interview
 - 1 Maintains a defensive stance throughout interview but is not outwardly hostile
 - 2 Defensive and shows excessive hostility and resentment for being questioned about the offense
15. Acknowledges Possibility of Change through Treatment
 - 0 Acknowledges offending is within his control and he is able to change with help
 - 1 Expresses that it is difficult to change, but is willing to be proven wrong
 - 2 Expresses that it is difficult to change abusive patterns; believes he cannot be helped
16. Expresses No Desire or Need for Help
 - 0 Acknowledges he needs help and welcomes intervention
 - 1 Seems reluctant to receiving any treatment
 - 2 Refuses to receive treatment; shows no desire for help
17. Denies Memory of Offense
 - 0 Remembers offense completely
 - 1 Partially remembers offense
 - 2 Claims not to remember; therefore, can't admit to committing it
18. Denies Deserving Sanction
 - 0 Regards offense as deserving sentence like that received
 - 1 Believes sentences generally too harsh for what they have done
 - 2 Believes type of offense should not be against law or they have been dealt unjustly

Table 5

*The Cluster Breakdown of the CID-SO**

	Cluster A Denying Sexually Deviant Behaviours and Arousal	Cluster B Denying Need for Treatment or Management of Sexual Offending	Cluster C Denying Responsibility for the Offense	Cluster D Minimizing Harm Done by the Offense
#1	Denies Current Specific Offense			
#2	Denies Sex Offending History			
#3				Lacks Feelings of Guilt and Embarrassment
#4	Focuses on Acceptable or Nonsexual Behaviours			
#5				Minimizes the Seriousness of the Offense
#6				Minimizes Harm Done to Victim
#7			Blames the Victim	
#8			Qualifies or Justifies with Internal Attribution	
#9			Qualifies or Justified with External Attribution	
#10		Denies Possibility of Future Offense		
#11			Denies Any Intent, Planning, or Premeditation	
#12	Denies Deviant Arousal and Fantasies			
#13	Denies Sexual Arousal During the Offense			
#14		Shows Defensive or Excessive Hostility		
#15		Acknowledges Possibility of Change through Treatment		
#16		Expresses No Desire or Need for Help		
#17			Denies Memory of Offense	
#18				Denies Deserving Sanction

* See CID-SO Worksheet version in Appendix A.

Table 6

Proposed Uses of the CID-SO

1. Methodological use of the CID-SO as
 - a. Drawing on several sources of information: verbal, behavioural, and collateral (e.g., legal)
 - b. Based expert clinical judgment
 - c. A reliable assessment

2. Conceptual use of the CID-SO to measure denial as
 - a. Specific to sex offenders, but to all kinds
 - b. A dynamic and potentially changing characteristic
 - c. A behavioural and communicative phenomenon
 - d. Distinct from social desirability, intelligence, and education
 - e. Comprising four different patterns (vs. binary or continuum), i.e., denying sexually deviant behaviours and arousal, denying need for treatment or management of sexual offending, denying responsibility for the offense, minimizing harm done by the offense

3. Practical use of the CID-SO to assess treatment variables

4. Theoretical use of the CID-SO to test existing hypotheses about sex offender denial

Table 7

Proposed Uses of the CID-SO and Evidence Gathered in this Dissertation

Proposed Use	Evidence Gathered
1. Methodological use of the CID-SO as	
a. Drawing on several sources of information: assessment verbal, behavioural, and collateral (e.g., legal)	Logical analysis of the process
b. Based expert clinical judgment	Logical analysis of the assessment process
c. A reliable assessment	Interrater reliability
2. Conceptual use of the CID-SO to measure denial as	
a. Specific to sex offenders, but to all kinds	Test content Broad sample No differences between categories of offenders
b. A dynamic and potentially changing characteristic	Test content Differences between treated and untreated offenders
c. A behavioural and communicative phenomenon	Logical analysis of the assessment process
d. Distinct from social desirability, intelligence, and education	Non-significant correlations to social desirability, intelligence variables, and education level
e. Comprising four different patterns (vs. binary or continuum), i.e., denying sexually deviant behaviours and arousal, denying need for treatment or management of sexual offending, denying responsibility for the offense, minimizing harm done by the offense	Previous literature Test content Internal structure
3. Practical use of the CID-SO to assess treatment variables	Differences between treated and untreated offenders
4. Theoretical use of the CID-SO to test existing hypotheses about sex offender denial	Correlations that are expected by extant hypotheses in the literature (H_1 to H_5)

Table 8

Demographic Information for the Total Sample

Demographic Variable	Mean	Standard Deviation	Range	N
Age (in years)	44.8	12.80	20.6 - 75.9	52
Education (in years)	11.4	2.28	4 - 18	52
Est. IQ (WAIS-R)	99.07	13.50	60 - 119	48

Table 9

Offense and Treatment Information for the Total Sample

Variable and its Categories	No. of Subjects
Type of Adjudication	
Provincial	32
Federal	20
Offense	
Child Molestation	13
Incest	24
Sexual Assault (Adult Victim)	11
Voyeurism	3
Exhibitionism	1
Victim Gender(s)	
Male	10
Female	41
Both	1
Victim Age	
Child	38
Adult	14
Sex Offender Treatment	
None	10
Ongoing	5
Completed	37
Setting of Participation	
Community	37
Prison	15

Table 10

Means and Standard Deviations for CID-SO Items and Total for Each Rater

CID-SO Clusters	Rater 1	Rater 2
1. Denies Current Specific Offense	1.09 (.70) 0 - 2	0.91 (.83) 0 - 2
2. Denies Sex Offending History	0.27 (.65) 0 - 2	0.36 (.81) 0 - 2
3. Lacks Feelings of Guilt and Embarrassment	.09 (.94) 0 - 2	0.73 (.90) 0 - 2
4. Focuses on Acceptable or Nonsexual Behaviours	0.73 (.90) 0 - 2	0.82 (.87) 0 - 2
5. Minimizes of the Seriousness of the Offense	1.00 (.89) 0 - 2	1.00 (.89) 0 - 2
6. Minimizes of Harm to Victim	1.09 (.94) 0 - 2	0.91 (.94) 0 - 2
7. Blames the Victim	1.18 (.75) 0 - 2	0.91 (.83) 0 - 2
8. Qualifies/Justifies with Internal Attribution	1.18 (.87) 0 - 2	1.09 (.83) 0 - 2
9. Qualifies/Justifies with External Attribution	1.09 (.83) 0 - 2	1.18 (.75) 0 - 2
10. Denies Possibility of Future Behaviour	1.27 (1.0) 0 - 2	1.27 (1.0) 0 - 2
11. Denies Any Intent, Planning, or Premeditation	1.45 (.82) 0 - 2	1.27 (.90) 0 - 2
12. Denies Deviant Arousal and Fantasies	1.36 (.92) 0 - 2	1.09 (1.0) 0 - 2
13. Denies Sexual Arousal During Current Offense	0.73 (1.01) 0 - 2	0.90 (1.04) 0 - 2
14. Shows Defensiveness or Excessive Hostility	0.09 (.30) 0 - 1	0.09 (.30) 0 - 1
15. Possibility of Change Through Treatment	0.73 (.90) 0 - 2	0.36 (.81) 0 - 2
16. Expresses No Desire or Need for Help	0.82 (.98) 0 - 2	0.72 (1.0) 0 - 2
17. Denies Memory of Offense	0.73 (.90) 0 - 2	0.63 (.92) 0 - 2
18. Denies Deserving	0.73 (.93) 0 - 2	0.73 (1.0) 0 - 2
CID-SO Total	17.00 (11.76) 4 - 34	15.00 (12.88) 1 - 34

Note: Means, standard deviations (in parentheses), range of ratings are listed. $N = 11$.

Table 11

Means and Standard Deviations for CID-SO Clusters and Total for Each Rater

CID-SO Clusters	Rater 1	Rater 2
Cluster A: Denying Sexually Deviant Behaviours and Arousal	4.18 (3.28) 0 - 10	4.09 (3.78) 0 - 10
Cluster B: Denying Need for Treatment or Management of Sexual Offending	2.91 (2.63) 0 - 6	2.45 (2.34) 0 - 6
Cluster C: Denying Responsibility	5.64 (3.35) 1 - 10	5.09 (3.65) 1 - 10
Cluster D: Minimizing Harm	4.27 (3.23) 0 - 8	3.36 (3.61) 0 - 8
CID-SO Total	17.00 (11.76) 4 - 34	15.00 (12.88) 1 - 34

Note: Means, standard deviations (in parentheses), range of ratings are listed. $N = 11$.

Table 12

Interrater Reliability of CID-SO Items, Clusters, and Total Score with Percentage Agreement, Kappas, and Correlation Coefficients

CID-SO Clusters and Items	Percent Agreement			Kappa coefficient (k)	Pearson correlation coefficient (r)
	Complete Agreement	1-point off	2-points off		
Cluster A: Denying Sexually Deviant Behaviours and Arousal					
1. Denies Current Specific Offense	82%	18%	0%	0.73 ***	0.92 ***
2. Denies Sex Offending History	91%	9%	0%	n/a	
4. Focuses on Acceptable or Nonsexual Behaviours	91%	9%	0%	0.86 ***	
12. Denies Deviant Arousal and Fantasies	82%	9%	9%	n/a	
13. Denies Sexual Arousal During Current Offense	91%	0%	9%	0.81 **	
Cluster B: Denying Need for Treatment or Management of Sexual Offending					
10. Denies Possibility of Future Behaviour	100%	0%	0%	n/a	0.95 ***
14. Shows Defensiveness or Excessive Hostility	100%	0%	0%	n/a	
15. Possibility of Change Through Treatment	73%	18%	9%	0.70 *	
16. Expresses No Desire or Need for Help	91%	9%	0%	0.95 ***	
Cluster C: Denying Responsibility for the Offense					
7. Blames the Victim	73%	27%	0%	0.59 **	0.91 ***
8. Qualifies/Justifies with Internal Attribution	73%	27%	0%	0.59 **	
9. Qualifies/Justifies with External Attribution	64%	27%	9%	0.44 *	
11. Denies Any Intent, Planning, or Premeditation	73%	18%	9%	0.52 *	
17. Denies Memory of Offense	91%	9%	0%	0.84 ***	

Cluster D: Minimizing Harm Done by the Offense					0.95 ***
3. Lacks Feelings of Guilt and Embarrassment	73%	18%	9%	0.58 ***	
5. Minimizes of the Seriousness of the Offense	64%	36%	0%	0.46 *	
6. Minimizes of Harm to Victim	82%	18%	0%	0.71 **	
18. Denies Deserving	91%	9%	0%	n/a	
<hr/>					
CID-SO Total					0.97 ***

Note: * $p < .05$, ** $p < .01$, *** $p < .001$. $N = 11$. "n/a" refers to items for which kappas could not be calculated due to low score variability.

Table 13

Internal Consistencies of the CID-SO for Different Categories of Offenders

CID-SO Clusters	Cronbach's Alpha				
	Total Sample (<u>N</u> = 52)	Age of Victim		Severity of Adjudication	
		Children (<u>N</u> = 38)	Adults (<u>N</u> = 14)	Provincial (<u>N</u> = 32)	Federal (<u>N</u> = 20)
Cluster A: Denying Sexually Deviant Behaviours and Arousal (5 items)	0.82	0.78	0.89	0.80	0.85
Cluster B: Denying Need for Treatment / Management of Sexual Offending (4 items)	0.73	0.67	0.78	0.76	0.67
Cluster C: Denying Responsibility (5 items)	0.82	0.72	0.94	0.83	0.83
Cluster D: Minimizing Harm (4 items)	0.92	0.90	0.95	0.92	0.92
CID-SO Total	0.95	0.93	0.97	0.95	0.94

Table 14

Means and Standard Deviations of the CID-SO for Different Categories of Offenders

CID-SO Clusters	Total Sample (<i>N</i> = 52)	Age of Victim		Severity of Adjudication	
		Children (<i>N</i> = 38)	Adults (<i>N</i> = 14)	Provincial (<i>N</i> = 32)	Federal (<i>N</i> = 20)
Cluster A: Denying Sexually Deviant Behaviours and Arousal (5 items)	3.35 (3.17) (0 - 10)	3.11 (2.92) (0 - 10)	4.00 (3.80) (0 - 10)	3.34 (3.13) (0 - 10)	3.35 (3.31) (0 - 10)
Cluster B: Denying Need for Treatment / Management of Sexual Offending (4 items)	2.04 (2.27) (0 - 6)	1.66* (2.03) (0 - 6)	3.07* (2.64) (0 - 6)	2.13 (2.35) (0 - 6)	1.90 (2.20) (0 - 6)
Cluster C: Denying Responsibility (5 items)	4.15 (3.21) (0 - 10)	3.79 (2.79) (0 - 10)	5.14 (4.11) (0 - 10)	4.28 (3.37) (0 - 10)	3.95 (3.02) (0 - 10)
Cluster D: Minimizing Harm (4 items)	3.15 (3.13) (0 - 8)	2.61* (2.82) (0 - 8)	4.64* (3.52) (0 - 8)	3.16 (3.13) (0 - 8)	3.15 (3.20) (0 - 8)
CID-SO Total	12.69 (10.88) (0 - 34)	11.16 (9.50) (0 - 34)	16.86 (13.48) (1 - 34)	12.91 (11.20) (0 - 34)	12.35 (10.61) (1 - 34)

Note. * $p < .05$, ** $p < .01$. Mean, standard deviation (in parentheses), range (in parentheses) are listed.

Table 15

Means and Standard Deviations for the CID-SO for Treated and Untreated Offenders

CID-SO Clusters	Total Sample (N = 52)	Treatment	
		Completed (N = 37)	None / Ongoing (N = 15)
Cluster A: Denying Sexually Deviant Behaviours and Arousal (5 items)	3.35 (3.17) (0 - 10)	2.68* (2.93) (0 - 10)	5.00* (3.23) (0 - 10)
Cluster B: Denying Need for Treatment / Management of Sexual Offending (4 items)	2.04 (2.27) (0 - 6)	1.51** (2.12) (0 - 6)	3.33** (2.19) (0 - 6)
Cluster C: Denying Responsibility (5 items)	4.15 (3.21) (0 - 10)	3.59* (3.16) (0 - 10)	5.53* (3.02) (2 - 10)
Cluster D: Minimizing Harm (4 items)	3.15 (3.13) (0 - 8)	2.49* (2.94) (0 - 8)	4.80* (3.05) (0 - 8)
CID-SO Total	12.69 (10.88) (0 - 34)	10.27** (10.29) (0 - 34)	18.67** (10.24) (4 - 34)

Note. * $p < .05$, ** $p < .01$. Mean, standard deviation (in parentheses), range (in parentheses) are listed.

Table 16

Internal Consistencies of the CID-SO for Treated and Untreated Offenders

CID-SO Clusters	Cronbach's Alpha		
	Total Sample (N = 52)	Treatment	
		Completed (N = 37)	None / Ongoing (N = 15)
Cluster A: Denying Sexually Deviant Behaviours and Arousal (5 items)	0.82	0.80	0.81
Cluster B: Denying Need for Treatment / Management of Sexual Offending (4 items)	0.73	0.77	0.57
Cluster C: Denying Responsibility (5 items)	0.82	0.84	0.73
Cluster D: Minimizing Harm (4 items)	0.92	0.91	0.91
CID-SO Total	0.95	0.95	0.93

Table 17

Correlations Between the CID-SO and Measures of Social Desirability, Intelligence, and Educational Level

CID-SO Clusters	Balanced Inventory of Desirable Responding			
	Self-Deceptive Enhancement (<i>N</i> = 52)	Impression Management (<i>N</i> = 52)	IQ Estimate (<i>N</i> = 48)	Education (<i>N</i> = 52)
Cluster A: Denying Sexually Deviant Behaviours and Arousal (5 items)	0.18	0.19	-0.04	-0.11
Cluster B: Denying Need for Treatment or Management of Sexual Offending (4 items)	0.23	0.28*	-0.13	-0.14
Cluster C: Denying Responsibility (5 items)	0.18	0.18	-0.18	-0.14
Cluster D: Minimizing Harm (4 items)	0.03	0.16	-0.07	-0.01
CID-SO Total	0.16	0.21	-0.11	-0.10

Note: * $p < .05$.

Table 18

Means and Standard Deviations for Measures of Social Desirability, Intelligence, and Educational Level for the Total Sample and for Subgroups of the Sample

Variables	Total Sample	Age of Victim			Severity of Adjudication			Treatment	
		Children	Adults	Provincial	Federal	Completed	None / Ongoing		
Balanced Inventory of Desirable Responding (BIDR)									
Self-Deceptive Enhancement	86.5 (14.63) N = 52	84.9 (15.22) N = 52	90.9 (12.3) N = 52	87.1 (14.98) N = 52	85.5 (14.39) N = 52	87.2 (13.68) N = 52	84.8 (17.16) N = 52		
Impression Management	80.0 (20.19) N = 52	79.8 (18.56) N = 52	80.6 (24.85) N = 52	81.8 (18.64) N = 52	77.1 (22.63) N = 52	80.3 (21.84) N = 52	79.3 (16.05) N = 52		
IQ Estimate	99.1 (13.50) N = 48	99.6 (13.99) N = 35	97.6 (12.50) N = 13	101.5 (10.39) N = 32	94.3 (17.66) N = 16	99.3 (14.52) N = 35	98.5 (10.79) N = 13		
Education (in years)	11.4 (2.28) N = 52	10.9* (2.19) N = 38	12.7* (2.02) N = 14	11.6 (1.88) N = 32	11.0 (2.81) N = 20	11.4 (2.40) N = 37	11.47 (2.03) N = 15		

Note: Subgroup differences, * $p < .05$. Standard deviations are given in parentheses.

Table 19

Internal Consistencies and Intercorrelation Coefficients Among CID-SO Clusters and Total

CID-SO	A	B	C	D	Total
Cluster A: Denying Sexually Deviant Behaviours and Arousal	0.82***	0.86***	0.86***	0.77***	0.95***
Cluster B: Denying Need for Treatment or Management of Sexual Offending		0.73***	0.84***	0.82***	0.94***
Cluster C: Denying Responsibility			0.82***	0.69***	0.92***
Cluster D: Minimizing Harm				0.91***	0.89***
CID-SO Total					0.95***

Note: *** $p < .001$. Internal consistency values given on the diagonal. $N = 52$.

Table 20

Internal Consistencies and Intercorrelation Coefficients Among CID-SO Clusters and Total with Full Deniers Removed

CID-SO	A	B	C	D	Total
Cluster A: Denying Sexually Deviant Behaviours and Arousal	0.50**	0.60**	0.54**	0.46**	0.82**
Cluster B: Denying Need for Treatment or Management of Sexual Offending		0.50**	0.51**	0.60**	0.84**
Cluster C: Denying Responsibility			0.41**	0.24	0.71**
Cluster D: Minimizing Harm				0.84**	0.77**
CID-SO Total					0.82**

Note: ** $p < .01$. Internal consistency values given on the diagonal. $N = 43$.

Table 21

Means and Standard Deviations of the CID-SO Clusters and Total Score by Total Sample and by Restricted Sample (excluding full deniers)

CID-SO Clusters	Total Sample including Full Deniers (N = 52)	Sample excluding Full Deniers (N = 43)
Cluster A: Denying Sexually Deviant Behaviours and Arousal (5 items)	3.35 (3.17) 0 - 10	2.16 (1.94) 0 - 9
Cluster B: Denying Need for Treatment or Management of Sexual Offending (4 items)	2.04 (2.28) 0 - 6	1.21 (1.49) 0 - 5
Cluster C: Denying Responsibility (5 items)	4.15 (3.21) 0 - 10	2.93 (1.92) 0 - 7
Cluster D: Minimizing Harm (4 items)	3.15 (3.13) 0 - 8	2.14 (2.41) 0 - 8
CID-SO Total	12.69 (10.88) 0 - 34	8.44 (6.05) 0 - 24

Table 22

Correlations Among the Intellectual, Educational, Personality, and Attitudinal Measures

Measure	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1. Est. IQ (N = 48)	-	.42*	-.07	.04	-.11	.19	-.09	.17	.05	-.28	-.16	-.34*	-.34*	.22	-.18	-.10	.28	-.01	.03	.14
2. Education (N = 52)		-	-.08	-.21	.07	.06	.01	-.15	.15	-.09	.21	-.43***	-.34*	.06	-.05	-.06	.14	.11	.01	.01
3. BIDR: SDE (N = 52)			.71	.51***	-.13	.56***	.39*	-.09	-.41**	-.54***	-.32*	-.41**	-.30*	-.04	-.41**	-.25	-.03	-.00	-.16	-.03
4. BIDR: IM (N = 52)			.83	.45***	.22	.27	.27	-.16	-.26	-.07	-.02	.00	.04	-.06	-.12	-.04	-.08	.02	-.08	.03
5. SMS (N = 52)			.78	.78	.01	.11	.11	-.16	.04	-.21	-.07	-.22	-.28*	-.05	-.27	-.30*	-.16	-.06	-.03	-.05
6. RSES (N = 52)			.86	.86	.10	.10	.10	-.79***	-.04	-.54***	-.26	-.43**	-.37**	.07	-.35*	-.49***	.13	.15	.02	.08
7. RCS: Cons (N = 39)									-.75***	-.22	-.31	-.31	-.29	-.29	-.19	.04	-.20	-.22	-.34*	-.14
8. RCS: Nd/Ns (N = 39)									.21	-.00	.16	.12	.20	.17	.03	.00	.03	.11	.18	.03
9. RCS: Nd/S (N = 39)									.13	.13	.13	.22	.11	.33*	.20	-.16	.33*	.22	.32*	.17
10. RCS: D/S (N = 39)											.47**	.63**	.59**	-.10	.51***	.42**	-.07	.02	.12	.02
11. RCS: Dir (N = 39)												.35*	.29	.01	.01	-.01	-.03	.21	.22	.20
12. MOLEST (N = 51)												.94	.69***	-.03	.45***	.39**	.13	.03	.10	.15
13. RAPE (N = 52)													.95	-.22	.71***	.65***	-.35*	-.08	-.06	-.04
14. SRS (N = 52)														.56	-.21	-.22	.75***	.63***	.84***	.58***
15. ASB (N = 52)															.86	.66***	-.20	-.14	-.09	-.15
16. SC (N = 52)																.63	-.20	-.11	-.15	-.26
17. ASFS: Int (N = 52)																	.90	.48***	.56***	.31*

Measure	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
18. ASFS: Imp (N = 52)																		.71	.73***	.54***
19. ASFS: Exp (N = 52)																			.76	.65***
20. ASFS: SM (N = 52)																				.78

Note: * $p < .05$, ** $p < .01$, *** $p < .001$. Internal consistency values provided on the diagonal where available.

BIDR = Balanced Inventory of Desirable Responding, SDE = Self-Deceptive Enhancement, IM = Impression Management, SMS = Self-Monitoring Scale, RSES = Rosenberg's Self-Esteem Scale, RCS = Revised Cognition Scale, Cons = Conservative, Nd/Ns = Nondeviant/Nonsexual, Nd/S = Nondeviant/Sexual, D/S = Deviant/Sexual, Dir = Directly Supporting Child-Adult Sex, SRS = Sex Role Stereotyping, ASB = Adversarial Sexual Beliefs, SC = Sexual Conservatism, ASFS = Appropriate Sexual Fantasy Scale, Int = Intimate Fantasies, Imp = Impersonal Fantasies, Exp = Exploratory Fantasies, SM = Sado-Masochistic Fantasies

Table 23

Correlations Between the CID-SO and Personality Measures

CID-SO Clusters	Self-Monitoring Scale	Rosenberg's Self-Esteem Scale
Cluster A: Denying Sexually Deviant Behaviours and Arousal (5 items)	-0.20	0.11
Cluster B: Denying Need for Treatment or Management of Sexual Offending (4 items)	-0.19	0.14
Cluster C: Denying Responsibility (5 items)	-0.19	0.12
Cluster D: Minimizing Harm (4 items)	-0.26	0.10
CID-SO Total	-0.23	0.12

Note: All correlation coefficients are non-significant. $N = 52$.

Table 24

Means and Standard Deviations for the Personality Measures for the Total Sample and for Subgroups of the Sample

Measures	Total Sample (N = 52)	Age of Victim			Severity of Adjudication			Treatment	
		Children (N = 38)	Adults (N = 14)	Provincial (N = 32)	Federal (N = 20)	Completed (N = 37)	None / Ongoing (N = 15)		
Self-Monitoring Scale	7.0 (3.93)	6.79 (3.93)	7.6 (4.03)	7.1 (4.37)	6.9 (3.20)	7.4 (3.80)	6.1 (4.24)		
Rosenberg Self-Esteem Scale	30.6 (5.22)	30.2 (5.31)	31.86 (4.94)	30.9 (5.51)	30.2 (4.82)	31.05 (4.40)	29.6 (6.92)		

Note: All subgroup differences are non-significant. Standard deviations are given in parentheses.

Table 25

Correlations Between the CID-SO and the Categories of the Revised Cognition Scale

CID-SO Clusters	Total Sample (<u>N</u> = 39)	Child Molester (<u>N</u> = 31)
Cluster A: Denying Sexually Deviant Behaviours and Arousal (5 items)	0.00	-0.04
	0.04	0.22
	-0.04	-0.12
	0.01	-0.14
	-0.04	-0.22
Cluster B: Denying Need for Treatment or Management of Sexual Offending (4 items)	-0.01	-0.08
	0.07	0.30
	-0.05	-0.13
	-0.06	-0.23
	-0.03	-0.09
Cluster C: Denying Responsibility (5 items)	-0.15	-0.27
	0.09	0.38*
	0.13	0.07
	0.14	0.030
	0.01	-0.11
Cluster D: Minimizing Harm (4 items)	-0.14	-0.28
	0.10	0.38*
	0.08	0.04
	0.14	0.08
	0.19	0.23
CID-SO Total	-0.09	-0.20
	0.08	0.37*
	0.04	-0.04
	0.07	-0.06
	0.04	-0.05

Note: * $p < .05$.

Values represent correlations between the CID-SO clusters and total and the number of responses in the following order of categories from the RCS:

- Conservative/Denial of Child Sexuality items
- Nonsexual/Nondeviant items
- Nondeviant/sexual items
- Deviant sexual items
- Directly supportive of adult/child sex items

Table 26

Means and Standard Deviations for the Revised Cognition Scale and the MOLEST Scale for the Total Sample and for Subgroups of the Sample

Measures	Total Sample	Age of Victim			Severity of Adjudication			Treatment	
		Children	Adults	Provincial	Federal	Completed	None / Ongoing		
Revised Cognition Scale									
Conservative responses	23.6 (5.87) N = 39	22.9 (6.27) N = 30	26.1 (3.48) N = 9	24.7 (5.63) N = 27	21.3 (5.97) N = 12	24.3 (5.86) N = 28	22.0 (5.85) N = 11		
Nonsexual/nondeviant responses	9.3 (3.84) N = 39	9.7 (3.99) N = 30	8.1 (3.22) N = 9	8.8 (3.52) N = 27	10.4 (4.44) N = 12	8.9 (3.62) N = 28	10.4 (4.34) N = 11		
Nondeviant/sexual responses	6.6 (3.44) N = 39	7.0 (3.52) N = 30	5.3 (2.96) N = 9	6.0 (3.41) N = 27	8.0 (3.22) N = 12	6.6 (3.89) N = 28	6.7 (2.01) N = 11		
Deviant/sexual responses	0.28 (0.69) N = 39	0.30 (0.70) N = 30	0.22 (0.67) N = 9	0.37 (0.79) N = 27	0.08 (0.29) N = 12	0.18 (0.48) N = 28	0.55 (1.04) N = 11		
Directly supportive of adult/child	0.15 (0.43) N = 39	0.13 (0.43) N = 30	0.22 (0.44) N = 9	0.15 (0.46) N = 27	0.17 (0.39) N = 12	0.07 (0.26) N = 28	0.36 (0.67) N = 11		
MOLEST Scale	56.1 (15.43) N = 51	58.3 (15.31) N = 37	50.3 (14.68) N = 14	57.3 (14.66) N = 32	54.11 (16.85) N = 19	55.0 (13.71) N = 37	59.1 (19.54) N = 14		

Note: All subgroup differences are non-significant. Standard deviations are given in parentheses.

Table 27

Correlations Between the CID-SO and the MOLEST Scale

CID-SO Clusters	Total Sample (<u>N</u> = 51)	Child Molesters (<u>N</u> = 36)
Cluster A: Denying Sexually Deviant Behaviours and Arousal (5 items)	0.06	0.08
Cluster B: Denying Need for Treatment or Management of Sexual Offending (4 items)	0.07	0.20
Cluster C: Denying Responsibility (5 items)	0.12	0.22
Cluster D: Minimizing Harm (4 items)	0.18	0.36*
CISOD Total	0.12	0.24

Note: * $p < .05$.

Table 28

Correlations Between the CID-SO and the RAPE Scale

CID-SO Clusters	Total Sample (<u>N</u> = 52)	Adults (<u>N</u> = 14)
Cluster A: Denying Sexually Deviant Behaviours and Arousal (5 items)	0.32*	0.51
Cluster B: Denying Need for Treatment or Management of Sexual Offending (4 items)	0.24	0.49
Cluster C: Denying Responsibility (5 items)	0.42**	0.47
Cluster D: Minimizing Harm (4 items)	0.30*	0.42
CID-SO Total	0.35*	0.49

Note: * $p < .05$, ** $p < .01$.

Table 29

Means and Standard Deviations for the RAPE Scale and the Burt Attitude Scales for the Total Sample and the Subgroups of the Sample

Measures	Total Sample (<i>N</i> = 52)	Age of Victim				Severity of Adjudication			Treatment	
		Children (<i>N</i> = 38)	Adults (<i>N</i> = 14)	Provincial (<i>N</i> = 32)	Federal (<i>N</i> = 20)	Completed (<i>N</i> = 37)	None / Ongoing (<i>N</i> = 15)			
RAPE Scale	54.6 (14.81)	55.4 (14.69)	52.6 (15.49)	55.5 (15.26)	53.3 (14.34)	52.6 (13.60)	59.7 (16.87)			
Burt Attitude Scales										
Sex Role Stereotyping	27.4 (6.83)	28.5* (6.98)	24.4* (5.53)	27.3 (7.48)	27.6 (5.81)	28.0 (7.13)	25.9 (5.99)			
Adversarial Sexual Beliefs	20.3 (9.23)	20.3 (8.72)	20.4 (10.86)	21.0 (10.29)	19.3 (7.36)	19.7 (7.44)	21.9 (12.83)			
Sexual Conservative	37.3 (8.93)	37.1 (8.65)	37.9 (9.95)	38.3 (9.94)	35.8 (6.99)	36.5 (8.40)	39.2 (10.16)			

Note: Subgroup differences, **p* < .05. Standard deviations are given in parentheses.

Table 30

Correlations Between the CID-SO and the Burt Attitude Scales

CID-SO Clusters	Sex Role Stereotyping		Adversarial Sexual Beliefs		Sexual Conservatism	
	Total (<u>N</u> = 52)	Offenders against adults (<u>N</u> = 14)	Total (<u>N</u> = 52)	Offenders against adults (<u>N</u> = 14)	Total (<u>N</u> = 52)	Offenders against adults (<u>N</u> = 14)
Cluster A: Denying Sexually Deviant Behaviours and Arousal (5 items)	-0.16	-0.50	0.24	0.26	0.11	0.03
Cluster B: Denying Need for Treatment or Management of Sexual Offending (4 items)	-0.16	-0.25	0.13	0.22	0.06	0.03
Cluster C: Denying Responsibility (5 items)	-0.12	-0.21	0.32*	0.23	0.20	0.02
Cluster D: Minimizing Harm (4 items)	0.02	-0.31	0.17	0.18	0.05	0.01
CID-SO Total	-0.11	-0.33	0.24	0.23	0.12	0.02

Note: * $p < .05$.

Table 31

Correlations Between the CID-SO and the Four Fantasy Themes from the Appropriate Sexual Fantasies Scale

CID-SO Clusters	Intimate	Impersonal	Exploratory	Sado-masochistic
Cluster A: Denying Sexually Deviant Behaviours and Arousal (5 items)	-0.14	-0.06	-0.20	-0.24
Cluster B: Denying Need for Treatment or Management of Sexual Offending (4 items)	-0.08	-0.04	-0.23	-0.31*
Cluster C: Denying Responsibility (5 items)	-0.10	0.01	-0.18	-0.21
Cluster D: Minimizing Harm (4 items)	0.08	0.21	0.04	-0.15
CID-SO Total	-0.06	0.04	-0.15	-0.24

Note: * $p < .05$. Correlations are for the entire sample ($N = 52$).

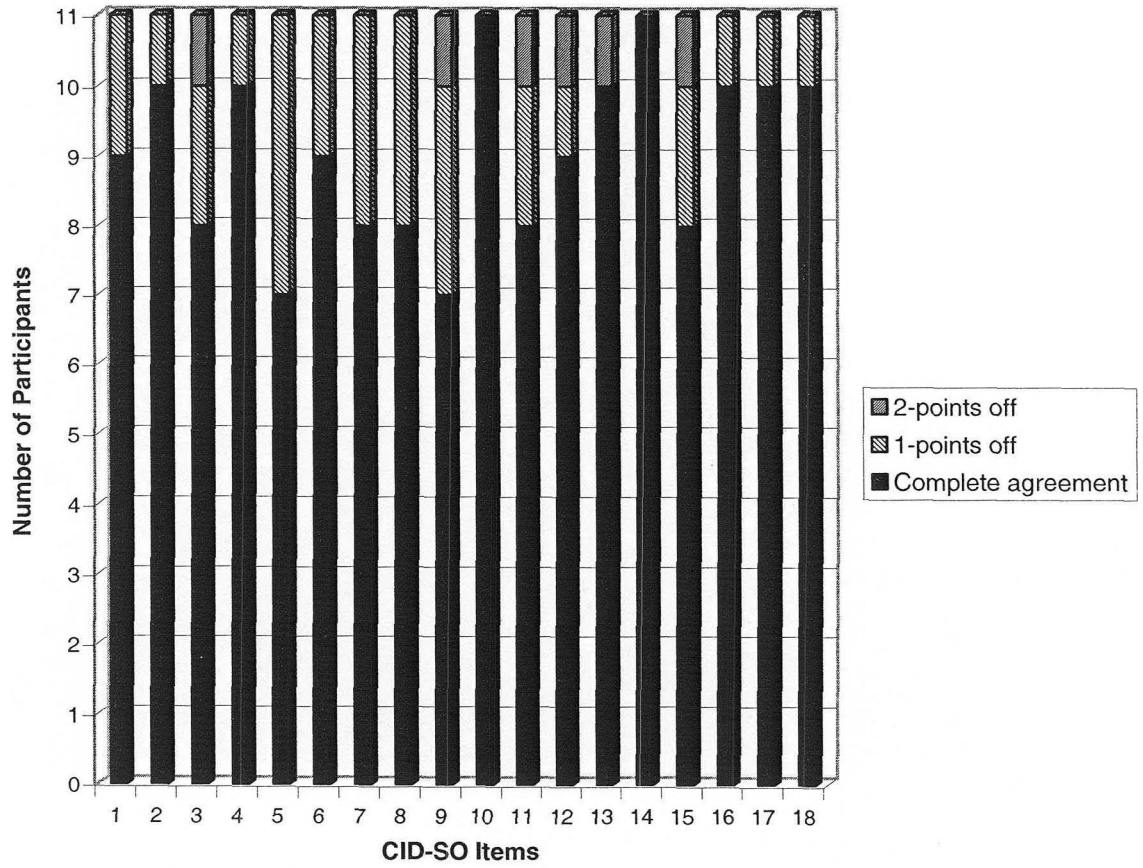
Table 32

Means and Standard Deviations for the Appropriate Sexual Fantasies Scale for the Total Sample and the Subgroups of the Sample

Fantasy Themes	Total Sample (N = 52)	Age of Victim			Severity of Adjudication			Treatment	
		Children (N = 38)	Adults (N = 14)	Provincial (N = 32)	Federal (N = 20)	Completed (N = 37)	None / Ongoing (N = 15)		
Intimate Fantasy	50.9 (12.96)	51.4 (13.11)	49.5 (12.91)	49.9 (13.22)	52.6 (12.71)	51.7 (12.71)	49.0 (13.83)		
Impersonal Fantasy	24.6 (8.74)	24.8 (9.36)	23.9 (7.06)	25.4 (10.02)	23.2 (6.15)	24.8 (8.99)	24.0 (8.38)		
Exploratory Fantasy	25.1 (8.62)	26.3 (8.91)	21.8 (7.03)	25.1 (9.59)	25.1 (7.03)	25.6 (8.49)	23.7 (9.05)		
Sado-Masochistic Fantasy	13.4 (5.14)	14.2** (5.75)	11.0** (1.18)	14.3 (5.92)	11.8 (3.11)	13.4 (5.32)	13.2 (4.87)		

Note: Subgroup differences, ** $p < .01$. Standard deviations are given in parentheses.

Figure 1. Agreement Between Raters for Each CID-SO Item



Appendix A:
Comprehensive Inventory of Denial - Sex Offender Version (CID-SO)

RATING GUIDE FOR
Comprehensive Inventory of Denial
Sex Offender Version (CID-SO)©

Sandy Jung

University of Victoria
Victoria, B.C.

Not to be copied under any circumstances without
the expressed written consent of the author.

Rationale and Assumptions

- Many treatment programmes for sex offenders are aimed at decreasing denial and encouraging the offender to accept responsibility for his behaviour.
- By measuring denial in a systematic way, it could be determined whether patterns do in fact change with treatment, and most importantly, whether this change is of prognostic importance.
- The Comprehensive Inventory of Denial - Sex Offender Version (CID-SO) is based both on my experience working with sex offenders, both individually and in groups, at Adult Forensic Psychiatric Services under the direction of D. Richard Laws, and on the existing research on sex offender denial (see References).
- The CID-SO is comprised of 18 items. It is an inventory that is to be completed by a mental health worker after he/she has interviewed the sex offender. Each item is scored on a 3-point scale ranging from 0 through to 2. Each point is given a more thorough description on the inventory such that the interviewer is to evaluate whether the client is representative of a score of 0, 1 or 2 (e.g., score of 0 for 'difficulty of change' would encompass a person who 'acknowledges offending is within his control and he is able to change with help). The interview is the basis for the CID-SO ratings.
- I am most interested in the pattern of the CID-SO items rather than the summation of the scores from each item, as this is most relevant to assessment and treatment of the sexual offender.
- These 18 items have been clustered into four conceptual forms of denial - described elsewhere. The use of clusters is purposely used to avoid treating denial as a binary concept or a series of levels ranging from weak to severe. Rather, denial has a variety of facets that can be identified and addressed through sex offender treatment (e.g., relapse prevention).

- My intentions behind the development of this instrument are not concerned with legal guilt or innocence - one must assume that the adjudicated offender is guilty of the crime for which he has been convicted or pled guilty. Rather, the issue explored here is denial as (1) a psychological defense mechanism used to protect oneself against anxiety-producing knowledge, or (2) conscious deception, and how such denial relates to supervision of sexual offenders.
- Please note that the instrument is currently being researched and is continually updated through this research and development. Hence, it is the user's responsibility to contact the author periodically and update their version of the CID-SO (or the previous version, CISOD). The author would appreciate receiving copies of completed CID-SO protocols and demographic and offense information. The data would solely be used for inclusion in a normative sample.

Conceptualization of CID-SO Denial Clusters

CLUSTER A:

Denying Sexually Deviant Behaviours and Arousal

This cluster represents an offender who does not acknowledge having committed a sexual offense nor having a sexual offending history (when file records indicate otherwise). They may minimize the sexual aspect of their offending and that they have no deviant sexual interests.

Items:

- 1: Deny Current Specific Offense
- 2: Deny Sex Offending History
- 4: Tends to Focus on Acceptable or Nonsexual Behaviours
- 12: Deny Deviant Arousal and Fantasies
- 13: Deny Sexual Arousal During Current Offense

CLUSTER B:

Denying Need for Treatment/Management of Sexual Offending

This cluster describes an offender who seems incapable of recognizing the need for treatment or management of a sexual offending problem. For those who completely deny committing the sexual offense or having a sexual offense history, they simply do not acknowledge having a problem that needs any psychological attention. For those who do not completely deny commission of offending, they may become defensive or hostile to mental health professionals or they may feel that this was a "one time deal" which does not require lifetime management. Some offenders may also feel that a change in his behaviour is "difficult" and that focus should be on secondary and tertiary changes, such as reunification of the family or getting a job.

Items:

- 10: Deny Possibility of Future Behaviour
- 14: Defensive/Excessive Hostility
- 15: Difficulty of Change
- 16: No Desire or No Expressed Need for Help

**CLUSTER C:
Denying Responsibility**

This cluster represents an offender who partly accepts responsibility, but qualifies offending with some stipulations or justifications. The offender may be accusatory and blame the victim for making up the accusations or exaggerating the sexual details of the offense or he may simply state that "it just happened". Many offenders may justify their offending with internal reasons, such as their mental status or some cognitive deficits. Often, the offender portrays himself as the real victim and may even say that he is a different person now. Others may justify their offending with external reasons, such as alcohol abuse, own sexual abuse as a child or wife's lack of interest in sex. When alcohol abuse is described as a proximate factor in their sexual offending, the offender may tend to claim that he does not remember the offending and therefore deny any responsibility for offending.

Items:

- 7: Blaming the Victim
- 8: Qualification/Justification - Internal Attribution
- 9: Qualification/Justification - External Attribution
- 11: Deny Any Intent/Planning/Premeditation
- 17: False Dissociation

**CLUSTER D:
Minimizing Harm**

This cluster represents an offender who shows little remorse for the commission of the offense and a lack of empathy for the victim. They have great difficulty acknowledging the seriousness of the offense and recognizing that they have done harm to their victim(s). They may also feel that they have been treated unjustly for their offense or that the offense should not be considered against the law.

Items:

- 3: Lacks Feelings of Guilt and Embarrassment
- 5: Minimization of the Seriousness of the Offense
- 6: Minimization of Harm to Victim
- 18: Social Sanction

Instructions for Scoring CID-SO Items

Overview of Scoring and Scorer

The Comprehensive Inventory of Denial - Sex Offender Version (CID-SO) is intended to be interview-based; professionals should conduct a thorough intake assessment interview with the offender, use collateral sources (e.g., file information, interviews with collateral sources, victim impact statements, police reports), and then subsequently complete the CID-SO rating form. Although it is possible for the CID-SO to be scored based on file information and corroborative information from relevant sources, it is best to conduct an interview with the offender.

Completing the items on the CID-SO requires that the practitioner has had some experience in the provision of psychological services within a forensic or correctional setting to sexual offenders.

Completing Items

Each item is described in great detail on the following pages. When scoring each sex offender practitioners should compare him to a prototypical sex offender represented by description detailed for that particular item. Hence, the characteristics of the items are described to represent an individual who represents a score of '2', unless otherwise indicated.

Some Considerations

It is important to note that offenders rarely volunteer information about other types of sexual deviance unless asked directly. Even when asked they may be less than honest, even when interviewed by experienced clinicians.

The rating of the CID-SO may change with the gathering of information, as each piece of information adds to the collective knowledge about the offender. The intention of the development of the CID-SO is to assess the change in a sex offender's cognitive distortions and his acceptance of responsibility for his own actions, particularly when he has engaged in a sex offender management/treatment program.

If the offender is in total denial of his current index offense, then score each item as '2' with the exception of Items 2: 'Sex Offending History' and 14: 'Defensive/Excessive Hostility'.

DESCRIPTION OF CID-SO ITEMS

Item 1: Denies Current Specific Offense

For a score of '2':

The offender denies committing the current sexual offense as charged and convicted. The offender denies the overall charge of sexual abuse and may or may not focus exclusively on the concrete details of a particular day, situation, or event. For example, he might say "I couldn't have done it because I wasn't there at the time," "I'm not the sort of person who would do that sort of thing. I am not a child molester; therefore, I did not molest this particular child." or "I didn't do anything wrong."

Some offenders focus concretely on the details of the alleged abuse and respond, not with an overall denial of the charges, but with an alibi for that particular day. Of these, some will have backup from family or friends for their alibi. While their families may support them and also deny the charge, family denial is less pathological than when the family produces a false alibi, since it does not involve outright lying to protect the offender (although family alibis are not infrequent).

They may tend to be preoccupied and focused on the child's memory, and have difficulty grasping the main point. For example, they cannot understand that whether it occurred on June 6th or 7th is not the main point.

For a score of '1':

Often, offenders withhold information on the extent of their sexual deviance because of a fear of additional legal charges. For example, the penalties for fondling are often less severe than for penetration; thus an offender may admit to one but not the other or may admit to intercourse but denies the period of time over which it occurred.

If the offender says that the act occurred (and this is mostly consistent with what is on record and what the victim has alleged) but denies that he committed an actual sexual offense, score him as a '1'. For example, he may see himself as having had consensual sex despite the allegations that he forced the victim or the allegation that he knew she was underage. Another example would be that he claims to not have known that the victim was underage. Hence, in both cases the offender may claim that no crime was committed since there was no intent or knowledge on his part.

Scoring:

- 0 *Not at all*
Fully admits current offense as charged
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Partially denies the current specific offense
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Denies the current offense completely
The item applies to the individual; a reasonably good match in most essential respects.

Item 2: Denies Sex Offending History

For a score of '2':

The offender denies committing any sexual offense at any other time even though collateral information indicates otherwise.

This is similar to Item 1 (Deny Current Specific Offense): The offender denies committing historical offenses as charged and convicted. The offender denies these past charge(s) of sexual abuse and may or may not focus exclusively on the concrete details of a particular day, situation, or event. For example, he might say that he "was only giving her a bath, but did not do that". The offender refuses to acknowledge responsibility for even remotely similar behaviours.

If the clinician has some suspicions about the offender's past offending behaviours (e.g., some indication through file records or probation officers that offenses were committed before the charged offense -- whether allegations were made or charges were made), this information is intended to be considered as unrecorded offenses. Hence, this item pertains to an offender's admission to these previous offenses as well as those that are well-documented.

For a score of '1':

If the offender says that these past act(s) occurred (and this is mostly consistent with what is on record and what the victim has alleged) but denies that he committed an actual **sexual offense**, score him as a '1'.

For a score of '0':

If there is no indication that the offender had any previous sex offending history, admission of history is not necessary and this item can be scored as '0'.

Scoring:

- 0 *Not at all*
Fully admits committing offenses at other times, both as recorded and unrecorded
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Partly admits offenses at other times; some not all recorded offenses
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Denies previous offenses completely
The item applies to the individual; a reasonably good match in most essential respects.

Item 3: Lacks Feelings of Guilt and Embarrassment

For a score of '2':

The offender does not feel guilt over being discovered, as they believe they are not behaving inappropriately, and they rarely feel shame. When they do feel shame, it is over what they have done to their own or their family's status in the community or over some secondary effect of the abuse such as incarceration. Note this item refers to feelings of guilt regarding his sexually deviant behaviour and *not to the discovery or disclosure of his offending*.

The offender has no or little guilt for hurting someone or for taking advantage of another, especially when he doesn't see his behaviour as deviant or offensive in nature. Hence, in order for this item to be rated a '0' or a '1', he **must not deny committing the offense**.

Offenders who deny committing the offense show little, or no, evidence of shame or guilt about offending, but merely to the disclosure of the offending. This warrants a score of '2'.

For a score of '1':

It is important to notice whether what he says is consistent with what is observable in his affect. Some offenders are aware of what they are supposed to say (i.e., expressing guilt over the offense), but their affect and expression may indicate a lack of true guilt feelings. If the offender shows minimal remorse for his offense, but instead primarily focuses on his embarrassment and shame for his behaviour and the discovery of the offending, this would warrant a '1'. However, this does not apply if his regret is due to his embarrassment and shame for the disclosure and discovery of his offending.

Scoring:

- 0 *Not at all*
Feels guilt and embarrassment for committing the offense(s)
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Feels embarrassed over the offending, but feels minimal guilt for the offense itself
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Lacks any guilty or embarrassment associated with the actual offense
The item applies to the individual; a reasonably good match in most essential respects.

Item 4: Focuses on Acceptable or Nonsexual Behaviours

For a score of '2':

Offenders will frequently admit part of their behaviour but deny the rest. Offenders with this characteristic do not admit committing the current sexual offense, but may admit to engaging in "less harmful" behaviours. They tend to focus on other nonsexual aspects of their behaviour, usually more "acceptable" or "nonsexual" aspects. For example, he might say "I hit the victim, but I didn't rape her." The offender could also focus on the "love" aspect. For example, he was only trying to show his love to her/him and hence, he minimizes the sexual nature of the abuse/offense.

For child molesters, they may emphasize a nonsexual possibility, such as saying "the behaviour was simply part of her hygiene."

Offenders who deny committing the offense altogether also deny any wrongdoing and focuses on other aspects of his behaviour which are all nonsexual in nature. This warrants a score of '2'.

For a score of '1':

If the offender is able to bring up the sexual nature of the offense but primarily emphasize the nonsexual aspects of his behaviour, this would warrant a '1'.

Note:

Although the scoring of item 1 and 4 are related, they are scored separately. An individual could be scored a '1' for item 1 and a '2' for item 4. However, it is unlikely that one can be scored '0' for item 1, but a '2' for item 4 (e.g., if an offender admits committing the sexual offense, it is unlikely that he focuses solely on the nonsexual behaviours; but it is likely that he may emphasize the nonsexual behaviours more than the sexual ones).

Scoring:

- 0 *Not at all*
Fully focuses on sexual nature of the offense
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Able to focus on sexual nature of offense, but emphasizes other nonsexual behaviours
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Focuses on other aspects of behaviour; usually more "acceptable" or "nonsexual" aspects
The item applies to the individual; a reasonably good match in most essential respects.

Item 5: Minimizes the Seriousness of the Offense

For a score of '2':

The offender does not appreciate the seriousness of the consequences of the behaviour. He belittles or denies the offense was "a big deal". He does not acknowledge the seriousness of the offense, the deviant nature of the offending, or the harm done to the victim (see Item 6 for further explanation).

He may tend to compare his offense to other types of offenses or other types of offenders. For example, "my offense wasn't that bad - at least I didn't have sex with her, I just had her suck my cock." He might compare it to what he thinks is the worst kinds of sexual offending, such as rape or sodomy. Another comparison approach is to emphasize that the frequency of offending wasn't that bad. For example, "I only touched her once - I knew not to penetrate her as that would harm her permanently."

He might also emphasize "loving them" or wanting to just give them pleasure, hence implying that his intentions were not bad. The offender may say that it wasn't rape or molestation as it was "consensual" in nature - regardless of the victim being an adult or a child.

Offenders who deny committing the offense do not accept that their behaviour was harmful to themselves and to others. This warrants a score of '2'.

For a score of '1':

If the offender is able to recognize that his behaviour was deviant and harmful but primarily focuses on the comparative approach with other types of offenders, this would warrant at least '1'.

Scoring:

- 0 *Not at all*
Accepts seriousness of his behaviours
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Accepts, in part, seriousness of offense
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Denies the offense was serious in nature; belittles the sex offense
The item applies to the individual; a reasonably good match in most essential respects.

Item 6: Minimizes Harm to Victim

For a score of '2':

Offenders have great difficulty acknowledging the harm done to their victim(s). They may even go as far to say that they helped the victim by educating them, showing them love, or not going any further (e.g., penetration). The latter is common - emphasizing that he didn't go too far and "saved" the victim from furthering the pain (e.g., "I was gentle and kind - I didn't penetrate her because I knew that would harm her").

Child molesters who tell themselves they are educating the child, comforting the child, being close to the child, loving the child, or satisfying the child's curiosity do not allow themselves to appreciate the destructiveness of their behaviour to the child (see Item 5 for further explanation of minimizing seriousness). Hence, child molesters maintain, for example, that they were educating the children and/or offering them affection and friendship. So rather than harming the victim, they feel that they were to some extent helping the victim. Such offenders do not necessarily blame the children for the acts (see Item 7 for further explanation). They may also minimize the harm by expressing that the child misses the offender; hence, harm to the victim is only because of the disclosure and the subsequently separation as forced by the courts. For example, "she loved me so much" or "she misses me." An excellent example shows typical minimization of harm that an offender attributes to his offending: "In my own mind back then, I thought I was doing her a favor. I made myself feel that I was not doing anything wrong, that I was actually sexually educating her. We never did have complete intercourse. I thought . . . just touching and playing and fondling and all that, that wasn't harmful" (Salter, 1988; p. 99).

For rapists, most often they claim that there was no harm to their victim and the sexual assault was actually consensual by making statements such as "she showed no signs of abuse - we just had a drink the other day". They are unable or not willing to acknowledge that the victim has experienced negative consequences as a result of the offender's actions. They may even rationalize the victim's behaviour, such as seeking counselling or attempts at suicide to the victim's personality or their possibly mental disturbances which preceded the offense, rather than to the offense itself.

Some offender may also have great difficulty connecting the victim's behaviour (i.e., attempts at suicide, having children early, seeking counselling) as a result of his offending against the victim.

For offenders with severe cognitive distortions, they may claim that the victim enjoyed the offending and found it pleasurable. For example, "she loved the sex as much as me."

Some offenders may portray themselves as the real victim. These offenders tend to not see any harm done to their victim(s).

Offenders who deny committing the offense obviously do not admit that their behaviour has harmed the victim. This warrants a score of '2'.

For a score of '1':

If the offender has difficulty acknowledging harm to the victim, but speculates that there could be possible future harm to his victim, although examples are generic and non-specific to the victim, this would warrant at least a '1'. This especially applies when the offender appears to have been "educated on the effect on kids" and it is not apparent that he truly feels his victims were harmed, especially when his affect and what he is saying is inconsistent.

Scoring:

- 0 *Not at all*
Acknowledges harm to victim; not applicable
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Minimizes the harm to victim; difficulty acknowledging harm to victim
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Denies any harm was done to the victim; or claims to have helped the victim
The item applies to the individual; a reasonably good match in most essential respects.

Item 7: Blames the Victim

For a score of '2':

Offenders blame the victim for the initiation of the sexual behaviour, the extent of the offending, or the resulting charges of sexual assault. The result of this facet of denial is that the offender becomes the victim in the offending and the target of ill-will.

Offenders may blame the victim for initiating sexual activity by saying they were dressing provocatively or discussing topics *that the offender perceived as sexually related topics*. The latter is emphasized as the offender may paraphrase what the child had said but it is not clear and confirmed that the child had made such a statement, nor did the child even imply anything that was sexual in nature. Some offenders blame the child for wearing "sexy" or revealing clothes. They might maintain that the child's wearing a nightgown, sitting in the offender's lap, putting her arms around the offender, or running around the house nude after a bath were provocative and responsible for the abuse. This is an equivalent mental process to that of the adult exhibitionist, rapist, or potential rapist, who declares that exposure or rape is justified because women "think they are so high and mighty on a pedestal that nobody can touch them." They may express that many women, for example, who are walking in secluded areas in skimpy clothes such as shorts and a tank top were simply "asking for it." **Hence, the offender distorts the idea that the victims initiated the sexual encounter and promoted it by their actions.**

Offenders may focus on their perception of the offending by saying that the victim seemed to enjoy it and never said anything to indicate she wasn't enjoying it. Rapists may blame victims for not disclosing their age up front, assuming this would hinder their decision to have sex. The last form is blaming the victim for the resulting charges or the consequences of the charges. For example, "she was plotting against me from the very beginning" or "this was revenge."

Offenders who deny committing the offense may insist that the victim and/or the system is "out to get" them, and that they are the real victims. This warrants a score of '2'.

For a score of '1':

If the offender acknowledges that the offending is a result of his own behaviour but also emphasizes the victim's role in the offending or resulting charges (e.g., "she came to my bed", "she made it seem worse than it really was", "she didn't really like me, so she led me to do this", "she started it by sitting on my knee and touching my penis), this would warrant at least a '1'.

Scoring:

- 0 *Not at all*
Acknowledges offending is a result of his own behaviour
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Partly acknowledges offending is a result of his behaviour, but also to the victim's ill-will or exaggeration
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Blames the victim for the offending and/or the consequences of the charges
The item applies to the individual; a reasonably good match in most essential respects.

Item 8: Qualifies or Justifies with Internal Attribution

For a score of '2':

Internalizers tend to admit both the offense and harm to the victim but couple it with a dissociative style of explanation in which their actions were attributed to a temporary aberration of behaviour or mental state which was out of keeping with their normal character. Blame is placed on their mental status, their difficulty coping with pressures at work, and on their own emotional neediness. For example, "I would not have committed the offense if I had not been drunk (stoned, depressed, etc.)." But he may insist that he needs no treatment at all (as he does not plan to drink again) or, at the most, needs treatment for alcoholism as *that* is the real problem.

Inevitably, the offender portrays himself as the real victim. The affect is frequently a mixture of self-pity and anger at the world for denying him what should have been freely given, usually emotional support and sex. The offender tends to not admit that he committed the offenses because he found them pleasurable sexually, nor does he admit the extent of fantasy and planning that preceded them (see Item 11 for further explanation of intent/ planning/premeditation).

He may make statements referring to himself as though he was a completely different person, such as "that was like a different person back then - I'm not like that now" or "I've never done it before, so how could it be me" - despite having never engaged in any formal treatment or formal changes to address sexual offending. Or he may stress that his offending was a result of his lifestyle which was taught by others, but he incorporated into his living (e.g., "this was considered normal where I lived [regarding the time period, or the community he lived in]").

Offenders who deny committing the offense will likely insist that they are not "that type of person" to commit such an offense. This warrants a score of '2'.

For a score of '1':

Although the offender attributes some of his offending to some mitigating factors, he also accepts responsibility for his commission of the offense. The offender may be less overt about not assuming responsibility. For example, he may say he is ultimately responsible for the offense; however, careful listening to their descriptions of the abuse will detect constant internalization (e.g., alcohol/substance abuse, emotional state).

Scoring:

- 0 *Not at all*
Accepts internal/personal responsibility; no mitigating internal factors
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Claims there were mitigating internal/personal factors, but accepts responsibility for committing the offense
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Denies internal/personal responsibility; claims offense was out of character
The item applies to the individual; a reasonably good match in most essential respects.

Item 9: Qualifies or Justifies with External Attribution

For a score of '2':

This item is similar to Item 8, but instead of simply not accepting that he is at fault and should accept responsibility, an individual scoring a '2' tends to externalize responsibility to outside factors. Blame is often placed on proximate factors, such as their wives' nagging, their wives' lack of interest in sex, their own problems at work, provocation by the child, lack of attention and care from the world in general (including lack of a romantic partner/lover), and excessive care and attention from the child ("she was the only one I could be close to"). Also, blame can often be placed on remote factors, such as their own sexual abuse as a child, poor upbringing, and lack of privileges during childhood.

The offender may admit the actual behaviours and may even accept their seriousness, but deny responsibility for them by attributing it to these proximate or remote factors. This is sometimes blatant, as when an offender attributes the abusive behaviour to his poor childhood and sexual victimization by a family member.

Inevitably, the offender portrays himself as the real victim. The affect is frequently a mixture of self-pity and anger at the world for denying him what should have been freely given, usually emotional support and sex. The offender may tend to not admit that he committed the offenses because he found them pleasurable sexually, nor does he admit the extent of fantasy and planning that preceded them (see Item 11 for further explanation of intent/ planning/ premeditation).

Offenders who deny committing the offense may blame external agencies (or persons) for conspiring against them (hence, the charges/convictions are not true because of these people). This warrants a score of '2'.

For a score of '1':

Although the offender attributes some of his offending to some mitigating factors, he also accepts responsibility for his commission of the offense. The offender may be less overt about not assuming responsibility. For example, he may say he is ultimately responsible for the offense; however, careful listening to their descriptions of the abuse will detect constant externalization (e.g., own sexual abuse, dissatisfaction with marriage, lack of a partner).

Note:

If an offender scores a '2' on item 7 (Blaming the Victim), then they would not score a '0' on this item (External Attribution).

Scoring:

- 0 *Not at all*
No blame of third parties
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Claims there were mitigating external factors, but accepts responsibility for committing the offense
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Blames remote and proximate factors
The item applies to the individual; a reasonably good match in most essential respects.

Item 10: Denies Possibility of Future Behaviour

For a score of '2':

The offender denies the possibility that he will commit a similar offense in the future. For example, "I know it'll never happen again." He may even go as far to say that he is at risk of being a victim of false allegations. However, there is no indication of *how* they will make sure it will never happen again. When asked, he may contend that he just knows that it will not happen, that he will use his willpower to overcome any temptations, that he will simply remind himself of the consequences (e.g., "I won't do it again, because I lost too much" - not really a reason to explain why he will not offend again), or that he will avoid potential victims (e.g., avoid children or blind dates with adult females). These "approaches" to reducing his potential for committing another offense are usually not realistic and, in many cases, not possible (e.g., avoiding women when he is heterosexual and is likely to pursue a relationship with a woman in the future). Even in those cases where the offender says he has not had sexual relations and states he will continue to abstain from sex (in order to make sure he does not give himself another a chance again), the offender does not acknowledge the possibility remains that he could offend again and abstinence is unlikely in the long-term.

Offenders who deny committing the offense do not see themselves as ever committing "another" offense in the future as they claim to have never done so in the past or in the charged offense. This warrants a score of '2'.

For a score of '1':

For those who have received sex offender treatment and do not deny committing the offense, if they acknowledge that there was planning in their offending, but they are ambiguous about it or not sure how, then the offender would appear to be "educated on the offending cycle" and actually lack insight into his own offending. Depending on the degree of lack of insight, this would warrant at least a '1'.

For a score of '0':

For offenders who have engaged in sex offender treatment, if they maintain that they will not commit further offenses as long as they continue to use the strategies learned from formal programming directed at sex offending, this may warrant a '0'.

Note this does not include offenders who have **not satisfactorily engaged in any sex offender treatment**, but only to those who have participated and completed a sex offender program. Also, offender may receive a '0' if they claim that they acknowledge that future offending is likely and that they cannot predict the future. For example, "I don't trust myself" and hence, he won't put himself in a risky situation.

Scoring:

- 0 *Not at all*
Acknowledges cannot predict future and identifies that future offending is likely; contends will not commit further offenses, if he or she uses strategies learned (Tx only)
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Partly denies possibility of committing similar offenses in the future
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Denies possibility of committing similar offenses in the future
The item applies to the individual; a reasonably good match in most essential respects.

Item 11: Denies Any Intent, Planning, or Premeditation

For a score of '2':

The offender denies that any decisions, intentions, or planning went into committing the sexual offense. Offenders who minimize the extent of their activities almost inevitably refuse to admit that either sexual fantasies or planning were present, even when the circumstances of the offenses were such that planning was clearly evidenced in the precautions against discovery. For example, many offenders say "it just happened" or "nothing led up to it".

They may acknowledge that different decisions could have been made but gives greater attribution to elements out of his control. For example, "I should have not been so nice to her - she took advantage of the situation". Also, the focus is on his lack of knowledge that he committed an offense (e.g., "I didn't even know her age" or "she lied to me about her age") and on how he could have prevented the **charges/conviction** rather than the actual sexual offense (e.g., "If I didn't pick her up hitchhiking, she would have never charged me"). Note these focus on no responsibility on the part of the offender in planning any offending - the rationale here is that because there was no intention, there was no responsibility.

Offenders who deny committing the offense obviously do not admit that they fantasized and planned prior to the offense. This warrants a score of '2'.

For a score of '1':

If the offender partly acknowledges that he should have made different decisions as some decisions specifically led to the offending, in other words, he made some bad decisions but still maintains that certain things were out of his hands (e.g., "she kept calling me - how else could I have responded to it" or "she kept wearing see-through nightgowns to tempt me"), this would warrant a '1'.

For those who have received sex offender treatment, if they acknowledge that there was planning in their offending, but they are ambiguous about it or not sure how, then the offender would appear to be "educated on the offending cycle" and actually lack insight into his own offending. This would warrant at least a '1'.

For a score of '0':

A score of '0' should only be given if they fully acknowledge that there was intent in offending or that he made decisions and engaged in behaviours that led to the offense.

Scoring:

- 0 *Not at all*
Fully acknowledges offense was planned
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Partially admits there were elements that were planned
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Completely denies offense was planned
The item applies to the individual; a reasonably good match in most essential respects.

Item 12: Denies Deviant Arousal and Fantasies

For a score of '2':

The offender denies any deviant arousal and deviant fantasies associated with his offending. For example "I'm not into kids - I like adult women." The offender may also emphasize only the known victims. For example, "I'm only into kids I'm close to."

It is common for an offender to be arrested for one type of offense, child molestation for example, to engage in but not to admit in other types of sexually deviant behavior, for example, rape or exhibitionism.

Offenders may even give examples of times that he had opportunities but not acted/offended, hence concluding that he is not interested in deviant sexual behaviours. For example, "I babysat through my teens and nothing happened then."

Offenders who deny committing the offense obviously do not admit that they fantasized and planned prior to the offense. This warrants a score of '2'.

For a score of '1':

If the offender partly admits having fantasies and deviant interests but downplays this to overly emphasize his "normal" interests, this may warrant a '1'.

Note:

If there is no or little (minimal) indication that he has deviant sexual interests (e.g., no recorded nor unrecorded sexual offenses other than the current index offense), then give a '0'. Note this especially if clinicians, plethysmography or other arousal indicating measures reveal no indication of paraphilias.

For rapists, particularly those who have committed violent offenses against their victim(s), there must be some acknowledgment that there has been some deviant thoughts about women or some patterns in his relationships with women that lead to the current offense.

Scoring:

- 0 *Not at all*
Fully acknowledges he has, or has had, deviant sexual interests and fantasies
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Partly admits having fantasies and deviant interest; qualifies by emphasizing 'normal' interests
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Claims sexual offending occurred only this once; there is no deviant sexual interest or fantasies
The item applies to the individual; a reasonably good match in most essential respects.

Item 13: Denies Sexual Arousal During Current Offense

For a score of '2':

The offender may admit to committing the current offense but denies that he was sexually aroused during the offense. For example, he may report that he was engaging in the sexual assault but does not remember feeling "aroused" during the offense, or that although he exposed himself, he didn't find it "stimulating" that his stepdaughter was watching. Usually the offender tends to focus on the mental component of sexual arousal, but makes statements which deny any experience of sexual excitement for the offending.

Some child molesters and date rapists may emphasize that they did not feel any sexual arousal because they were simply "showing (or expressing) love" to the victim by engaging in sexual activities. Child molesters, in particular, may also emphasize that they were simply teaching the child about sex; hence, the assault was simply for instruction only and they felt no sexual arousal during the offense.

Offenders who commit crimes in which they access child pornography or they expose themselves to others may not acknowledge a sexual component to their offense, but rather they stress that they were only "curious" or that they "felt free and unfettered when they were not wearing clothes."

Offenders who deny committing the offense or claims not to remember at all obviously do not admit they were sexually aroused while offending. This warrants a score of '2'.

For a score of '1':

Some offenders admit sexual arousal but downplay it by focusing on guilt afterwards, in which case would warrant a score of '1' instead of a '0'.

Scoring:

- 0 *Not at all*
Admits being sexually aroused during offense
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Partially admits he was sexually aroused
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Fully denies any sexual arousal
The item applies to the individual; a reasonably good match in most essential respects.

Item 14: Shows Defensive or Excessive Hostility

For a score of '2':

The offender is excessively hostile or defensive. He may make directive and stand-offish statements such as "you people all are the same - you don't care what *actually* happened" or "what's the point in telling you, you already made up your mind about me." The hostile offender tends to have summed up what your role is and what he is forced to do regardless of what he says or does. Often the hostile client may swear or use a threatening and intimidating stance with the interviewer. On the other hand, some clients may not necessarily use such an aggressive stance, but rather a passive-aggressive approach whereby he may often roll his eyes and brush off what the interviewer has asked, particularly if the offender resents the interviewer for questioning the offender's version of the events.

For a score of '1':

If the offender maintains a defensive stance throughout the interview, but is not outwardly hostile, this warrants at least '1'.

Note:

Note this item can be scored 0, 1 or 2, regardless of whether the offender denies committing any offenses.

This is the only item which could be a '0' or a '1' even if the offender is in total and complete denial of the sexual offense.

Scoring:

- 0 *Not at all*
Fully compliant; may initially be defensive, but fades partway through the interview
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Maintains a defensive stance throughout the interview but is not outwardly hostile
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Defensive and shows excessive hostility and resentment for being questioned about the offense
The item applies to the individual; a reasonably good match in most essential respects.

Item 15: Acknowledges Possibility of Change through Treatment

For a score of '2':

The offender feels that a change in his behaviour is "difficult" (e.g., treatment is a waste of time) or not necessary as he knows he will never commit such an act again. This is particularly evident in those offenders who feel the offense was out of character for him and change is not necessary. Offenders who have a lengthy history of offending tend to see change as difficult and nearly impossible to change. They view their deviant sexual interests as pervasive and unyielding.

The offender may underestimate the difficulty of change, and feel that simply deciding not to abuse again will be sufficient to prevent relapse.

The offender may tend to focus on secondary changes, such as the reunification of the family, or reconciliation with his partner/victim, without changes to his offending behaviour. This item focuses on primary changes to the offending behaviour, **not secondary changes**.

Some offenders may see treatment as a way of learning to avoid risky situations. It is not their offending that is the problem, it is all the "traps" that people set for them. Although they endorse treatment for these purposes, they would still receive a score of '2', since they do not believe they, themselves, can be helped in terms of their own offending.

Offenders who deny committing the offense may acknowledge that people "of this sort" who actually committed these offenses can change their behaviour, but deny that they need any treatment and do not need change. Hence, it is difficult to change a behaviour that was never there to begin with. They feel no real need to change the abusive behaviour, and therefore do not quibble over whether their abusive patterns will be easy or difficult to change. This warrants a score of '2'.

For a score of '0':

A score of '0' is warranted only if it is evident that the offender has acknowledged that he is in control and believes that he can change.

If post-treatment and the offender acknowledges that change has been possible with the aid of sex offender treatment, then a '0' is warranted.

Scoring:

- 0 *Not at all*
Acknowledges offending is within his control and he is able to change with help
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Expresses that it is difficult to change, but is willing to be proven wrong
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Expresses that it is difficult to change abusive patterns; believes he cannot be helped
The item applies to the individual; a reasonably good match in most essential respects.

Item 16: Expresses No Desire or Need for Help

For a score of '2':

The offender has no desire or no expressed need for treatment or any sex offending related programming. In the offender's view, the sex offense was a one time mistake, not a serious condition that may require lifetime management.

The offender may express the wish that he would not reoffend, but nothing more. Offenders may feel that the best strategy was "just not to think about it" and treatment may make things worse, since he would have to dwell on it. Of course, when an offender who copes by "not thinking" about the offense is released and finds himself in situations that arouse sexual impulses towards children or adults, he has no coping mechanisms or strategies to rely on in order to resist them. Not thinking about it at that point is likely to be of little help.

Others may even say they are willing to accept some therapeutic input such as treatment for substance abuse or anger management, but not treatment aimed at their sexual deviance. This does **not** warrant a '0' as the desire or need for help must be sex offense related.

A variation of the refusal to accept sex offender treatment is the claim of an offender that he has no need for treatment because he has undergone a religious or a moral conversion. They insist that they will rely on God for guidance which only serves only to protect offenders from treatment and, of course, does not reduce the risk of reoffense.

Offenders who deny committing the offense see no reason to change an abusive pattern that they deny exists. They feel no real need to change the 'abusive' behaviour. This warrants a score of '2'.

For a score of '1':

The offender be willing to see what the program has to offer and feel that it might give them insight into why they committed the sexual offense. These offenders who seek understanding of their offending, but not necessarily acknowledge that the program is completely suitable for them, would warrant a score of a '1'.

If the offender is willing to see what sex offender treatment is like, but if not ordered to doing the programming would prefer not to do it, then this warrants at least a '1'.

For a score of '0':

If the offender has received treatment for sexual offending specific to the current offense (e.g., pled guilty to child molestation and received sex offender management treatment) and it is clear in the records that he has participated and done adequately in the program, a lack of desire or expressed need for further treatment is not to be construed as a '2', but rather should receive a '0'. On the other hand, if he has received treatment in the past for similar sex offenses, but has a new charge and conviction, the offender does not necessarily receive a '0'.

Scoring:

- 0 *Not at all*
Acknowledges he needs help and welcomes intervention
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Seems reluctant to receive any treatment
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Refuses to receive treatment; shows no desire for help
The item applies to the individual; a reasonably good match in most essential respects.

Item 17: Denies Memory of Offense

For a score of '2':

The offender simply says that he cannot recall the behaviour in question. The offender claims that he does not remember the offense and therefore cannot admit to committing it. For example, he might state that he was drunk at the time or "I guess it happened, if she said so, but I don't remember" (the latter example exemplifies a lack of responsibility for the offending).

It is important to differentiate between false dissociation and remembering the behaviours differently than the victim. False dissociation refers to claiming not to remember parts of the offending or the entire offense. The offender may propose such a dissociation as a result of substance use or a long period of time (e.g., historical offense that occurred over 20 years ago). For example, an offender may say "it was so long ago - I can't remember that far back."

Offenders who deny committing the offense do not recall or remember committing an offense as charged. This warrants a score of '2'.

For a score of '1':

If the offender admits to some parts of offending but claims that they cannot really recall the behaviour in question, then this may warrant a '1'.

If there is concrete evidence that substantiates the offender's claim that he could not possibly have remembered, for example, he was extremely intoxicated or had larger than normal dosages of illicit drugs, then this warrants a score of '1'.

Scoring:

- 0 *Not at all*
Remembers offense completely
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Partially remembers offense
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Claims not to remember; therefore, cannot admit to committing it
The item applies to the individual; a reasonably good match in most essential respects.

Item 18: Denies Deserving Sanction

For a score of '2':

The offender harbours a sense of injustice against the way people like himself are dealt within the legal system. In a more extreme scenario, he may see his offending as legitimate and he may even advocate that it should not be considered illegal.

He may have difficulty completely accepting that his sentence was fair or he feels that crown counsel was out to get him and made things worse than necessary (in light of the offenses for which he was charged).

Of course, offenders who deny committing the offense feel they have been dealt with unjustly and the consequences received were not warranted. This warrants a score of '2'.

For a score of '1':

The offender tends to acknowledge his sentence and his treatment by the criminal justice system as almost fair, although he may also make statements which support the idea that his sentence was somewhat harsh. For example, he may say that "I suppose things could have been worse" or "it worked out in the end, but I don't think I should have served time in jail (or such a long probationary sentence)."

Note:

This item refers to whether the offender sees the sentence as fair considering the offense only, not whether it was fair based on how he pled, how incompetent his lawyer was, etc.

Scoring:

- 0 *Not at all*
Regards offense as deserving sentence like that received
The item is absent or does not apply to the individual; does not exhibit the facet of denial in question, or exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.
- 1 *Maybe/in some respects*
Believes sentence generally too harsh for what they have done
The item applies to a limited extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2.
- 2 *Yes*
Believes type of offense should not be against law or they have been dealt unjustly
The item applies to the individual; a reasonably good match in most essential respects.

Comprehensive Inventory of Denial - Sex Offender Version (CID-SO): Rating Form

Name of Offender: _____ ID #: _____ Date Completed: _____

Offense Type (check one): Child Molestation Date of Birth: _____
 Incest
 Sexual Assault (Adult Victim) Age: _____
 Other Paraphilias (i.e., exhibitionism, voyeurism, zoophilia)

Victim Gender Preference: Male Female Sex Offender Treatment: Never engaged in sex offender treatment program
 Female Ongoing (currently engaged in sex offender treatment program)
 (check one) Completed sex offender treatment program

1. Denies Current Specific Offense
 - 0 Fully admits current offense as charged
 - 1 Partially denies the current specific offense
 - 2 Denies the current offense completely
2. Denies Sex Offending History
 - 0 Fully admits committing offenses at other times, both as recorded and unrecorded
 - 1 Partly admits offenses at other times; some not all recorded offenses
 - 2 Denies previous offenses completely
3. Lacks Feelings of Guilt and Embarrassment
 - 0 Feels guilt and embarrassment for committing the offense(s)
 - 1 Feels embarrassed over the offending, but feels minimal guilt for the offense itself
 - 2 Lacks any guilty or embarrassment associated with the actual offense
4. Focuses on Acceptable or Nonsexual Behaviours
 - 0 Fully focuses on sexual nature of the offense
 - 1 Able to focus on sexual nature of offense, but emphasizes other nonsexual behaviours
 - 2 Focuses on other aspects of his behaviour; usually more "acceptable" or "nonsexual" aspects
5. Minimizes the Seriousness of the Offense
 - 0 Accepts seriousness of his behaviours
 - 1 Accepts, in part, seriousness of offense
 - 2 Denies the offense was serious in nature; belittles the sex offense
6. Minimizes Harm to Victim
 - 0 Acknowledges harm to victim; not applicable
 - 1 Minimizes the harm to victim; difficulty acknowledging harm to victim
 - 2 Denies any harm was done to the victim; or claims to have helped the victim
7. Blames the Victim
 - 0 Acknowledges offending is a result of his own behaviour
 - 1 Partly acknowledges offending is a result of his behaviour, but also to the victim's ill-will or exaggeration
 - 2 Blames the victim for the offending and/or the consequences of the charges
8. Qualifies or Justifies with Internal Attribution
 - 0 Accepts internal responsibility; no mitigating internal factors
 - 1 Claims there were mitigating internal factors, but accepts responsibility for committing the offense
 - 2 Denies internal responsibility; claims offense was out of character
9. Qualifies or Justifies with External Attribution
 - 0 No blame of third parties
 - 1 Claims there were mitigating external factors, but accepts responsibility for committing the offense
 - 2 Blames remote and proximate factors
10. Denies Possibility of Future Behaviour
 - 0 Acknowledges cannot predict future and identifies that future offending is likely; contends will not commit further offenses, if he or she uses strategies learned (Tx only)
 - 1 Partly denies possibility of committing similar offenses in the future
 - 2 Denies possibility of committing similar offenses in the future
11. Denies Any Intent, Planning, or Premeditation
 - 0 Fully acknowledges offense was planned
 - 1 Partially admits there were elements that were planned
 - 2 Completely denies offense was planned
12. Denies Deviant Arousal and Fantasies
 - 0 Fully acknowledges he has, or has had, deviant sexual interests and fantasies
 - 1 Partly admits having fantasies and deviant interest; qualifies this by emphasizing 'normal' interests
 - 2 Claims sexual offending occurred only this once; there is no deviant sexual interest or fantasies
13. Denies Sexual Arousal During Current Offense
 - 0 Admits being sexually aroused during offense
 - 1 Partially admits he was sexually aroused
 - 2 Fully denies any sexual arousal
14. Shows Defensive or Excessive Hostility
 - 0 Fully compliant; may initially be defensive, but diminishes partway through the interview
 - 1 Maintains a defensive stance throughout interview but is not outwardly hostile
 - 2 Defensive and shows excessive hostility and resentment for being questioned about the offense
15. Acknowledges Possibility of Change through Treatment
 - 0 Acknowledges offending is within his control and he is able to change with help
 - 1 Expresses that it is difficult to change, but is willing to be proven wrong
 - 2 Expresses that it is difficult to change abusive patterns; believes he cannot be helped
16. Expresses No Desire or Need for Help
 - 0 Acknowledges he needs help and welcomes intervention
 - 1 Seems reluctant to receiving any treatment
 - 2 Refuses to receive treatment; shows no desire for help
17. Denies Memory of Offense
 - 0 Remembers offense completely
 - 1 Partially remembers offense
 - 2 Claims not to remember; therefore, can't admit to committing it
18. Denies Deserving Sanction
 - 0 Regards offense as deserving sentence like that received
 - 1 Believes sentences generally too harsh for what they have done
 - 2 Believes type of offense should not be against law or they have been dealt unjustly

**Comprehensive Inventory of Denial - Sex Offender Version (CID-SO)
WORKSHEET - #1**

Name of Offender/ID#: _____

Date Completed: _____

<u>Item</u>	<u>Rating</u>	<u>Notes</u>
1. Denies Current Specific Offense		
2. Denies Sex Offending History		
3. Lacks Feelings of Guilt and Embarrassment		
4. Focuses on Acceptable or Nonsexual Behaviours		
5. Minimizes the Seriousness of the Offense		
6. Minimizes Harm to Victim		
7. Blames the Victim		
8. Qualifies or Justifies with Internal Attribution		
9. Qualifies or Justifies with External Attribution		
10. Denies Possibility of Future Behaviour		
11. Denies Any Intent, Planning, or Premeditation		
12. Denies Deviant Arousal and Fantasies		
13. Denies Sexual Arousal During Current Offense		
14. Shows Defensive or Excessive Hostility		
15. Acknowledges Possibility of Change through Treatment		
16. Expresses No Desire or Need for Help		
17. Denies Memory of Offense		
18. Denies Deserving Sanction		

**Comprehensive Inventory of Denial - Sex Offender Version (CID-SO)
WORKSHEET - #2**

Name of Offender/ID#: _____

Date Completed: _____

	Cluster A	Cluster B	Cluster C	Cluster D	Item
#1	<input type="checkbox"/>				Denies Current Specific Offense
#2	<input type="checkbox"/>				Denies Sex Offending History
#3				<input type="checkbox"/>	Lacks Feelings of Guilt and Embarrassment
#4	<input type="checkbox"/>				Focuses on Acceptable or Nonsexual Behaviours
#5				<input type="checkbox"/>	Minimizes the Seriousness of the Offense
#6				<input type="checkbox"/>	Minimizes Harm to Victim
#7			<input type="checkbox"/>		Blames the Victim
#8			<input type="checkbox"/>		Qualifies or Justifies with Internal Attribution
#9			<input type="checkbox"/>		Qualifies or Justifies with External Attribution
#10		<input type="checkbox"/>			Denies Possibility of Future Behaviour
#11			<input type="checkbox"/>		Denies Any Intent, Planning, or Premeditation
#12	<input type="checkbox"/>				Denies Deviant Arousal and Fantasies
#13	<input type="checkbox"/>				Denies Sexual Arousal During Current Offense
#14		<input type="checkbox"/>			Shows Defensive or Excessive Hostility
#15		<input type="checkbox"/>			Acknowledges Possibility of Change through Treatment
#16		<input type="checkbox"/>			Expresses No Desire or Need for Help
#17			<input type="checkbox"/>		Denies Memory of Offense
#18				<input type="checkbox"/>	Denies Deserving Sanction
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Totals per Cluster

References

- Abel, G. G., Gore, D. K., Holland, C. L., Camp, N., Becker, J. V., & Rathner, J. (1989). The measurement of cognitive distortions of child molesters. Annals of Sex Research, *2*, 135-152.
- Baldwin, K., & Roys, D. T. (1998). Factors associated with denial in a sample of alleged adult sexual offenders. Sexual Abuse: A Journal of Research and Treatment, *10*, 211-226.
- Barbaree, H. E. (1991). Denial and minimization among sex offenders: Assessment and treatment outcome. Forum on Corrections Research, *3*, 30-33.
- Baumeister, R. F. (1991). Escaping the self. New York, NY: Basic Books.
- Birgisson, G. H. (1996). Differences of personality, defensiveness, and compliance between admitting and denying male sex offenders. Journal of Interpersonal Violence, *11*, 118-125.
- Brake, S. C., & Shannon, D. (1997). Using pretreatment to increase admission in sex offenders. In D. R. Laws, & W. O'Donohue (Eds.), Sexual deviance: Theory, assessment, and treatment (pp. 5-1 - 5-16). New York: The Guilford Press.
- 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 Treatment, *8*, 37-54.
- Burt, M. R. (1980). Cultural myths and supports for rape. Journal of Personality and Social Psychology, *38*, 217-230.
- DeBono, K. G. (1987). Investigating the social-adjustive and value-expressive functions of attitudes: Implications for persuasion processes. Journal of Personality and Social Psychology, *52*, 279-287.
- DeBono, K. G., & Edmonds, A. E. (1989). Cognitive dissonance and self-monitoring: A matter of context? Motivation and Emotion, *13*, 259-269.
- Festinger, L. (1957). A theory of cognitive dissonance. Evanston, IL: Row, Peterson.
- Fiske, S. T. (1989). Examining the role of intent: Toward understanding its role in stereotyping and prejudice. In J. S. Uleman, & J. A. Bargh (Eds.), Unintended thought: The limits of awareness, intention and control (pp. 153-283). New York: Guilford Press.
- Fiske, S. T., & Taylor, S. E. (1991). Social cognition (2nd Ed.). New York: McGraw-Hill.
- 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 behavior (pp. 303-319). New York: The Guilford Press.
- Gocke, B. (1991). Tackling denial in sex offenders: A therapeutic dilemma exacerbated by the criminal justice system. Social Work Monographs, Norwich.

Grossman, L. S., & Cavanaugh, J. L., Jr. (1990). Psychopathology and denial in alleged sex offenders. The Journal of Nervous and Mental Disease, *178*, 739-744.

Hall, R. L. (1989). Self-efficacy ratings. In D. R. Laws (Ed.), Relapse prevention with sex offenders (pp. 137-146). New York, NY: The Guilford Press.

Happel, R. M., & Auffrey, J. J. (1995). Sex offender assessment: Interrupting the dance of denial. American Journal of Forensic Psychology, *13*, 5-22.

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

Haywood, T. W., Grossman, L. S., & Hardy, D. W. (1993). Denial and social desirability in clinical evaluations of alleged sex offenders. The Journal of Nervous and Mental Disease, *181*, 183-188.

Haywood, T. W., Grossman, L. S., Kravitz, H. M., & Wasyliv, O. E. (1994). Profiling psychological distortion in alleged child molesters. Psychological Reports, *75*, 915-927.

Hoke, S. L. (1989). Systemic/Strategic interventions targeting denial in the incestuous family. Journal of Strategic and Systemic Therapies, *8*, 44-51.

Jackson, C., & Thomas-Peter, B. A. (1994). Denial in sex offenders: workers' perceptions. Criminal Behaviour and Mental Health, *4*, 21-32.

Johnston, L., & Ward, T. (1996). Social cognition and sexual offending: A theoretical framework. Sexual Abuse: A Journal of Research and Treatment, *8*, 55-80.

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

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

Lafien, B., & Sturm, W. R. (1994). Understanding and working with denial in sexual offenders. Journal of Child Sexual Abuse, *3*, 19-37.

Lanyon, R. I., Dannenbaum, S. E., & Brown, A. R. (1991). Detection of deliberate denial in child abusers. Journal of Interpersonal Violence, *6*, 301-309.

Lanyon, R. I., & Lutz, R. W. (1984). MMPI discrimination of defensive and nondefensive felony sex offenders. Journal of Consulting and Clinical Psychology, *52*, 841-843.

Laws, D. R., & Marshall, W. L. (1989). Revised Cognition Scale. Unpublished manuscript.

Maletzky, B. M. (1993). Factors associated with success and failure in the behavioral and cognitive treatment of sexual offenders. Annals of Sex Research, *6*, 241-258.

Marshall, W. L. (1989). Sex with Children Scale. Kingston, ON: Kingston Sexual Behaviour Clinic.

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

Marshall, W. L. (1997). Pedophilia: Psychopathology and theory. In D. R. Laws, & W. O'Donohue (Eds.), Sexual deviance: Theory, assessment, and treatment (pp. 152-174). New York: The Guilford Press.

Nelson, C., & Jackson, P. (1989). High-risk recognition: The cognitive-behavioral chain. In D. R. Laws (Eds.), Relapse prevention with sex offenders (pp. 167-177). New York, NY: The Guilford Press.

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.

O'Donohue, W., & Letourneau, E. (1993). A brief group treatment for the modification of denial in child sexual abusers: Outcome and follow-up. Child Abuse & Neglect, *17*, 299-304.

O'Donohue, W., Letourneau, E. J., & Dowling, H. (1997). Development and preliminary validation of a paraphilic sexual fantasy questionnaire. Sexual Abuse: A Journal of Research and Treatment, *9*, 167-178.

Paulhus, D. L. (1984). Two-component models of socially desirable responding. Journal of Personality and Social Psychology, *46*, 598-609.

Potter, J., & Wetherall, M. (1987). Discourse and Social Psychology. London: Sage Publications.

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.

Rosenberg, M. J. (1965). Society and the adolescent self-image. Princeton, NJ: Princeton University Press.

Salter, A. (1988). Treating child sex offenders and victims: A practical guide. Newbury Park, CA: Sage.

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.

Schlank, A. M., & Shaw, T. (1997). Treating sexual offenders who deny -- a review. In B. K. Schwartz, & H. R. Cellini (Eds.), The sex offender: New insights, treatment innovations and legal developments (pp. 6-1 - 6-7). Kingston, NJ: Civic Research Institute.

Scully, D., & Marolla, J. (1984). Convicted rapists' vocabulary of motive: Excuses and justifications. Social Problems, *31*, 530-544.

Snyder, M. (1974). The self-monitoring of expressive behavior. Journal of Personality and Social Psychology, *30*, 526-537.

Snyder, M. (1987). Public appearances/Private realities. New York: W. H. Freeman.

Snyder, M., & Gangestad, S. (1986). On the nature of self-monitoring: Matters of assessment, matters of validity. Journal of Personality and Social Psychology, *51*, 125-159.

Stevenson, H. C., Castillo, E., & Sefarbi, R. (1990). Treatment of denial in adolescent sex offenders and their families. Journal of Offender Counseling, Services & Rehabilitation, 14, 37-50.

Strate, D. C., Jones, L., Pullen, S., & English, K. (1996). Criminal justice policies and sex offender denial. In K. English, S. Pullen, & L. Jones (Eds.), Managing adult sex offenders on probation and parole: a containment approach (pp 4-3 - 4-18). Lexington, NY: American Probation and Parole Association.

Ward, T., Hudson, S. M., & Keenan, T. (1998). A self-regulation model of the sexual offense process. Sexual Abuse: A Journal of Research and Treatment, 10, 141-157.

Ward, T., Hudson, S. M., & Marshall, W. L. (1995). Cognitive distortions and affective deficits in sex offenders: A cognitive deconstructionist interpretation. Sexual Abuse: A Journal of Research and Treatment, 7, 67-83.

Wilson, G. (1978). The secrets of sexual fantasy. London, England: J.M. Dent & Sons.

Winn, M. E. (1996). The strategic and systemic management of denial in the cognitive/behavioral treatment of sexual offenders. Sexual Abuse: A Journal of Research and Treatment, 8, 25-36.

Zachary, R. A. (1991). Shipley Institute of Living Scale - Revised Manual. Los Angeles, CA: Western Psychological Services.

Appendix B:
Balanced Inventory of Desirable Responding - Version 6 (BIDR-6)

SCORING KEY FOR BIDR-6:

The scores for the two factors will be totalled: Self-Deceptive Enhancement and Impression Management.

When denoted with REVERSE, reverse score as follows: 1 = 4, 2 = 3, 3 = 2, 4 = 1

(For items only: 2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 21, 23, 25, 27, 29, 31, 33, 35, 37, and 39)

SELF-DECEPTIVE ENHANCEMENT SCORE

Calculated by totalling the scores from items from 1 through 20:

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

IMPRESSION MANAGEMENT

Calculated by totalling the scores from items from 21 through 40:

21. I sometimes tell lies if I have to. REVERSE
22. I never cover up my mistakes.
23. There have been occasions when I have taken advantage of someone. REVERSE
24. I never swear.
25. I sometimes try to get even rather than forgive and forget. REVERSE
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. REVERSE
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. REVERSE
30. I always declare everything at customs.
31. When I was young I sometimes stole things. REVERSE
32. I have never dropped litter on street.
33. I sometimes drive faster than the speed limit. REVERSE
34. I never read sexy books or magazines.
35. I have done things that I don't tell other people about. REVERSE
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. REVERSE
38. I have never damaged a library book.
39. I have some pretty awful habits. REVERSE
40. I don't gossip about other people's business.

**Appendix C:
Self Monitoring Scale (SMS)**

For each statement answer true or false (please circle response).

- | | | |
|---|---|---|
| 1. I find it hard to imitate the behavior of other people. | T | F |
| 2. At parties and other social gatherings, I do not attempt to do or say things that others will like. | T | F |
| 3. I can only argue for ideas which I already believe. | T | F |
| 4. I can make impromptu speeches even on topics about which I have almost no information. | T | F |
| 5. I guess I put on a show to impress or entertain others. | T | F |
| 6. I would probably make a good actor. | T | F |
| 7. In a group of people I am rarely the center of attention. | T | F |
| 8. In different situations and with different people, I often act like very different persons. | T | F |
| 9. I am not particularly good at making other people like me. | T | F |
| 10. I am not always the person I appear to be. | T | F |
| 11. I would not change my opinions (or the way I do things) in order to please someone or win their favour. | T | F |
| 12. I have considered being an entertainer. | T | F |
| 13. I have never been good at games like charades or improvisational acting | T | F |
| 14. I have trouble changing my behavior to suit different people and different situations. | T | F |
| 15. At a party, I let others keep the jokes and stories going. | T | F |
| 16. I feel a bit awkward in company and do not show up quite as well as I should. | T | F |
| 17. I can look anyone in the eye and tell a lie with a straight face (if for a right end). | T | F |
| 18. I may deceive people by being friendly when I really dislike them. | T | F |

To score the scale, you should give a point if they answered true to items 4, 5, 6, 8, 10, 12, 17, 18 (hsm), or false to items 1, 2, 3, 7, 9, 11, 13, 14, 15, 16

Appendix D:
Rosenberg Self-Esteem Scale (RSES)

Please indicate your degree of agreement with each of the following statements where:

1	2	3	4
strongly disagree	disagree	agree	strongly agree

- ___ 1. I feel that I'm a person of worth, at least on an equal plane with others.
- ___ 2. On the whole, I am satisfied with myself.
- ___ 3. I wish I could have more respect for myself.
- ___ 4. I certainly feel useless at times.
- ___ 5. At times, I think I am no good at all.
- ___ 6. I feel that I have a number of good qualities.
- ___ 7. All in all, I am inclined to feel that I am a failure.
- ___ 8. I am able to do things as well as most other people.
- ___ 9. I feel that I do not have much to be proud of.
- ___ 10. I take a positive attitude toward myself.

Half of the items (1, 2, 6, 8 and 10) are positively worded; agreeing with these items indicates *higher* self-esteem. The remaining items (3, 4, 5, 7 and 9) are negatively worded; agreeing with these items indicates *lower* self-esteem. The items must be recoded before summing by reversing their values (for example, 1 is rescored as 4, 2 is rescored as 3, and so on). Scores can thus range from 10 to 40, with higher scores indicating higher self-esteem.

Appendix E:
Revised Cognition Scale (RCS)

The following items ask about your opinion concerning relationships between children and adults. Below each item you will see five comments about its content. These comments are things that might come to your mind when you read the statement.

Choose the comment that most closely matches your reaction to each statement. We realize that different people will have different reactions to these statements and your reaction may not correspond closely to the given comments. Nevertheless, please answer each question, even when you are unsure of your answer. Please circle your response.

1. If a child willingly goes into the home of a man s/he does not know, then the man can hardly be blamed for thinking s/he wants to have sex play.
 - a. The child may actually want to have sex with the man.
 - b. The child may just be acting friendly.
 - c. The child may just be sexually teasing the man.
 - d. The child may want some affection from the man.
 - e. A child should never go into a stranger's home.

2. Children actually enjoy sex if the man is nice to them.
 - a. Children might not know how to refuse with a man.
 - b. Children like adults to be nice to them, nothing more.
 - c. Children never enjoy sex with adults.
 - d. Children especially like having sex with a man who is nice to them.
 - e. Children often come on sexually to adult males.

3. Most children actually enjoy sex with an adult as long as the man does not hurt them.
 - a. Most children would be afraid that they might get hurt if they had sex with an adult.
 - b. Children are afraid of adults and probably wouldn't even think about sex with them.
 - c. Some children might play dumb so the adult will force them to have sex.
 - d. Adults can harm children in a lot of ways.
 - e. Many children just like sex with adults and never even think of getting hurt.

4. Many children are sexually seductive toward adults.
 - a. Some kids are real cockteasers.
 - b. Children are never sexually seductive with adults.
 - c. Most children want adults to like them and are friendly toward them.
 - d. A child's friendliness could be misinterpreted by some adults.
 - e. Some children are openly seductive toward adults because they really prefer to have sex that way.

5. Children enjoy sexual attention from adults.
 - a. A child's asking for attention could be misread as asking for sex.
 - b. Children just like adults to pay attention to them.
 - c. Sexual attention from adults gives a child real self-confidence.
 - d. A child's asking for attention may, in some cases, be a real sexual message.
 - e. No child really enjoys sexual attention from an adult.
6. Men who have sex with children are usually led into it by the child.
 - a. A man could take a child's manipulation of him the wrong way.
 - b. Children are often socially manipulative with adults.
 - c. Children never initiate sexual behaviour with adults.
 - d. Some kids probably feel that they have to take the initiative to get the adult to have sex with them.
 - e. Some kids know that being a little sexy with adults can get them what they want.
7. Children could easily resist the sexual advances of an adult if they really wanted to.
 - a. Children are so weak and helpless that it is impossible for them to stop the sexual advances of an adult no matter what they do.
 - b. Resisting an adult's sexual advances could be one way for a child to tease an adult.
 - c. A lot of children wouldn't resist an adult's advances because they really want to have sex.
 - d. Some adults might think that a child's resisting them is one of those cases where "no" really means "yes."
 - e. A child might think that any move by an adult was just a gesture of friendliness.
8. If a child willingly sits on an adult man's knee then it is the child's fault if the adult touches him/her sexually.
 - a. Kids always sit on adults' knees.
 - b. Depending on how a child sits on a man's knee, s/he might be giving the adult a sexual message.
 - c. A man might think that a child sitting on his knee was something more than friendly.
 - d. Sitting on an adult man's knee is sometimes just a kind of sex play before the child has real sex with the man.
 - e. You would have to be sick to see anything sexual in a child sitting on a man's knee.
9. Children who do not wear underwear and who sit in a way that is revealing are suggesting sex.
 - a. Kids who unwittingly display their genitals might be seen as suggesting sex.
 - b. Kids often do not pay any attention to how they sit when they're not wearing any underwear.
 - c. Some kids might actually flash a man to show that they are interested in sex.
 - d. A child would never suggest sex in this way.
 - e. When kids flash an adult they want to get him excited so that sex between them will really be good.

10. Children who are not loved by their parents (or guardians) are actually helped by men who have sex with them.
 - a. Not being loved by parents is a sure way for a kid to get a lonely adult to have sex with him/her.
 - b. Kids who feel unloved at home might go to extreme lengths to get attention from adults.
 - c. Kids whose parents don't love them might use a sexual come-on as a way to attract the attention of other adults.
 - d. Unloved children can get nothing good at all from any man who would have sex with them.
 - e. Unloved children should be cared for, not manipulated by adults.

11. Sex between adults and children is quite natural and healthy and it is only because of the repressive rules of our society that men are punished for this.
 - a. The long-term effects of adult-child sex on the child have not been fully determined.
 - b. It is true that some social rules are intentionally repressive.
 - c. The laws against sex with children should be much more severe than they are now.
 - d. One of these days governments will realize that adult-child sex is healthy and normal and the rules will be changed.
 - e. The fact that adult-child sex is forbidden fruit is one way for kids to get adults sexually interested in them.

12. It is far better for a young person to have the first sexual experience during childhood with an adult, than to risk what is certain to be an unpleasant sexual experience with someone his/her own age when as a teenager.
 - a. Some young kids use adults to learn about sex so they can feel more sexually competent when they are teenagers.
 - b. Early sex education would probably be beneficial for most children.
 - c. Sex with an adult is certain to damage a child's sexual development.
 - d. Children get their basic social education from adults.
 - e. The best sex education a child could have is a caring and loving sexual relationship with an adult.

13. Having any sexual experience with a child is always wrong.
 - a. Some children encourage sex with adults because they know that they need the experience.
 - b. Sex with children is against the law, and that is all there is to it.
 - c. Many children have experiences they could do without.
 - d. Sexual experience is something that should occur naturally with peers when a child is growing up.
 - e. If an adult is seduced into a sexual relationship by a willing, enthusiastic child, he can hardly be blamed for that.

14. When an adult is caught having sex with a child it is rarely the first time for the child.
 - a. Kids today know a lot more about sex than when most adults were that age.
 - b. Kids are more experienced today than when most adults were growing up.
 - c. A man can hardly be blamed if he has been conned into a relationship by a sexually experienced child.
 - d. It is a known fact that many children are quite sexually experienced, often with adults.
 - e. Children do not sexually seduce adults.

15. Although children are usually cooperative partners in sex with adults, they often report the man because they are afraid they will get into trouble.
 - a. Children may feel really confused and uncomfortable after having had sex with an adult and feel they have to tell somebody.
 - b. Children often report a man who has been mean to them.
 - c. Children will only have sex with an adult if they are threatened or forcibly raped.
 - d. Children report a man who has had sex with them because they don't want their parents or guardians to know they really enjoyed it.
 - e. Children may report a man who has had sex with them just to let him know who has the upper hand in the relationship.

16. A father should be allowed to have sex with his daughter if she consents to it.
 - a. Consent is not an issue because father-daughter sex is against the law.
 - b. On most issues a minor daughter should obey her father.
 - c. Fathers are powerful figures and can often make a daughter do things she doesn't want to do.
 - d. Some young women learn how powerful sex is by manipulating their fathers to get what they want.
 - e. Having a loving sexual relationship with her father can prepare a daughter for marriage and other adult responsibilities.

17. A man can't help having sex with a child if the child acts in a sexually provocative manner.
 - a. Simple friendliness in a child might be mistaken by some people as another kind of provocative behaviour.
 - b. There's no question about it, some kids really are cockteasers.
 - c. No normal man would ever become sexually aroused by a child or young teenager.
 - d. It is natural for children to provoke adults in all sorts of ways.
 - e. If a child is openly suggesting sex and there seems to be little or no risk involved, you might as well go ahead and do it.

18. Having sex with a child is really not all that bad because it really doesn't harm the child.
 - a. Sex with an adult always harms a child.
 - b. This notion of children being harmed by sex with adults is not based on any good evidence.
 - c. If children are harmed by sex with adults, then why do they come on to them the way they do?
 - d. Sex occurring naturally with a peer at the right time may not be harmful.
 - e. Children can be harmed in a lot of ways by adults.

19. When you consider all the crimes a person could commit, having sex with a child is not all that bad.
 - a. Having sex with a child is one of, if not the worst, crimes a man could commit.
 - b. Adults often do a lot of bad things, especially sexually.
 - c. Having sex with a child is not as bad as, for example, robbing or assaulting someone.
 - d. Adults often do a lot of bad things to children.
 - e. If an adult is openly manipulated into a sexual relationship with a child, you could hardly call that a crime.

20. It is all right for a father to have sex with his daughter to prepare her for her husband.
 - a. If she's smart, a young woman can use her sexuality to get her father to do what she wants.
 - b. It is wrong for a father to tell his daughter that she is physically attractive.
 - c. Fathers have a responsibility to prepare their daughters to assume adult obligations.
 - d. A young woman's awakening sexual desire needs to be properly channeled and a father has a role in this.
 - e. A daughter can more easily make the transition to adult responsibilities if she has had a caring and loving sexual relationship with her father.

21. Merely fondling a child or having oral sex is not as bad as having sexual intercourse with a child.
 - a. Some kinds of adult behaviour toward children are more harmful than others.
 - b. While full sexual intercourse might be painful and frightening, it is difficult to see how giving pleasure to a child by caressing or licking his/her genitals could be harmful.
 - c. Some kinds of sexual activity involve less danger of disease than sexual intercourse.
 - d. Experienced kids may allow an adult to touch them or have oral sex to get the adult to give them what they really want.
 - e. Children should not be exposed to any sexual activities.

22. You can't blame a man for having sex with his child if his wife doesn't satisfy him sexually.
 - a. A poor sexual relationship in marriage is a common problem in our society.
 - b. A father who even thinks about turning to his children for sex should be forced out of the family.
 - c. Men often use a poor sexual relationship with their wives as an excuse to do some pretty outrageous things.
 - d. If your wife isn't good in bed, having sex with your kids is a more understandable alternative than, for example, having an affair.
 - e. Some kids might use a poor sexual relationship between their parents as a way to sexually manipulate their fathers.

23. If an adult has sex with a child who enjoys it and seems to want it, it shouldn't be considered a crime.
- Having sex with a child is a serious crime under any circumstances.
 - Kids who come on sexually to adults often don't realize that they're placing the adult in a very dangerous position.
 - If a child is enthusiastic and clearly asking for sex with an adult, there's nothing wrong with that.
 - Sexual behaviours, under certain circumstances, could be considered sex.
 - If a child by an adult is a crime.
24. Children are old enough to decide whether or not they want to have sex with adults.
- Children probably know a lot more about sex than they let on.
 - Children probably think about sex more than we imagine they do.
 - If children consent to sex with an adult, that means they want to do it and it's probably all right to go ahead.
 - Children are a lot smarter today than when most adults were growing up.
 - Children under the age of 18 cannot legally give consent to sexual behaviour.
25. Having sex with a child is a way of expressing your love and affection for that child.
- Some people think that sex, love, and affection are the same thing.
 - There are a lot of ways in which an adult can show love and affection toward a child.
 - Having sex with an adult is one way for children to gain affection.
 - Having sex with a child has nothing whatever to do with love and affection.
 - Having a caring and loving sexual relationship with an adult can be a real growth experience for a child.
26. If you are taking care of children by feeding and clothing them you have a right to expect sexual favours in return.
- Some kids will have sex with an adult just to get the adult to buy things for them.
 - An adult has a legal obligation to feed and clothe an underage child who is in his/her care.
 - When you're taking care of all a child's needs you ought to be able to do pretty much as you please with them.
 - Adults often expect sexual favours in return for doing something for someone.
 - No adult has a right to expect anything in return for anything s/he does for a child.
27. A father has a right to have sex with his own daughters.
- Some men think that their rights extend to having sex with anyone they want.
 - When you come down to it, a daughter is not so different from a wife and you ought to be able to have sex with her once in a while if you both want to.
 - A pretty young daughter can often use her sex to get her father to do what she wants.
 - A father has a legal right to tell an underage daughter what she can and can't do.
 - A father should be careful not to give his daughters too much physical affection.

Original

28. Having sex with a child is a good way to teach them about sexuality.
 - a. Children often learn everything they need to know about sex from their peers.
 - b. By conning an adult into a sexual relationship a child can easily learn necessary sexual and social skills.
 - c. Having sex with an adult provides a child with sexual and social skills it would take years to learn otherwise.
 - d. Adults have a responsibility to teach children many things.
 - e. Adults should never talk about or do anything sexual when children are around.

29. Many children benefit from having sex with an adult.
 - a. A lot of men believe that sex benefits whoever they have sex with.
 - b. Some children may benefit from a sexual relationship with an adult because it gets them other things that they want.
 - c. It is hard to believe that a child would not benefit from a gentle and caring sexual relationship with an adult.
 - d. Children gain many benefits from relationships with adults.
 - e. No child ever benefits from having sex with an adult.

30. It is okay to have sex with a child as long as you don't force the child into it.
 - a. Some kids may pretend that they don't want to have sex when what they really want is for you to make them do it.
 - b. Many adults can persuade children to have sex with them.
 - c. Children should not have sex with anyone, force or no force.
 - d. It is always better to use persuasion than force to get a child to do what you want.
 - e. When no force is necessary to get a child to have sex with an adult, that means that the child is consenting.

31. Sexually molesting a child is the worst crime a man could do.
 - a. There is no crime worse than molesting a helpless child.
 - b. It is a crime for an adult to physically harm a child.
 - c. Some common adult behaviours might be considered sexual molestation in some circumstances.
 - d. Some children get adults into trouble by being openly sexual with them.
 - e. If a child tricks an adult into a sexual relationship, then that's not a crime.

32. Even if the child suggests that s/he have a sexual relationship with a man, the man should be punished if he has sex with him/her.
 - a. Children often suggest things that they know they shouldn't be doing.
 - b. Children often may not use good sense where sex is concerned.
 - c. If a child suggests sex with an adult, s/he is giving consent, and the adult shouldn't be punished for doing it.
 - d. Adults who get punished for sex with children have usually been led into it by a sexually experienced child.
 - e. Children cannot give consent to sex with anyone, adults or peers.

33. Children are harmed more by the people who react badly to them disclosing about a sexual relationship with a man than by the sexual activity itself.
- Children can be harmed in a lot of different ways by adults.
 - People who trick children into talking about their sexual experiences with adults are just indulging in their own sexual fantasies.
 - Children often get punished unjustly when they tell parents or guardians that they had an enjoyable sexual experience with an adult.
 - Forcing children to talk about sexual experiences of any kind can be upsetting to them.
 - Children are harmed by an type of sex whether or not they disclose it to anyone.
34. An adult having sex with a child will always hurt the child in some way.
- Having sex too early in life can be harmful to a child.
 - When you consider all the real harm a person could do to a child, having sex with him/her is not all that bad.
 - Children may say that they're afraid to have sex with an adult, but they're really playing hard to get.
 - Adults can harm children in a lot of different ways.
 - Children are always harmed by having sex with adults.
35. If a child is a prostitute and sells his/her body for profit, then a man who has sex with him/her should not be punished.
- Children who sell their bodies for sex can get into real serious legal and medical difficulties.
 - A lot of kids behave like hookers, and often a guy can't tell which is which.
 - Children prostitution, like adult prostitution, should be legalized so that no one gets hurt.
 - Street kids can get themselves into a whole lot of trouble.
 - Any man who has sex with a prostitute is immoral.
36. Children are not as innocent and naive about sexual matters as some people think they are.
- A lot of kids seems to know a great deal about sex.
 - Kids are smarter these days than when most adults were growing up.
 - Smart kids act innocent and naive about sex because they know this turns a lot of guys on.
 - When a kid comes right on to you and is clearly suggesting sex, you could hardly call him/her innocent.
 - Children can be seriously harmed if they learn about sex at a young age.
37. Nowadays it is not so bad to have a sexual relationship with someone who is underage because kids know so much more about sex than they used to.
- A kid who's knowledgeable about sex can always get an adult's attention.
 - It is amazing how much kids nowadays know about sex.
 - Children should be protected from knowing about sex for as long as possible.
 - Kids seem to know a lot about everything these days.
 - Because of the information revolution, kids are a lot more comfortable these days about having sex with adults.

38. Children are pretty smart and if they act in a sexual way they know very well that they are suggesting sex.
- Children never suggest sex.
 - Children these days often prove capable of doing things we never expected.
 - Children these days seem to know quite a bit about sex.
 - Kids are so smart these days that they really know how to manipulate adults, especially where sex is concerned.
 - These days smart kids really know the score, and if they suggest sex with you, you might as well go for it.
39. As long as you don't get a young girl pregnant, having sex with her will not particularly harm her.
- Young girls often run risks when they shouldn't.
 - Some young girls run the risk of getting pregnant by their same-age boyfriends.
 - Provided you don't get her pregnant, having sex with a young girl is an excellent way to teach her about her adult responsibilities.
 - Some young girls might actually try to get pregnant so that they can get a man to take care of them.
 - Young girls should not do anything sexual with anybody.
40. If you can get away with having a sexual relationship with a young person you might as well go for it.
- Some young persons seem to suggest that it would be easy to have a sexual relationship with them.
 - In the end, you can't really get away with having sex with a young person.
 - Some adults get away with a lot that they shouldn't.
 - Some adults seem to get away with a lot in their sexual behaviour.
 - Where's the harm in having sex with a youngster if s/he doesn't get hurt and no one's the wiser?

SCORING KEY FOR RCS:

PLEASE NOTE: The order of "a" thru "e" items within any single question should be randomized.

Scoring of the Revised Cognition Scale:

1. Count the number of each type of response, e.g.,
 - (25) out of 40 conservative/denial of child sexuality ("a") items.
 - (6) out of 40 nonsexual/nondeviant ("b") items.
 - (8) out of 40 nondeviant/sexual ("c") items.
 - (1) out of 40 deviant/sexual ("d") items.
 - (0) out of 40 directly supportive of adult/child sex ("e") items.
2. Interpretation:
 - The respondent should be considered to have problematic attitudes supportive of adult/child sex if he endorses any "d" or "e" item.
 - Flag and list all "d" and "e" items endorsed.
 - The respondent should be suspected of faking good if he endorses >33 of the "a" items.
 - Normal subjects tend to endorse only the "a" items. Thus, an offender subject would have to endorse almost exclusively "a" items before he should be suspected of faking good.

The following is a key for the RCS such that

"a" is conservative/denial of child sexuality
 "b" is nonsexual/nondeviant
 "c" is nondeviant/sexual
 "d" is deviant/sexual
 "e" directly supports adult/child sexual relations

1. If a child willingly goes into the home of a man s/he does not know, then the man can hardly be blamed for thinking s/he wants to have sex play.
 - a. A child should never go into a stranger's home.
 - b. The child may just be acting friendly.
 - c. The child may want some affection from the man.
 - d. The child may just be sexually teasing the man.
 - e. The child may actually want to have sex with the man.
2. Children actually enjoy sex if the man is nice to them.
 - a. Children never enjoy sex with adults.
 - b. Children like adults to be nice to them, nothing more.
 - c. Children might not know how to refuse with a man.
 - d. Children often come on sexually to adult males.
 - e. Children especially like having sex with a man who is nice to them.
3. Most children actually enjoy sex with an adult as long as the man does not hurt them.
 - a. Children are afraid of adults and probably wouldn't even think about sex with them.
 - b. Adults can harm children in a lot of ways.
 - c. Most children would be afraid that they might get hurt if they had sex with an adult.
 - d. Some children might play dumb so the adult will force them to have sex.
 - e. Many children just like sex with adults and never even think of getting hurt.
4. Many children are sexually seductive toward adults.
 - a. Children are never sexually seductive with adults.
 - b. Most children want adults to like them and are friendly toward them.
 - c. A child's friendliness could be misinterpreted by some adults.
 - d. Some kids are real cockteasers.
 - e. Some children are openly seductive toward adults because they really prefer to have sex that way.
5. Children enjoy sexual attention from adults.
 - a. No child really enjoys sexual attention from an adult.
 - b. Children just like adults to pay attention to them.
 - c. A child's asking for attention could be misread as asking for sex.
 - d. A child's asking for attention may, in some cases, be a real sexual message.
 - e. Sexual attention from adults gives a child real self-confidence.

6. Men who have sex with children are usually led into it by the child.
 - a. Children never initiate sexual behaviour with adults.
 - b. Children are often socially manipulative with adults.
 - c. A man could take a child's manipulation of him the wrong way.
 - d. Some kids know that being a little sexy with adults can get them what they want.
 - e. Some kids probably feel that they have to take the initiative to get the adult to have sex with them.
7. Children could easily resist the sexual advances of an adult if they really wanted to.
 - a. Children are so weak and helpless that it is impossible for them to stop the sexual advances of an adult no matter what they do.
 - b. A child might think that any move by an adult was just a gesture of friendliness.
 - c. Some adults might think that a child's resisting them is one of those cases where "no" really means "yes."
 - d. Resisting an adult's sexual advances could be one way for a child to tease an adult.
 - e. A lot of children wouldn't resist an adult's advances because they really want to have sex.
8. If a child willingly sits on an adult man's knee then it is the child's fault if the adult touches him/her sexually.
 - a. You would have to be sick to see anything sexual in a child sitting on a man's knee.
 - b. Kids always sit on adults' knees.
 - c. A man might think that a child sitting on his knee was something more than friendly.
 - d. Depending on how a child sits on a man's knee, s/he might be giving the adult a sexual message.
 - e. Sitting on an adult man's knee is sometimes just a kind of sex play before the child has real sex with the man.
9. Children who do not wear underwear and who sit in a way that is revealing are suggesting sex.
 - a. A child would never suggest sex in this way.
 - b. Kids often do not pay any attention to how they sit when they're not wearing any underwear.
 - c. Kids who unwittingly display their genitals might be seen as suggesting sex.
 - d. Some kids might actually flash a man to show that they are interested in sex.
 - e. When kids flash an adult they want to get him excited so that sex between them will really be good.
10. Children who are not loved by their parents (or guardians) are actually helped by men who have sex with them.
 - a. Unloved children can get nothing good at all from any man who would have sex with them.
 - b. Unloved children should be cared for, not manipulated by adults.
 - c. Kids who feel unloved at home might go to extreme lengths to get attention from adults.
 - d. Kids whose parents don't love them might use a sexual come-on as a way to attract the attention of other adults.
 - e. Not being loved by parents is a sure way for a kid to get a lonely adult to have sex with him/her.
11. Sex between adults and children is quite natural and healthy and it is only because of the repressive rules of our society that men are punished for this.
 - a. The laws against sex with children should be much more severe than they are now.
 - b. It is true that some social rules are intentionally repressive.
 - c. The long-term effects of adult-child sex on the child have not been fully determined.
 - d. The fact that adult-child sex is forbidden fruit is one way for kids to get adults sexually interested in them.
 - e. One of these days governments will realize that adult-child sex is healthy and normal and the rules will be changed.
12. It is far better for a young person to have the first sexual experience during childhood with an adult, than to risk what is certain to be an unpleasant sexual experience with someone his/her own age when as a teenager.
 - a. Sex with an adult is certain to damage a child's sexual development.
 - b. Children get their basic social education from adults.
 - c. Early sex education would probably be beneficial for most children.
 - d. Some young kids use adults to learn about sex so they can feel more sexually competent when they are teenagers.
 - e. The best sex education a child could have is a caring and loving sexual relationship with an adult.
13. Having any sexual experience with a child is always wrong.
 - a. Sex with children is against the law, and that is all there is to it.
 - b. Many children have experiences they could do without.
 - c. Sexual experience is something that should occur naturally with peers when a child is growing up.
 - d. Some children encourage sex with adults because they know that they need the experience.
 - e. If an adult is seduced into a sexual relationship by a willing, enthusiastic child, he can hardly be blamed for that.

14. When an adult is caught having sex with a child it is rarely the first time for the child.
 - a. Children do not sexually seduce adults.
 - b. Kids are more experienced today than when most adults were growing up.
 - c. Kids today know a lot more about sex than when most adults were that age.
 - d. It is a known fact that many children are quite sexually experienced, often with adults.
 - e. A man can hardly be blamed if he has been conned into a relationship by a sexually experienced child.
15. Although children are usually cooperative partners in sex with adults, they often report the man because they are afraid they will get into trouble.
 - a. Children will only have sex with an adult if they are threatened or forcibly raped.
 - b. Children often report a man who has been mean to them.
 - c. Children may feel really confused and uncomfortable after having had sex with an adult and feel they have to tell somebody.
 - d. Children may report a man who has had sex with them just to let him know who has the upper hand in the relationship.
 - e. Children report a man who has had sex with them because they don't want their parents or guardians to know they really enjoyed it.
16. A father should be allowed to have sex with his daughter if she consents to it.
 - a. Consent is not an issue because father-daughter sex is against the law.
 - b. On most issues a minor daughter should obey her father.
 - c. Fathers are powerful figures and can often make a daughter do things she doesn't want to do.
 - d. Some young women learn how powerful sex is by manipulating their fathers to get what they want.
 - e. Having a loving sexual relationship with her father can prepare a daughter for marriage and other adult responsibilities.
17. A man can't help having sex with a child if the child acts in a sexually provocative manner.
 - a. No normal man would ever become sexually aroused by a child or young teenager.
 - b. It is natural for children to provoke adults in all sorts of ways.
 - c. Simple friendliness in a child might be mistaken by some people as another kind of provocative behaviour.
 - d. There's no question about it, some kids really are cockteasers.
 - e. If a child is openly suggesting sex and there seems to be little or no risk involved, you might as well go ahead and do it.
18. Having sex with a child is really not all that bad because it really doesn't harm the child.
 - a. Sex with an adult always harms a child.
 - b. Children can be harmful in a lot of ways by adults.
 - c. Sex occurring naturally with a peer at the right time may not be harmful.
 - d. If children are harmed by sex with adults, then why do they come on to them the way they do?
 - e. This notion of children being harmed by sex with adults is not based on any good evidence.
19. When you consider all the crimes a person could commit, having sex with a child is not all that bad.
 - a. Having sex with a child is one of, if not the worst, crimes a man could commit.
 - b. Adults often do a lot of bad things to children.
 - c. Adults often do a lot of bad things, especially sexually.
 - d. Having sex with a child is not as bad as, for example, robbing or assaulting someone.
 - e. If an adult is openly manipulated into a sexual relationship with a child, you could hardly call that a crime.
20. It is all right for a father to have sex with his daughter to prepare her for her husband.
 - a. It is wrong for a father to tell his daughter that she is physically attractive.
 - b. Fathers have a responsibility to prepare their daughters to assume adult obligations.
 - c. A young woman's awakening sexual desire needs to be properly channeled and a father has a role in this.
 - d. If she's smart, a young woman can use her sexuality to get her father to do what she wants.
 - e. A daughter can more easily make the transition to adult responsibilities if she has had a caring and loving sexual relationship with her father.
21. Merely fondling a child or having oral sex is not as bad as having sexual intercourse with a child.
 - a. Children should not be exposed to any sexual activities.
 - b. Some kinds of sexual activity involve less danger of disease than sexual intercourse.
 - c. Experienced kids may allow an adult to touch them or have oral sex to get the adult to give them what they really want.
 - d. Experienced kids may allow an adult to touch them or have oral sex to get the adult to give them what they really want.
 - e. While full sexual intercourse might be painful and frightening, it is difficult to see how giving pleasure to a child by caressing or licking his/her genitals could be harmful.

22. You can't blame a man for having sex with his child if his wife doesn't satisfy him sexually.
- A father who even thinks about turning to his children for sex should be forced out of the family.
 - A poor sexual relationship in marriage is a common problem in our society.
 - Men often use a poor sexual relationship with their wives as an excuse to do some pretty outrageous things.
 - Some kids might use a poor sexual relationship between their parents as a way to sexually manipulate their fathers.
 - If your wife isn't good in bed, having sex with your kids is a more understandable alternative than, for example, having an affair.
23. If an adult has sex with a child who enjoys it and seems to want it, it shouldn't be considered a crime.
- Having sex with a child is a serious crime under any circumstances.
 - Mistreatment of a child by an adult is a crime.
 - Some adult behaviours, under certain circumstances, could be considered sex crimes.
 - Kids who come on sexually to adults often don't realize that they're placing the adult in a very dangerous position.
 - If a child is enthusiastic and clearly asking for sex with an adult, there's nothing criminal in that.
24. Children are old enough to decide whether or not they want to have sex with someone.
- Children under the age of 18 cannot legally give consent to sexual behaviour.
 - Children are a lot smarter today than when most adults were growing up.
 - Children probably think about sex more than we imagine they do.
 - Children actually know a lot more about sex than they let on.
 - If children consent to sex with an adult, that means they want to do it and it's probably all right to go ahead.
25. Having sex with a child is a way of expressing your love and affection for that child.
- Having sex with a child has nothing whatever to do with love and affection.
 - There are a lot of ways in which an adult can show love and affection toward a child.
 - Some people think that sex, love, and affection are the same thing.
 - Having sex with an adult is one way for children to gain affection.
 - Having a caring and loving sexual relationship with an adult can be a real growth experience for a child.
26. If you are taking care of children by feeding and clothing them you have a right to expect sexual favours in return.
- No adult has a right to expect anything in return for anything s/he does for a child.
 - An adult has a legal obligation to feed and clothe an underage child who is in his/her care.
 - Adults often expect sexual favours in return for doing something for someone.
 - Some kids will have sex with an adult just to get the adult to buy things for them.
 - When you're taking care of all a child's needs you ought to be able to do pretty much as you please with them.
27. A father has a right to have sex with his own daughters.
- A father should be careful not to give his daughters too much physical affection.
 - A father has a legal right to tell an underage daughter what she can and can't do.
 - Some men think that their rights extend to having sex with anyone they want.
 - A pretty young daughter can often use her sex to get her father to do what she wants.
 - When you come down to it, a daughter is not so different from a wife and you ought to be able to have sex with her once in a while if you both want to.
28. Having sex with a child is a good way to teach them about sexuality.
- Adults should never talk about or do anything sexual when children are around.
 - Adults have a responsibility to teach children many things.
 - Children often learn everything they need to know about sex from their peers.
 - By conning an adult into a sexual relationship a child can easily learn necessary sexual and social skills.
 - Having sex with an adult provides a child with sexual and social skills it would take years to learn otherwise.
29. Many children benefit from having sex with an adult.
- No child ever benefits from having sex with an adult.
 - Children gain many benefits from relationships with adults.
 - A lot of men believe that sex benefits whoever they have sex with.
 - Some children may benefit from a sexual relationship with an adult because it gets them other things that they want.
 - It is hard to believe that a child would not benefit from a gentle and caring sexual relationship with an adult.

30. It is okay to have sex with a child as long as you don't force the child into it.
 - a. Children should not have sex with anyone, force or no force.
 - b. It is always better to use persuasion than force to get a child to do what you want.
 - c. Many adults can persuade children to have sex with them.
 - d. Some kids may pretend that they don't want to have sex when what they really want is for you to make them do it.
 - e. When no force is necessary to get a child to have sex with an adult, that means that the child is consenting.
31. Sexually molesting a child is the worst crime a man could do.
 - a. There is no crime worse than molesting a helpless child.
 - b. It is a crime for an adult to physically harm a child.
 - c. Some common adult behaviours might be considered sexual molestation in some circumstances.
 - d. Some children get adults into trouble by being openly sexual with them.
 - e. If a child tricks an adult into a sexual relationship, then that's not a crime.
32. Even if the child suggests that s/he have a sexual relationship with a man, the man should be punished if he has sex with him/her.
 - a. Children cannot give consent to sex with anyone, adults or peers.
 - b. Children often suggest things that they know they shouldn't be doing.
 - c. Children often may not use good sense where sex is concerned.
 - d. Adults who get punished for sex with children have usually been led into it by a sexually experienced child.
 - e. If a child suggests sex with an adult, s/he is giving consent, and the adult shouldn't be punished for doing it.
33. Children are harmed more by the people who react badly to them disclosing about a sexual relationship with a man than by the sexual activity itself.
 - a. Children are harmed by an type of sex whether or not they disclose it to anyone.
 - b. Children can be harmed in a lot of different ways by adults.
 - c. Forcing children to talk about sexual experiences of any kind can be upsetting to them.
 - d. People who trick children into talking about their sexual experiences with adults are just indulging in their own sexual fantasies.
 - e. Children often get punished unjustly when they tell parents or guardians that they had an enjoyable sexual experience with an adult.
34. An adult having sex with a child will always hurt the child in some way.
 - a. Children are always harmed by having sex with adults.
 - b. Adults can harm children in a lot of different ways.
 - c. Having sex too early in life can be harmful to a child.
 - d. Children may say that they're afraid to have sex with an adult, but they're really playing hard to get.
 - e. When you consider all the real harm a person could do to a child, having sex with him/her is not all that bad.
35. If a child is a prostitute and sells his/her body for profit, then a man who has sex with him/her should not be punished.
 - a. Any man who has sex with a prostitute is immoral.
 - b. Street kids can get themselves into a whole lot of trouble.
 - c. Children who sell their bodies for sex can get into real serious legal and medical difficulties.
 - d. A lot of kids behave like hookers, and often a guy can't tell which is which.
 - e. Children prostitution, like adult prostitution, should be legalized so that no one gets hurt.
36. Children are not as innocent and naive about sexual matters as some people think they are.
 - a. Children can be seriously harmed if they learn about sex at a young age.
 - b. Kids are smarter these days than when most adults were growing up.
 - c. A lot of kids seems to know a great deal about sex.
 - d. Smart kids act innocent and naive about sex because they know this turns a lot of guys on.
 - e. When a kid comes right on to you and is clearly suggesting sex, you could hardly call him/her innocent.
37. Nowadays it is not so bad to have a sexual relationship with someone who is underage because kids know so much more about sex than they used to.
 - a. Children should be protected from knowing about sex for as long as possible.
 - b. Kids seem to know a lot about everything these days.
 - c. It is amazing how much kids nowadays know about sex.
 - d. A kid who's knowledgeable about sex can always get an adult's attention.
 - e. Because of the information revolution, kids are a lot more comfortable these days about having sex with adults.

38. Children are pretty smart and if they act in a sexual way they know very well that they are suggesting sex.
- Children never suggest sex.
 - Children these days often prove capable of doing things we never expected.
 - Children these days seem to know quite a bit about sex.
 - Kids are so smart these days that they really know how to manipulate adults, especially where sex is concerned.
 - These days smart kids really know the score, and if they suggest sex with you, you might as well go for it.
39. As long as you don't get a young girl pregnant, having sex with her will not particularly harm her.
- Young girls should not do anything sexual with anybody.
 - Young girls often run risks when they shouldn't.
 - Some young girls run the risk of getting pregnant by their same-age boyfriends.
 - Some young girls might actually try to get pregnant so that they can get a man to take care of them.
 - Provided you don't get her pregnant, having sex with a young girl is an excellent way to teach her about her adult responsibilities.
40. If you can get away with having a sexual relationship with a young person you might as well go for it.
- In the end, you can't really get away with having sex with a young person.
 - Some adults get away with a lot that they shouldn't.
 - Some adults seem to get away with a lot in their sexual behaviour.
 - Some young persons seem to suggest that it would be easy to have a sexual relationship with them.
 - Where's the harm in having sex with a youngster if s/he doesn't get hurt and no one's the wiser?

**Appendix F:
MOLEST Scale**

For the statements which follow, please write the number down that best indicates your opinion - to what degree do you agree with the statement.

1	2	3	4
strongly disagree	disagree	agree	strongly agree

Choice

1. I believe that sex with children can make the child feel closer to adults.	
2. Since some victims tell the offender that it feels good when the offender touches them, the child probably enjoys it and it probably won't affect the child much.	
3. Many children who are sexually assaulted do not experience any major problems because of the assaults.	
4. Sometimes, touching a child sexually is a way to show love and affection.	
5. Sometimes children don't say no to sexual activity because they are curious about sex or enjoy it.	
6. When kids don't tell that they were involved in sexual activity with an adult it is probably because they liked it or weren't bothered by it.	
7. Having sexual thoughts and fantasies about a child isn't all that bad because at least it is not really hurting the child.	
8. If a person does not use force to have sexual activity with a child, it will not harm the child as much.	
9. Some people are not "true" child molesters -- they are just out of control and made a mistake.	
10. Just fondling a child is not as bad as penetrating a child, and will probably not affect the child as much.	
11. Some sexual relations with children are a lot like adult sexual relationships.	
12. Sexual activity with children can help the child learn about sex.	
13. I think child molesters often get longer sentences than they really should.	
14. Kids who get molested by more than one person probably are doing something to attract adults to them.	
15. Society makes a much bigger deal out of sexual activity with children than it really is.	
16. Sometimes child molesters suffer the most, lose the most, or are hurt the most as a result of a sexual assault on a child more than a child suffers, loses, or is hurt.	
17. It is better to have sex with one's child than to cheat on one's wife.	
18. There is no real manipulation or threat used in a lot of sexual assaults on children.	

1	2	3	4
strongly disagree	disagree	agree	strongly agree

Choice

19. Some kids like sex with adults because it makes them feel wanted and loved.	
20. Some men sexually assaulted children because they really thought the children would enjoy how it felt.	
21. Some children are willing and eager to have sexual activity with adults.	
22. During sexual assaults on children, some men ask their victims if they liked what they were doing because they wanted to please the child and make them feel good.	
23. Children who have been involved in sexual activity with an adult will eventually get over it and go on with their lives.	
24. Some children can act very seductively.	
25. Trying to stay away from children is probably enough to prevent a molester from molesting again.	
26. A lot of times, kids make up stories about people molesting them because they want to get attention.	
27. Many men sexually assaulted children because of stress, and molesting helped to relieve that stress.	
28. A lot of times, kids make up stories about people molesting them because they want to get attention.	
29. If a person tells himself that he will never molest again, then he probably won't.	
30. If a child looks at an adult's genitals, the child is probably interested in sex.	
31. Sometimes victims initiate sexual activity.	
32. Some people turn to children for sex because they were deprived of sex from adult women.	
33. Some young children are much more adult-like than other children.	
34. Children who come into the bathroom when an adult is getting undressed or going to the bathroom are probably just trying to see the adult's genitals.	
35. Children can give adults more acceptance and love than other adults.	
36. Some men who molest children really don't like molesting children.	
37. I think the main thing wrong with sexual activity with children is that it is against the law.	
38. If most child molesters hadn't been sexually abused as a child, then THEY probably never would have molested a child.	

Items are scored on a 4-point scale from "strongly disagree" to "strongly agree".

Appendix G:
RAPE Scale

For the statements which follow, please write the number down that best indicates your opinion - to what degree do you agree with the statement.

1
2
3
4

strongly disagree
disagree
agree
strongly agree

Choice

1. Men who commit rape are probably responding to a lot of stress in their lives, and raping helps to reduce that stress.	
2. Women who get raped probably deserved it.	
3. Women generally want sex no matter how they can get it.	
4. Since prostitute sell their bodies for sexual purposes anyway, it is not as bad if someone forces them into sex.	
5. If a woman does not resist strongly to sexual advances, she is probably willing to have sex.	
6. Women often falsely accuse men of rape.	
7. A lot of women who get raped had "bad reputations" in the first place.	
8. If women did not sleep around so much, they would be less likely to get raped.	
9. If a woman gets drunk at a party, it is really her own fault if someone takes advantage of her sexually.	
10. When women wear tight clothes, short skirts, and no bra or underwear, they are asking for sex.	
11. A lot of women claim they were raped just because they want attention.	
12. Victims of rape are usually a little bit to blame for what happens.	
13. If a man has had sex with a woman before, then he should be able to have sex with her any time he wants.	
14. Just fantasizing about forcing someone to have sex isn't all that bad since no one is really being hurt.	
15. Women who go to bars a lot are mainly looking to have sex.	
16. A lot of times, when women say "no" they are just playing hard to get, and really mean "yes."	
17. Part of a wife's duty is to satisfy her husband sexually whenever he wants it, whether or not she is in the mood.	
18. Often a woman reports rape long after the fact because she gets mad at the man she had sex with and is just trying to get back at him.	

1	2	3	4
strongly disagree	disagree	agree	strongly agree

Choice

19. As long as a man does not slap or punch a woman in the process, forcing her to have sex is not as bad.	
20. When a woman gets raped more than once, she is probably doing something to cause it.	
21. Women who get raped will eventually forget about it and get on with their lives.	
22. On a date, when a man spends a lot of money on a woman, the woman ought to at least give the man something in return sexually.	
23. I believe that if a woman lets a man kiss her and touch her sexually, she should be willing to go all the way.	
24. When women act like they are too good for men, most men probably think about raping the women to put them in their place.	
25. I believe that society and the courts are too tough on rapists.	
26. Most women are sluts and get what they deserve.	
27. Before the police investigate a woman's claim of rape, it is a good idea to find out what she was wearing, if she had been drinking, and what kind of person she is.	
28. Generally, rape is not planned - a lot of times it just happens.	
29. If a person tells himself that he will never rape again, then he probably won't.	
30. A lot of men who rape do so because they are deprived of sex.	
31. The reason a lot of women say "no" to sex is because they don't want to seem loose.	
32. If a woman goes to the home of a man on the first date, she probably wants to have sex with him.	
33. Many women have a secret desire to be forced into having sex.	
34. Most of the men who rape have stronger sexual urges than other men.	
35. I believe that any woman can prevent herself from being raped if she really wants to.	
36. Most of the time, the only reason a man commits rape is because he was sexually assaulted as a child.	

Items are scored on a 4-point scale from "strongly disagree" to "strongly agree".

**Appendix H:
Burt Attitude Scales**

For the statements which follow, please write the number down that best indicates your opinion - what you believe. If you strongly disagree you would answer "1"; if you strongly agree you would answer "7"; if you feel neutral you would answer "4"; and so on.

1	2	3	4	5	6	7
disagree strongly	disagree somewhat	disagree slightly	neutral	agree slightly	agree somewhat	agree strongly

- ___ 1. A man should fight when the woman he's with is insulted by another man.
- ___ 2. It is acceptable for the woman to pay for the date.
- ___ 3. A woman should be a virgin when she marries.
- ___ 4. There is something wrong with a woman who doesn't want to marry and raise a family.
- ___ 5. A wife should never contradict her husband in public.
- ___ 6. It is better for a woman to use her feminine charm to get what she wants rather than ask for it outright.
- ___ 7. It is acceptable for a woman to have a career, but marriage and family should come first.
- ___ 8. It looks worse for a woman to be drunk than for a man to be drunk.
- ___ 9. There is nothing wrong with a woman going to a bar alone.
- ___ 10. A woman will only respect a man who will lay down the law to her.
- ___ 11. Many women are so demanding sexually that a man just can't satisfy them.
- ___ 12. A man's got to show the woman who's boss right from the start or he'll end up henpecked.
- ___ 13. Women are usually sweet until they've caught a man, but then they let their true self show.
- ___ 14. A lot of men talk big, but when it comes down to it, they can't perform well sexually.
- ___ 15. In a dating relationship a woman is largely out to take advantage of a man.

- | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|----------------------|----------------------|----------------------|---------|-------------------|-------------------|-------------------|
| disagree
strongly | disagree
somewhat | disagree
slightly | neutral | agree
slightly | agree
somewhat | agree
strongly |
- ___ 16. Men are out for only one thing.
- ___ 17. Most women are sly and manipulating when they are out to attract a man.
- ___ 18. A lot of women seem to get pleasure in putting men down.
- ___ 19. A woman who initiates a sexual encounter will probably have sex with anybody.
- ___ 20. A woman shouldn't give in sexually to a man too easily or he'll think she's loose.
- ___ 21. Men have a biologically stronger sex drive than women.
- ___ 22. A nice woman will be offended or embarrassed by dirty jokes.
- ___ 23. Masturbation is a normal sexual activity.
- ___ 24. People should not have oral sex.
- ___ 25. I would have not respect for a woman who engages in sexual relationships without any emotional involvement.
- ___ 26. Having sex during the menstrual period is unpleasant.
- ___ 27. The primary goal of sexual intercourse should be to have children.
- ___ 28. Women have the same needs for a sexual outlet as men.

SCORING KEY FOR BURT ATTITUDE SCALES:

The questions will be combined and randomized as one scale to the respondent. Items for each scale is totalled.

SEX ROLE STEREOTYPING

- 1. A man should fight when the woman he's with is insulted by another man.
- 2. It is acceptable for the woman to pay for the date.
- 3. A woman should be a virgin when she marries.
- 4. There is something wrong with a woman who doesn't want to marry and raise a family.
- 5. A wife should never contradict her husband in public.
- 6. It is better for a woman to use her feminine charm to get what she wants rather than ask for it outright.
- 7. It is acceptable for a woman to have a career, but marriage and family should come first.
- 8. It looks worse for a woman to be drunk than for a man to be drunk.
- 9. There is nothing wrong with a woman going to a bar alone.

ADVERSARIAL SEXUAL BELIEFS

- 10. A woman will only respect a man who will lay down the law to her.
- 11. Many women are so demanding sexually that a man just can't satisfy them.
- 12. A man's got to show the woman who's boss right from the start or he'll end up henpecked.
- 13. Women are usually sweet until they've caught a man, but then they let their true self show.
- 14. A lot of men talk big, but when it comes down to it, they can't perform well sexually.
- 15. In a dating relationship a woman is largely out to take advantage of a man.
- 16. Men are out for only one thing.
- 17. Most women are sly and manipulating when they are out to attract a man.
- 18. A lot of women seem to get pleasure in putting men down.

SEXUAL CONSERVATISM

- 19. A woman who initiates a sexual encounter will probably have sex with anybody.
- 20. A woman shouldn't give in sexually to a man too easily or he'll think she's loose.
- 21. Men have a biologically stronger sex drive than women.
- 22. A nice woman will be offended or embarrassed by dirty jokes.
- 23. Masturbation is a normal sexual activity.
- 24. People should not have oral sex.
- 25. I would have no respect for a woman who engages in sexual relationships without any emotional involvement.
- 26. Having sex during the menstrual period is unpleasant.
- 27. The primary goal of sexual intercourse should be to have children.
- 28. Women have the same needs for a sexual outlet as men.

Appendix I:
Appropriate Sexual Fantasies Scale (ASFS)

For the following fantasy themes, please write down the number that best describes your opinion about how appropriate this fantasy would be for a person to have:

1	2	3	4	5	6	7
extremely inappropriate	moderately inappropriate	slightly inappropriate	neutral	slightly appropriate	moderately appropriate	extremely appropriate

Choice

1. Making love out of doors in a romantic setting, e.g., field of flowers, beach at night	
2. Having intercourse with a loving partner	
3. Intercourse with someone you know but have not had sex with	
4. Intercourse with an anonymous stranger	
5. Sex with two other people	
6. Participating in an orgy	
7. Being forced to do something	
8. Forcing someone to do something	
9. Homosexual activity	
10. Receiving oral sex	
11. Giving oral sex	
12. Watching others have sex	
13. Sex with an animal	
14. Whipping or spanking someone	
15. Being whipped or spanked	
16. Taking someone's clothes off	
17. Having your clothes taken off	
18. Making love elsewhere than bedroom (e.g., kitchen or bathroom)	

1	2	3	4	5	6	7
extremely inappropriate	moderately inappropriate	slightly inappropriate	neutral	slightly appropriate	moderately appropriate	extremely appropriate

Choice

19. Being excited by material or clothing (e.g., rubber, leather, underwear)	
20. Hurting a partner	
21. Being hurt by a partner	
22. Mate-swapping	
23. Being aroused by watching someone urinate	
24. Being tied up	
25. Tying someone up	
26. Having incestuous sexual relations	
27. Exposing yourself provocatively	
28. Transvestitism (wearing clothes of the opposite sex)	
29. Being promiscuous	
30. Having sex with someone much younger than yourself	
31. Having sex with someone much older than yourself	
32. Being much sought after by the opposite sex	
33. Being seduced as an "innocent"	
34. Seducing an "innocent"	
35. Being embarrassed by failure of sexual performance	
36. Having sex with someone of a different race	
37. Using objects for stimulation (e.g., vibrators, candles)	
38. Being masturbated to orgasm by a partner	
39. Looking at obscene pictures or film	
40. Kissing passionately	

SCORING KEY FOR ASFS:

Each item is scored on a 7-point scale from extremely sexually inappropriate to extremely sexually appropriate. The four fantasy factors consist of the following items:

Intimate 1,2,3,10,11,16,17,18,38,40 Exploratory 5,6,9,22,26,29,32,33,34,36
 Impersonal 4,12,13,19,23,30,31,35,37,39 Sado-masochistic 7,8,14,15,20,21,24,25,27,28

Scores for each of these themes are added up separately.

INTIMATE

- 1. Making love out of doors in a romantic setting, e.g., field of flowers, beach at night.
- 2. Having intercourse with a loving partner
- 3. Intercourse with someone you know but have not had sex with
- 10. Receiving oral sex
- 11. Giving oral sex
- 16. Taking someone's clothes off
- 17. Having your clothes taken off
- 18. Making love elsewhere than bedroom (e.g., kitchen or bathroom)
- 38. Being masturbated to orgasm by a partner
- 40. Kissing passionately

EXPLORATORY

- 5. Sex with two other people
- 6. Participating in an orgy
- 9. Homosexual activity
- 22. Mate-swapping
- 26. Having incestuous sexual relations
- 29. Being promiscuous
- 32. Being much sought after by the opposite sex
- 33. Being seduced as an "innocent"
- 34. Seducing an "innocent"
- 36. Having sex with someone of a different race

IMPERSONAL

- 4. Intercourse with an anonymous stranger
- 12. Watching others have sex
- 13. Sex with an animal
- 19. Being excited by material or clothing (e.g., rubber, leather, underwear)
- 23. Being aroused by watching someone urinate
- 30. Having sex with someone much younger than yourself
- 31. Having sex with someone much older than yourself
- 35. Being embarrassed by failure of sexual performance
- 37. Using objects for stimulation (e.g., vibrators, candles)
- 39. Looking at obscene pictures or film

SADO-MASOCHISTIC

- 7. Being forced to do something
- 8. Forcing someone to do something
- 14. Whipping or spanking someone
- 15. Being whipped or spanked
- 20. Hurting a partner
- 21. Being hurt by a partner
- 24. Being tied up
- 25. Tying someone up
- 27. Exposing yourself provocatively
- 28. Transvestism (wearing clothes of the opposite sex)

Appendix J:
Ethical Approval: University of Victoria, Human Research Ethics Committee



University of Victoria
Human Research Ethics Committee

CERTIFICATE OF APPROVAL

<u>Principal Investigator</u> Sandy Jung Graduate Student	<u>Department/School</u> PSYC	<u>Supervisor</u> Dr. J. Bavelas
---	----------------------------------	-------------------------------------

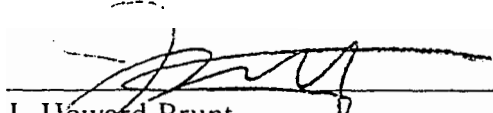
Co-investigator(s):
N/A

Title: Assessing Clients Charged for Sexual Offenses

<u>Project No.</u> 030-00	<u>Start Date</u> 31 Jan 00	<u>End Date</u> 30 Jan 01	<u>Approval Date</u> 31 Jan 00
------------------------------	--------------------------------	------------------------------	-----------------------------------

Certification

This is to certify that the University of Victoria Ethics Review Committee on Research and Other Activities Involving Human Subjects has examined the research proposal and concludes that, in all respects, the proposed research meets appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Subjects.



 J. Howard Brunt,
 Associate Vice-President, Research

This Certificate of Approval is valid for the above term provided there is no change in the procedures. Extensions/minor amendments may be granted upon receipt of "Request for Continuing Review or Amendment of an Approved Project" form.

Office of Vice President Research
Room 424, Business & Economics Building
P.O. Box 1700,
Victoria, BC V8W 2Y2

Tel: (250)472-4362
Fax: (250)721-8960
Email: lallemann@uvic.ca

Appendix K:
Ethical Approval: Forensic Psychiatric Services Commission, Research Application

MEMORANDUM
Forensic Psychiatric Services
Golden Willows Building
Port Coquitlam, B.C. V3C 5X9

Date: 23/03/00

To: Sandy Jung

From: Diane Lamb
Manager, Policy, Research, Evaluation

Subject: Research Agreement

I am pleased to forward you, at last, a copy of the signed Research agreement for your study "Assessing Clients Charged for Sexual Offenses".

Once again I would simply ask that you kindly forward me a copy of the ethics approval when you have received it.

Thank you, and good luck with this research project. Please contact me if you have any further questions.

Diane Lamb.

MEMORANDUM
Forensic Psychiatric Services
Golden Willows Building
Port Coquitlam, B.C. V3C 5X9

Date: 07/01/00

To: Sandy Jung
From: Diane Lamb
Manager, Policy, Research, Evaluation

Subject: Research Proposal
Assessing Clients Charged for Sexual Offenses


Thank you for your research agreement submission. I am pleased to tell you that your proposal is approved, in principle, with the following comments:

1. In the statement of consent, under "What will I do in this study", it states "I have been referred to the AFPCS for possible participation in a research project." I don't believe that people are actually referred for research but would have been referred for treatment purposes. Research may take place as a result of this referral. Could you please clarify this on the consent form.
2. In the risks of participation section on the consent form you caution individuals not to discuss past criminal behaviour. I am advised by the Clinical Director that we are obliged to report *information where there is an immediate risk or substantial danger*, but we are not obliged to report upon learning about past offences where there have been no charges laid and there is currently no risk to anyone. You may wish to clarify this point in the consent form.
3. You should also include a point that states that information will not be kept confidential if you learn that a child may be at risk of harm.

Please also provide a copy of the ethics committee approval when you have received it.

The research agreement requires final sign off by the Professional and Program Advisory Committee (PPAC). This committee meets next at the end of January. I will forward to you a copy of the signed agreement at that time, in the meanwhile, your research may go ahead with the minor modifications to the consent form.

Good luck with your research, and if you have any questions, please feel free to contact me.


Cc. Dr. Derek Eaves
Judith Hayes

RESEARCH AGREEMENT

Page 3

FORENSIC PSYCHIATRIC SERVICES COMMISSION

APPLICATION AND AGREEMENT
FOR RESEARCH

Purpose: This form is for use in obtaining approval to conduct research and for requesting access, for research or statistical purposes, to personal information found in records covered by the *Freedom of Information and Protection of Privacy Act*, SBC 1992, c. 61 (the Act). Once the researcher has signed this form and the terms and conditions have been approved by the Forensic Psychiatric Services Commission, it becomes a legal agreement between the researcher and the Forensic Psychiatric Services Commission.

Collection of the information which the applicant provides on this form, and the conditions of access described, are authorized by Section 35 of the Act. Any questions about this form may be directed to the Manager, Policy, Evaluation and Research, Forensic Psychiatric Services Commission.

PART A - Identification of Researcher

Jung, Sandy
Name (last name/first name/initials)

Registration number
(if applicable)

Address: Forensic Psychiatric Services
2840 Nanaimo Street
Victoria, BC. V8T 4W9

Telephone: (250) 387-1465

Please provide the following additional information if applicable:

Institutional Affiliation: Psychology, University of Victoria
(include department if relevant)

Position: Graduate Student

Academic Advisor (if student): D. Richard Laws, Ph.D. and Janet B. Bavelas

- (a) Does the project require access to records? Yes No
- (b) Does the project require subject interviews? Yes No

PART B - Description of Research Project

Please attach the following information:

- 1) A general description of the purpose and objectives of the research project
- 2) A summary of the methodology and procedures.
- 3) A description of the population:
 - (a) How many subjects/cases will be used?;
 - (b) What are the criteria for selection of subjects/cases?
 - (c) How are subjects to be recruited?
 - (d) If using a control group, provide the number of subjects/cases, criteria for selection, & recruitment.
- 4) Project details:
 - (a) Where will the project be conducted? (specific facilities, wards, clinics, etc.)
 - (b) Who will actually conduct the study? (i.e. interviews, examinations, testing, etc.)
 - (c) Describe how the consent of the subjects will be obtained, (attach consent forms to be used)
 - (d) What is known about the risks and benefits of the proposed research?
 - (e) What discomfort or incapacity are the subjects likely to experience as a result of the procedures?
 - (f) How much time will be required of a subject?
 - (g) How much time will be required of the control group (if any)?
- 5) A copy of the ethics approval (external applicants only).
- 6) An explanation of why the research project cannot reasonably be accomplished without access to personal information in individually identifiable form (i.e. personal information about named or identifiable individuals).
- 7) An explanation of how the personal information will be used, including a description of any proposed linkages to be made between personal information in the records requested and any other personal information.
- 8) The time frame of the study (expected start and completion date and period of time during which access to records may be required).
- 9) The resource implications to Forensic Psychiatric Services Commission
- 10) The anticipated benefits to be derived from the research project.

Please also provide a curriculum vitae including the following information: education; research experience; knowledge of subject and proposed methodology; three references.

RESEARCH AGREEMENT

Page 5

PART C - Records Requested (Use additional sheets as required)

Please list all records containing personal information to which access is requested. Access will be given only to records listed below. Any changes or additions to this list after the application is submitted should be made in writing and will require approval in writing from the Forensic Psychiatric Services Commission.

1. Clinic files of participants
2. _____
3. _____
4. _____
5. _____
6. _____

Originals may be consulted only at the offices of the Forensic Psychiatric Services Commission.

PART D - Agreement on Terms and Conditions of ResearchTerm of the Research

- 1) This research is approved for the following period of time:
from January 2000 to January 2001.
- 2) I understand that any requests for extension to the project must be made in writing.

Reporting Requirements

- 1) I understand that I am to provide written reports at six month intervals, or when requested, as to the progress of the research project to the Forensic Psychiatric Services Commission.
- 2) At the completion of the research project, I will provide a copy of the final report to the Forensic Psychiatric Services Commission.

If I am granted access to the records listed in Part C, I understand and will abide by the following terms and conditions:

Security

- 1) I understand that I am responsible for maintaining the security and confidentiality of all personal information found in or taken from these records.
- 2) Apart from myself, only the following persons will have access to this personal information in a form which identifies or could be used to identify the individual(s) to whom it relates:

D. Richard Laws, Ph.D.

Before any personal information is disclosed to these persons, I will obtain a written undertaking from each of them to ensure that they will not disclose that information to any other person and that they will be bound by all terms and conditions of the present agreement. I will maintain a copy of each such guarantee, and will provide the Forensic Psychiatric Services Commission with a photocopy.

- 3) None of these records (including copies of them or notes containing personal information taken from them) will be left unattended at any time, except under the conditions described in Paragraphs 4, 5 and 6, below. If I am using these records on the premises of the Forensic Psychiatric Services Commission I will comply with the Forensic Psychiatric Services Commission's security procedures.
- 4) Any copies of the requested records and any notes which contain personal information taken from them will be kept at the following address(es):

AFPCS, 2840 Nanaimo St, Victoria, BC.

They will not be removed from the above premises without the prior written consent of the Forensic Psychiatric Services Commission.

- 5) Physical security at the above premises will be maintained by ensuring that the premises are securely locked, except when one or more of the individuals named in paragraph 1) are present, as well as by the following additional measures (e.g. locked filing cabinet):

Locked filing cabinet

- 6) Individually identifiable information from the requested records will be maintained on a computer system to which users other than those listed in paragraph 1) have access.

Yes No

If yes, access to the information will be restricted through the use of passwords and by other computer - security measures that prevent unauthorized access or that trace such unauthorized access, including the following methods:

- 7) The Forensic Psychiatric Services Commission will be permitted to carry out on-site visits and such other inspections or investigations that it deems necessary to ensure compliance with the conditions of this agreement.

RESEARCH AGREEMENT

Page 7

Use of Personal Information

- 8) Personal information contained in the records described in Part C of this form will not be used or disclosed for any purpose other than as described in Part B (including additional linkages between sources of personal information), nor for any subsequent purpose, without the express written permission of the Forensic Psychiatric Services Commission.
- 9) Papers or any other works which describe the results of the research undertaken will be written and/or presented in such a way that no individuals in the requested records can be identified and no linkages can be made between any personal information found in the requested records and personal information that is publicly available from other sources. There will be no exceptions to this rule without prior and specific written permission from the Forensic Psychiatric Services Commission.
- 10) Any case file numbers or other individual identifiers to be recorded on computer will be created by myself or one of the persons listed in paragraph 1) and will not relate to any real case numbers found in the records. Any such identifiers are to be used for statistical purposes only.
- 11) No case file numbers or other individual identifiers assigned for the purposes of the research project described in Part B will appear in any other work.
- 12) No personal information which identifies or could be used to identify the individual(s) to whom it relates will be transmitted by means of any telecommunications device, including telephone, fax or modem.
- 13) Unless expressly authorized in writing by the Forensic Psychiatric Services Commission, no direct or indirect contact will be made with the individuals to whom the personal information relates.
- 14) Individual identifiers associated with the records described in Part C, or contained in copies of them, will be removed or destroyed at the earliest time at which removal or destruction can be accomplished consistent with the research purpose described in Part B. At the latest (maximum 2 years), this will occur by:
2003/ 1 / 1
(year / month / day)

Any extension to this time limit must be approved in writing by the Forensic Psychiatric Services Commission. The removal of individual identifiers will be done in a manner that ensures that remaining personal information (including any found in research notes) cannot be used to identify the individual to whom it relates. If necessary, this will be done by destroying copies of requested records or pages of notes in their entirety. All destruction or removal of individual identifiers will be confidential and complete in order to prevent access by any unauthorized persons.

15) I understand that I am responsible for ensuring complete compliance with these terms and conditions. In the event that I become aware of a breach of any of the conditions of this agreement, I will immediately notify the Forensic Psychiatric Services Commission in writing. Contravention of the terms and conditions of this agreement may lead to the withdrawal of research privileges; the Forensic Psychiatric Services Commission may also take legal action to prevent any further disclosure of the personal information concerned.

Signed at Victoria, BC, this 23 day of November, 1999.

[Signature]
Signature of Researcher

Signature of Witness

Name and Position of Witness

Signature of Co-Investigator

Signature of Co-Investigator

PART E - Approval of Terms and Conditions (to be completed by the Forensic Psychiatric Services Commission)

The above research proposal is hereby approved, including access to the required records, and the terms and conditions of this agreement. Forensic Psychiatric Services Commission reserves the right to withdraw access to records without prior notice if this becomes necessary under the Act.

The expiry date for access to the records listed in Part C is:

2001 / 12 / 31
(year / month / day)

[Signature]
Signature
Manager, Policy Evaluation, Research

Feb 3, 2000
Date

[Signature]
Signature
Executive Commissioner, Clinical Services

Feb 3, 2000.
Date

Signature
Commission Chairman

Date

FORENSIC PSYCHIATRIC COMMISSION
APPLICATION AND AGREEMENT FOR RESEARCH

PART B - Description of Research Project

1) A general description of the purpose and objectives of the research project.

Many sex offenders go untreated because they are deemed unamenable to treatment due to poor motivation (Garland & Dougher, 1987; Marshall, 1994). This lack of motivation is usually due to denial and minimization of their offending. Generally, treatment programs require an admission of sexual offending by the offender. This is primarily due to the importance of allowing information to emerge which is essential for successful therapy with sex offenders (Nelson & Jackson, 1989). For example, an individual denying any offense would not willingly discuss past offenses and sexually deviant interests (e.g., pedophilia) which may lead to future re-offending. As a result, sex offenders who deny or minimize their offending can inhibit any progress in therapy and are often not admitted into any sex offender treatment groups.

The purpose of the proposed research is to determine to what extent a sex offender may be in denial or may minimize the seriousness of his offense. Considering the importance of assessing denial, especially before entering community-based programming, understanding the processes that underlie the sex offender's level of denial is vital to reducing his risk of committing another sex offense. Furthermore, community safety is the first consideration in any sex offender treatment and therefore, the availability of a tool to assist in monitoring the behaviour and treatment compliance of these clients is urgently needed. In my experience, I have observed that offenders tend to see value in their treatment far too late in the program. By targetting the social and cognitive factors which contribute to a particular sex offender's denial, a treatment provider is able to concentrate on that individual in one-to-one therapy prior to admitting him into treatment. To date, there have been no empirical studies which have examined the social and cognitive factors related to denial among sexual offenders, and there are no clinical instruments available to aid treatment providers for such a purpose. The goal of this research is to examine the utility of an instrument specifically designed to identify these social and cognitive components of denial. Hence, such an instrument can help practitioners target areas that should be addressed in therapy.

2) A summary of the methodology and procedures.

AFPCS clinic staff will be told of the nature and purpose of the study and asked to inquire whether their clients would be willing to participate in the research. The criteria for eligibility is that they have not previously entered and completed a sex offender treatment or management program in a community outpatient center or in a correctional center.

The primary investigator will arrange an appointment to meet with each referred participant at the AFPCS clinic on Nanaimo Street. Potential participants will be informed about the nature of the study and what is involved in participation. After obtaining consent to participate in the study (see Appendix A for Statement of Informed Consent), participants will be assessed and interviewed by an individual with at least a Masters in clinical psychology. The interview will be semi-structured, including a series of standard questions which tap into whether he has minimized any part of his offending or his deviant sexual arousal (see Appendix B for Interview Guideline). Based on the interview and collateral information (e.g., clinic file review), the investigator will assess and evaluate the sex offender on the Comprehensive Inventory of Sex Offenders in Denial (CISOD).

1. The CISOD is a checklist with 18 components in which the investigator completes. It is intended to tap into different elements of denial and minimization among sexual offenders (see Appendix C). The instrument was specifically developed for this study as there are no such measures available for such clinical use.

The participant will then be asked to complete a battery of questionnaires tapping into social characteristics, cognitive attitudes, and probability of socially desirable responding.

Social

1. Self-Monitoring Scale (SMS; Snyder, 1974) measures one's tendency to manage one's impression to fit the situation (see Appendix D).
2. Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965) measures general feelings of self-worth and addresses a person's overall evaluation of himself and his attitudes across times and situations (see Appendix E).

Cognitive

1. The RAPE Scale (Bumby, 1996) measures a respondent's endorsement of rape myths commonly reported by sexual offenders (see Appendix F).
2. The MOLEST Scale (Bumby, 1996) measures a person's endorsement of cognitive distortions many sex offenders hold regarding the sexual molestation of children (see Appendix G).
3. The Revised Cognition Scale (RCS; Marshall, 1989) taps into problematic attitudes which support adult/child sexual relations (see Appendix H).
4. The scale, Appropriate Sexual Fantasies Scale (ASFS) was adapted, for the purpose of this study, from other sexual fantasy scales (O'Donohue, Letourneau & Dowling, 1997; Salter, 1988). It is used to examine a respondent's opinion of the appropriateness of a series of sexual fantasies (see Appendix I).
5. Three of the five Burt Attitudes Scales will also be given to address more general sex roles and attitudinal beliefs (Burt, 1980). The first scale, Sex Role Stereotyping, asks questions regarding sex roles in familial, work or social settings. The second scale, Adversarial Sexual Beliefs, examines to what extent a person believes sexual relationships are fundamentally exploitative. The third scale, Sexual Conservatism, examines a person's view on the appropriateness of sexual partners, sexual acts, conditions or circumstances under which sex should occur (see Appendix J for all three scales).

Probability of Socially Desirable Responding

1. Balanced Inventory of Desirable Responding Version 6 (BIDR-6) assesses to what extent does an individual respond to self-reports in a socially desirable manner (see Appendix K).

Participants will be assured complete confidentiality. All information obtained from participants (e.g., interview responses, written responses, questionnaire responses) will be coded with a 3 digit number. Participant names or other identifying information will not be included in the research records. The list of participant names and the matching random number will be kept in a locked cabinet separate from the rest of the test data and data from this research will be kept separate from AFPCS clinic files. The data from this study will not appear in any of the participant's clinic files at AFPCS or elsewhere.

All participants will be fully debriefed and offered feedback on their responses, if requested. This is outlined below:

At this point I would like to give you further information in addition to what I've told you at the start of the study. What we are looking at here is the extent to which you have taken responsibility for your sexual offending and how you view the sexual offenses for which you have been charged for. Many people have different views of their offending and I am not here to judge you specifically, but what we would like to do with your data is to target what needs you might have and how we can examine them at our clinic. This is based on your responses to my questions during the interview and in the questionnaires you've filled out. This type of information may be useful for our staff to use prior to anybody entering our sex offender management group that we hold in our clinic. We are hoping to find that the interview that we went through and the questionnaires you filled out will be a useful screening tool to see who may benefit from individual treatment and group treatment.

I would like to remind you at this point that your probation officer and other people at this clinic will not have access to your data. Only my supervisors, Dr. Bavelas and Dr. Laws, will have access to this information and this will not have any affect on your status at this clinic.

Also, I would like you to keep in mind that we are not looking at individual responses, but rather average responses on each of the questionnaires that you have filled out and on the questions I have asked you

during the initial interview. So, in other words, I won't be looking at your responses by itself, but as a whole with all the participants' data. Is this clear?

Do you have any questions about your participation or about the study at this point?

If you are interested in the results of the study, please feel free to contact me at the clinic number, 387-1465. Once we have completed the research, overall results (and not individual ones) will be available for those who have participated in the research.

Thank-you for your participation in this study.

3) A description of the population:

(a) How many subjects/cases will be used?

50 participants

(b) What are the criteria for selection of subjects/cases?

Fifty (50) adult males who have been charged and sentenced for a sexual offense will be recruited. The criteria for eligibility is that they have not previously entered and completed a sex offender treatment or management program in a community outpatient center or in a correctional center.

(c) How are subjects to be recruited?

All AFPCS clinic staff will be told of the nature and purpose of the study. Participants will be recruited by obtaining referrals from these professionals. They will inform their clients about the purpose of the study and what would be involved if they were to partake in the study. Then they would ask their clients if they are interested. If so, the primary investigator would contact the client by phone shortly after and schedule an appointment to further discuss the details of the study with them which is outlined in the Statement of Informed Consent Form (see Appendix A).

(d) If using a control group, provide the number of subjects/cases, criteria for selection, & recruitment.

N/A

4) Project details:

(a) Where will the project be conducted? (specific facilities, wards, clinics, etc.)

FPS Clinic in Victoria, 2840 Nanaimo Street, Victoria, B.C.
Interviews will be conducted in available rooms (e.g., psychological assessment room, boardroom).

(b) Who will actually conduct the study? (i.e., interviews, examinations, testing, etc.)

The Primary Investigator, Sandy Jung, will conduct the interviews and administer the questionnaires.

(c) Describe how the consent of the subjects will be obtained. (attach consent forms to be used)

Participants will give preliminary consent to their case worker at FPS-Victoria for him/her to forward their names to the primary investigator. The primary investigator will contact them and schedule a convenient appointment. It will be at this appointment that written informed consent will be obtained (see Appendix A for Statement of Informed Consent).

(d) What is known about the risks and benefits of the proposed research?

RISKS

There may be risks and discomforts in participating in this research. Each participant will be made fully aware of these risks and discomforts prior to participating and will be reminded that they may withdraw at any time.

- (1) They may feel anxious, ashamed, depressed or guilty as a result of participating in this evaluation. Because these things may happen, they are made aware that they may, at any time, seek help from the professional staff for any discomfort that they may be having as a result of the procedures. If they become upset during the procedure, they may also ask that they discontinue.
- (2) No matter what their responses may be, it will be stressed that this is just a research project and the data does not present psychological or legal value.
- (3) The investigator will caution participants, that if they discuss any past criminal behaviour, that they should limit it to crimes for which they have been arrested, charged, prosecuted, or convicted only. Participants will be fully cautioned that if they describe crimes which nobody knows about, investigators must report them to the authorities.
- (4) Participants will also be cautioned that, if they have a crime that is still before the court, they may wish to seriously consider whether they should participate in this research. It will be recommended that they consult their lawyer regarding this situation.
- (5) There is a social risk that other clients, clinic staff, friends, or members of my family might discover that they participated in sex research (e.g., seen going into the AFPCS clinic). Because of the nature of the research, this might prove embarrassing to them.
- (6) There is a legal risk that the research results might be requested by a court. This is unlikely because the results will not be part of the participant's clinical record. However, they might be subpoenaed from the researchers who could be required to testify in court about their probable meaning.

BENEFITS

There will be no direct benefits to participants as a result of participating in the research. However, this investigation is intended to help the researchers better understand how to address the needs of sex offenders referred to the community outpatient clinics. Hence, the contribution of participants to the research might be useful to other persons like themselves in the future.

- (e) What discomfort or incapacity are the subjects likely to experience as a result of the procedures?**

Please see response to questions 4 (d) above.

- (f) How much time will be required of a subject?**

It is expected that participants will dedicate 3 to 4 hours to the project.

- (g) How much time will be required of the control group (if any)?**

N/A

5) A copy of the ethics approval (external applicants only).

A copy of the Human Research Ethics Committee (HREC) approval will be forwarded upon receipt from the University of Victoria. The application to HREC has been submitted; we are currently awaiting results.

6) An explanation of why the research project cannot be reasonably be accomplished without access to personal information in individually identifiable form (i.e., personal information about named or identifiable individuals).

In order to assess a participant's level of denial (e.g., ranging from full denier to full admitter), it is necessary to obtain information from their records to get the full picture of the 18 components of the Comprehensive Inventory for Sex Offenders in Denial (CISOD; see Appendix C). Note that there will be no copied documents nor handwritten reproductions of any information obtained from the files. This is unnecessary as a simple review of the file records will be adequate to get a complete picture of the participant's sexual offenses.

7) An explanation of how the personal information will be used, including a description of any proposed linkages to be made between personal information in the records requested and any other personal information.

The primary investigator will be conducting interviews with the participants and reviewing their records in order to have enough knowledge to adequately complete the Comprehensive Inventory of Sex Offenders in Denial (CISOD). This is the only proposed linkage to be made between personal information from their records and the personal information obtained during the interview.

8) The time frame of the study (expected start and completion date and period of time during which access to records may be required).

Proposed Start Date: January 2000

Proposed End Date: January 2001

9) The resource implications to Forensic Psychiatric Services Commission.

There will be no resource implications to Forensic Psychiatric Services Commission. The primary investigator is a contracted employee at the Victoria FPS clinic and will already have access to files and has full knowledge about the organization of the files and the availability of rooms. Therefore, it is her responsibility to obtain, review, and return files promptly to not disrupt the work of the clinic staff. Furthermore, it is her responsibility to schedule appointments during times when the clinic is less active and when there is available rooms to conduct the research sessions.


10) The anticipated benefits to be derived from the research project.

Please see response to questions 4 (d) above.

CURRICULUM VITAE

Please see Appendix K for the primary investigator's curriculum vitae.

Appendix L:
Ethical Approval: Correctional Service Canada, Pacific Region

 Correctional Service Canada / Service correctionnel Canada
Pacific Region / Région du Pacifique

Your file / Votre référence

Our file / Notre référence

2000-07-11

Ms. Sandy Jung
Forensic Psychiatric Services Commission
2840 Nanaimo Street
Victoria, BC
V8T 4W9

Dear Ms. Jung:

RE: Assessing Clients Charged for Sexual Offenses

This is to advise that your research proposal has been approved by our Regional Research Committee members.

Thank you.

Yours truly,



for Dr. Doug Boer
Research Coordinator
Mountain Institution
P.O. Box 1600
Agassiz, BC
V0M 1A0
(604) 796-2231

/rn

Canada

THE CORRECTIONAL SERVICE OF CANADA (PACIFIC REGION) RESEARCH APPLICATION GUIDELINES

**TO: Dr Michelle McBride / Dr. Carson Smiley
Regional Research Committee
Regional Reception and Assessment Centre
P.O. Box 2500
Abbotsford, BC, V2S 4P3**

**Tel: (604) 859-4841
Fax: (604) 850-8288**

Date: April 26, 2000

- 1. Reporting Institution, District Office (or Headquarters):
(This applies only to Correctional Service of Canada [CSC] applicants)**

Not applicable.

- 2. Respondent (Senior Investigator)**

Name:	Sandy Jung	
Employer/Educational Institution:	University of Victoria	Forensic Psychiatric Services Commission
Position:	Ph.D. Candidate	Psychological Assistant
Business Address:	Department of Psychology P.O. Box 3050 Victoria, BC V8W 3P5	2840 Nanaimo Street Victoria, BC V8T 4W9
Business Phone:	(250) 744-4600	(250) 387-1465
Residence Address:	1433 Courtland Avenue Victoria, BC V8X 3X1	
Residence Phone:	(250) 727-0015	

- 3. Title of Project.**

Assessing Clients Charged for Sexual Offenses

4. What is the applied potential of this research?

Many sex offenders go untreated because they are deemed unamenable to treatment due to poor motivation (Garland & Dougher, 1987; Marshall, 1994). This lack of motivation is usually due to denial and minimization of their offending. Generally, treatment programs require an admission of sexual offending by the offender. This is primarily due to the importance of allowing information to emerge which is essential for successful therapy with sex offenders (Nelson & Jackson, 1989). For example, an individual denying any offense would not willingly discuss past offenses and sexually deviant interests (e.g., pedophilia) which may lead to future re-offending. As a result, sex offenders who deny or minimize their offending can inhibit any progress in therapy and are often not admitted into any sex offender treatment groups. The availability of a tool to *assist* in monitoring the behaviour and treatment compliance of these clients is urgently needed. To date, there have been no empirical studies that have examined the social and cognitive factors related to denial and minimization among sexual offenders.

By targetting the social and cognitive factors that contribute to a sex offender's denial, a treatment provider is able to concentrate on individual aspects of that offender in one-to-one therapy *prior to admitting him into a sex offender treatment program*. For example, if social reasons have been identified as why a sex offender continues to deny his offending, cognitive restructuring (e.g., by challenging his thinking errors) may likely be ineffective. Incorporating a family systems approach may have better results in reducing his level of denial and make him more accountable for his behaviour and deviant sexual interests with the support of his family and friends. Thus, a particular level of denial can have different implications for treatment for one offender compared to another because of different motivational and cognitive reasons.

The instrument specifically designed for this study to address the various patterns of denial has important implications for the assessment and treatment of sex offenders. In my experience, I have observed that people tend to see value in their treatment (e.g., relapse prevention) far too late in the program. Hence, it is critical to identify at what level of denial they may present. A quantitative criterion for the inclusion and exclusion of sex offenders in treatment is greatly needed. It would make sense to include sex offenders who have a low or moderate level of denial in any of the four patterns clustered on the CISOD. However, those who are at a moderate level of denial in any of the patterns identified on the CISOD may be included only on a conditional basis such that they attend and complete the program satisfactorily. However, sex offenders who are deeply entrenched in their denial or are at a high level of denial may not benefit from sex offender treatment and it is suggested that they enter a pre-group treatment program for an unspecified time whereby they would address the acceptance of responsibility for their offending. Therefore, a comprehensive inventory of denial has been developed specifically for these reasons and will be examined in this research.

5. Agency other than CSC (if any) with which this project is identified. If a university-supported project, the names and telephone numbers of the respective faculty members are required.University of Victoria

Dr. Jan B. Bavelas, (Co-Supervisor) Professor (250) 721-7550

Dr. D. Richard Laws, (Co-Supervisor) Adjunct Professor (250) 387-1465

Dr. Bruce Monkhouse, Adjunct Professor (250) 480-6123

Dr. Heather Scott, Adjunct Professor (250) 387-1465

6. What financial contribution, if any, would be required from CSC? (Indicate amount, purpose, time period)

None.

7. What space, assistance, or other indirect costs would be required from CSC? (Describe fully, including locations, positions, amounts, time periods, etc.)

There will be minimal personnel resource implications to the Correctional Service of Canada. The senior investigator has the responsibility to obtain, review, and return files promptly to not disrupt the work of the CSC staff.

William Head Institution
Regional Reception and Assessment Centre (RRAC)
Regional Health Centre
Community Corrections: Victoria Parole Office
 Vancouver Parole Office

Interview room to conduct 1 hour interview and to have participants complete a series of questionnaire (approx 2 hours).

Total Time required per participant: 4 hours maximum.

8. Describe the participating personnel (indicate types, numbers, functions, agency affiliation, time period, etc., as well as names, if known). Please note that all individuals who wish to enter CSC institutions and have access to offender information will be required to have a security clearance completed.

Sandy Jung, M.A. (Senior Investigator)
Heather Scott, Ph.D. (R.Psych.)

The above forementioned will require access to file records and to participants to conduct interviews and testing.

9. When are the following operations expected to commence and be completed?

<u>Operation</u>	<u>Commencement</u>	<u>Completion</u>
Preliminary Fieldwork	n/a	n/a
Data Collection	May 15, 2000	November 30, 2000
Data Analysis	November 30, 2000	January 31, 2000
Final Report		February 28, 2000

10. Describe the type and amount of participation required by offenders, or staff of the Solicitor General's department (indicate type, how, where, when and numbers).

Fifty (50) adult males who have been charged and sentenced for a sexual offense will be recruited. The sole criteria for eligibility is that they are currently not engaging in a sex offender treatment program.

Each participant will be asked to partake in a 4 hour maximum session at the inmate's home institution which involves the following:

- Engage in an interview with the senior investigator discussing the details and events surrounding their sexual offenses and deviant sexual behaviour.
(Estimated time: 1 hour)
- Complete a series of questionnaires, including a timed test of cognitive ability.
(Estimated time: 2.5 hours)
- Attend to the senior investigator's debriefing which will fully inform them of the intentions

of the study and be given an opportunity to ask any questions that they may have.
(Estimated time: .5 hour)

11. To what extent, and for what purpose, would use of offenders records be required?

Offenders' records will be required in this research project. The senior investigator will be conducting interviews with the participants and reviewing their records in order to have enough knowledge to assess a participant's level of denial. It is necessary to obtain information from their records to get the full picture of the 18 components of the Comprehensive Inventory for Sex Offenders in Denial (CISOD). Note that there will be no copied documents nor handwritten reproductions of any information obtained from the files. This is unnecessary as a simple review of the file records will be adequate to get a complete picture of the participant's sexual offenses.

12. If any penitentiary or parole documents would be required, indicate what sort and for what purpose.

Case Management files, Psychology files for review purposes only.

13. What reports or publications are anticipated as a result of this research project?

The proposed research is my Ph.D. dissertation research. Hence, I will be producing a dissertation which will comprehensively describe, analyze and discuss the research methodology and results of this project.

I plan to disseminate the results of this project within the academic community by presenting papers at national and international meetings (e.g., Association of the Treatment of Sexual Abusers, American Psychology-Law Society), by publishing empirical articles in peer-reviewed journals such as *Criminal Justice and Behavior*, *Sexual Abuse: A Journal of Research and Treatment*, *Annals of Sex Research*, and *Behavioral Science and the Law*, and by publishing empirical articles in non-peer reviewed journals such as *Forum on Corrections Research*. Because the proposed study is on a topic of interest to various correctional and forensic professionals, I would like to also reach an audience outside of the academic community. Therefore, I will volunteer to share my results to professionals who work with sex offenders and other types of inmates at both the provincial and federal level.

14. Please give three (3) personal references and phone numbers who are familiar with your research capabilities and research work.

Dr. Janet Beavin Bavelas, Professor
Department of Psychology, University of Victoria
P.O. Box 3050, Victoria, B.C. V8W 3P5
(250) 721-7550 Office
(250) 721-8929 Facsimile
jbb@uvic.ca

Dr. D. Richard Laws, Registered Psychologist and Adjunct Professor (U. of Victoria)
Forensic Psychiatric Services Commission
2840 Nanaimo Street, Victoria, B.C. V8T 4W9
(250) 387-1465 Office
(250) 356-2145 Facsimile
drlaws@islandnet.com

Dr. Heather Scott, Registered Psychologist and Adjunct Professor (U. of Victoria)
Forensic Psychiatric Services Commission
2840 Nanaimo Street, Victoria, B.C. V8T 4W9
(250) 387-1465 Office
(250) 356-2145 Facsimile
heather.scott@moh.hnet.bc.ca

Dr. Bruce Monkhouse, Registered Psychologist and Adjunct Professor (U. of Victoria)
Victoria Parole Office and William Head Institution
816 Government Street, Victoria, B.C.
(250) 363-3267 Office
bmonk@ampsc.com

15. Attach a detailed research proposal indicating:

- a) A brief description of project**
- b) A brief description of the experimental design**
- c) Suspected findings/hypothesis**
- d) How the data is going to be analyzed and interpreted**

Please see "Research Proposal"

Research Proposal: Assessing Clients Charged for Sexual Offenses

Many sex offenders go untreated because they are deemed unamenable to treatment due to poor motivation (Garland & Dougher, 1987; Marshall, 1994). This lack of motivation is usually due to denial and minimization of their offending. Generally, treatment programs require an admission of sexual offending by the offender. This is primarily due to the importance of allowing information to emerge which is essential for successful therapy with sex offenders (Nelson & Jackson, 1989). For example, an individual denying any offense would not willingly discuss past offenses and sexually deviant interests (e.g., pedophilia) which may lead to future re-offending. As a result, sex offenders who deny or minimize their offending can inhibit any progress in therapy and are often not admitted into any sex offender treatment groups.

The purpose of the proposed research is to determine to what extent a sex offender may be in denial or may minimize the seriousness of his offense. Considering the importance of assessing denial and minimization, especially before entering community-based programming, understanding the processes that underlie the sex offender's level of denial is vital to reducing his risk of committing another sex offense. Furthermore, community safety is the first consideration in any sex offender treatment and therefore, the availability of a tool to assist in monitoring the behaviour and treatment compliance of these clients is urgently needed. In my experience, I have observed that offenders tend to see value in their treatment far too late in the program. By targetting the social and cognitive factors which contribute to a particular sex offender's denial, a treatment provider is able to concentrate on that individual in one-to-one therapy prior to admitting him into treatment. To date, there have been no empirical studies which have examined the social and cognitive factors related to denial among sexual offenders, and there are no clinical instruments available to aid treatment providers for such a purpose. The goal of this research is to examine the utility of an instrument which I specifically designed to identify these social and cognitive components of denial. Hence, such an instrument can help practitioners target areas that should be addressed in therapy.

METHODS

Ethical approval has been obtained from the Human Research Ethics Committee (HREC) at the University of Victoria and from the Forensic Psychiatric Services Commission.

The criteria for eligibility is that they are not currently participating in a sex offender treatment or management program.

After an appointment has been arranged with the correctional facility and the participating inmate, the senior investigator will inform the participant about the nature of the study and what is involved in participation. After ensuring participants both understand the consent form and give consent to participate, participants will be assessed and interviewed by the senior investigator. The interview will be semi-structured, including a series of standard questions which tap into whether he has minimized any part of his offending or his deviant sexual arousal. This interview will NOT be recorded by audio- or videotape. However, the investigator will be taking hand-written notes throughout the interview. Based on the interview and collateral information (e.g., clinic file review), the investigator will assess and evaluate the sex offender on the Comprehensive Inventory of Sex Offenders in Denial (CISOD).

1. The CISOD is a checklist with 18 components in which the investigator completes. It is intended to tap into different elements of denial and minimization among sexual offenders. The 18 items are clustered into four conceptual forms of denial: (1) denying sexually deviant behaviours and arousal, (2) denying need for treatment/management of sexual offending, (3) denying responsibility, and (4) minimizing harm. The instrument was specifically developed for this study as there are no such measures available for such clinical use.

The participant will then be asked to complete a brief measure of intelligence and a battery of questionnaires tapping into social characteristics, cognitive attitudes, and probability of socially desirable responding.

Brief Intelligence Measure

1. The Shipley Institute of Living Scale (SILS; Zachary, 1991) is designed to assess general intellectual functioning in adults and adolescents and consists of two subtests: (1) a 40-item vocabulary test and (2) a 20-item test of abstract thinking.

Offense Description

1. Participant's will be asked to give a written account of their sexual offense. The questionnaire asks what he was charged for, what actually happened and what the victim(s) say happened. This will provide a verbatim statement from the participant.

Social

1. Self-Monitoring Scale (SMS; Snyder, 1974) measures one's tendency to manage one's impression to fit the situation.
2. Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965) measures general feelings of self-worth and addresses a person's overall evaluation of himself and his attitudes across times and situations.

Cognitive

1. The RAPE Scale (Bumby, 1996) measures a respondent's endorsement of rape myths commonly reported by sexual offenders.
2. The MOLEST Scale (Bumby, 1996) measures a person's endorsement of cognitive distortions many sex offenders hold regarding the sexual molestation of children.
3. The Revised Cognition Scale (RCS; Marshall, 1989) taps into problematic attitudes which support adult/child sexual relations.
4. The scale, Appropriate Sexual Fantasies Scale (ASFS) was adapted, for the purpose of this study, from other sexual fantasy scales (O'Donohue, Letourneau & Dowling, 1997; Salter, 1988). It is used to examine a respondent's opinion of the appropriateness of a series of sexual fantasies.
5. Three of the five Burt Attitudes Scales will also be given to address more general sex roles and attitudinal beliefs (Burt, 1980). The first scale, Sex Role Stereotyping, asks questions regarding sex roles in familial, work or social settings. The second scale, Adversarial Sexual Beliefs, examines to what extent a person believes sexual relationships are fundamentally exploitative. The third scale, Sexual Conservatism, examines a person's view on the appropriateness of sexual partners, sexual acts, conditions or circumstances under which sex should occur.

Probability of Socially Desirable Responding

1. Balanced Inventory of Desirable Responding Version 6 (BIDR-6) assesses to what extent does an individual respond to self-reports in a socially desirable manner.
2. Burke Awareness of Deviant Fantasy Scales (BADFS) has 18 different paraphilia scales and two lie scales (one is a social desirability scale and the other focuses on whether or not they are admitting to the crime or crimes they have been adjudicated of). The fantasy scales are designed to indicate if the participant is aware of his deviant fantasy processes.

DATA ANALYSIS AND RESEARCH HYPOTHESES

Psychometric Properties of the CISOD and its Clusters. It is critical to establish whether the CISOD is psychometrically sound. Item-to-total analyses, such as coefficient alpha values, will be calculated for the whole instrument and for each cluster to determine the internal consistency of the CISOD. To examine whether the clusters are related to one another, intercorrelations will be calculated among the four clusters and the total CISOD rating.

It is hypothesized that the CISOD will be psychometrically sound with good internal consistency and that the clusters will be correlated with one another.

Interrater Reliability of the CISOD. Interrater reliability will be obtained by comparing ratings made by both interviewers with each interviewer blind to the ratings of the other. Overall weighted Kappa and Intraclass correlation coefficients will be calculated to establish reliability. It is hypothesized that the raters will not differ significantly from each other in their CISOD ratings.

Correlation Among the CISOD, IQ, and Educational Level. Correlations will be calculated among the CISOD rating, IQ, and educational level. It is hypothesized that a greater degree of overall denial, as measured by the CISOD, will be associated with a lower level of education and intellectual functioning. It is, furthermore, hypothesized that there would be a correlation between each pattern of denial and IQ and educational levels. More specifically, it is predicted that education and IQ will be negatively associated with denying the need for treatment/management of sexual offending, denying responsibility, and minimizing harm.

Correlation Among Scales. Each cluster of the CISOD will be correlated with each questionnaire, with the following predictions:

- a) It is predicted that all four clusters will significantly correlate with the scores on the social variables and the probability of desirable responding (SMS, RSES, BIDR-6, and BADFS).
- b) It is predicted that the two CISOD clusters, denying the need for treatment (#2) and minimizing harm (#4), will be significantly correlated with greater endorsements of impersonal and exploratory fantasies (factors measured by the ASFS).
- c) For child molesters, denying the need for treatment (#2) and minimizing harm (#4) will be significantly correlated with greater endorsements of child molestation myths (measured on the MOLEST Scale), and problematic attitudes which support adult/child sexual relations (measured on the RCS). For rapists, these same clusters will be correlated with greater endorsements of rape myths (measured on the RAPE Scale), greater endorsements of sado-masochistic fantasies (factor on the ASFS), and greater scores on the SRS, ASB, and SC Scales.

Language of Denial. Discourse analysis will be used to analyze the offender's written description of his offense. This approach allows an inductive way of examining the written account of each sex offender's offense description.

16. **Support from ethics and supervisory committee is required prior to data collection. In this regard, copies of letters from both committees are required to be on file prior to data collection. Please note that all projects are subject to ongoing review and may be cancelled if serious concerns are brought to the attention of the research committee.**

Documentation will be forwarded (hard copies) by postal mail verifying approval from the Human Research Ethics Committee of the University of Victoria and the senior investigator's supervisory committee.

17. **Biannual progress reports on the research study are required by the end of September and February of each year that the study is in process.**
18. **Acknowledgment that a copy of the data and final written product will be given to CSC. A footnote that states "The support of the Correctional Service of Canada is gratefully acknowledged, however, the reported findings and their interpretation do not necessarily reflect the original policy of the Correctional Service of Canada".**
19. **Please sign and date your research proposal.**

Sandy Jung, M.A.
Senior Investigator and Graduate Student

**Appendix M:
Statement of Informed Consent (Provincial and Federal)**

FOR PROVINCIAL (FORENSIC) PARTICIPANTS:

**STATEMENT OF INFORMED CONSENT FOR PARTICIPATION IN THE STUDY
ENTITLED:
"Assessing Clients Charged for Sexual Offenses"**

Sandy Jung, M.A. (Graduate Student) (250) 387-1465
Janet B. Bavelas, Ph.D. (Supervisor) (250) 721-7525
Department of Psychology, University of Victoria

D. Richard Laws, Ph.D. (Supervisor) (250) 387-1465
Adult Forensic Psychiatric Community Services

What is the Purpose of the Study?

Many sex offenders are referred to the Adult Forensic Psychiatric Community Services as part of their probation or conditional sentence order. Because of this, it is very important to identify what the client's needs may be. We need this information to decide what services to give each individual.

The purpose of this research is to learn what a particular client's needs are. If we can do this, then the services can be most helpful to our clients.

What Will I Do In This Study?

You have been referred to the principal investigator, Sandy Jung, to participate in this research.

The study will be asking for your perception about the offense you have been charged with and convicted for.

We will be interviewing you and asking you to complete some questionnaires. The interview will not be tape-recorded. We will be asking some personal questions about your sex offending and how you feel about sex offending. Because of this, you can stop at any time if it is upsetting.

How Much Time is Required To Participate?

You can expect participation to last for approximately 3 to 4 hours including breaks. The interview will be no longer than 1 hour. Completing the questionnaires will take about 2 to 3 hours. It is up to you if you want to complete this in 2 sessions instead of 1.

May I Withdraw From This Study At My Discretion?

Your participation is purely voluntary. You may refuse to participate at any time without penalty or loss of benefits to which you are otherwise entitled. If you choose to withdraw, your data will be disregarded and destroyed.

How Confidential Are My Responses?

All of your responses are confidential, but there are limits to this confidentiality. If the courts subpoena your responses in this research, we cannot guarantee confidentiality. However, we would point out that this is for group research only and not for individual clinical assessment.

All of your responses will be coded with a 3-digit number rather than your name. The list matching your name to the number will be kept in a locked cabinet. The data from this research will NOT be included in the clinic's files.

Five years after the project has ended, all of your responses to the questionnaires and the interview will be destroyed.

What Are the Risks and Benefits of My Participation?

Benefits. There will be no direct benefits to you for participating in this research. However, the research is to help us meet the needs of sex offenders. Your contribution may be helpful to individuals like yourself in the future.

Risks. There may be risks and discomforts to you if you participate in this research.

- (1) You may feel anxious, ashamed, depressed or guilty as a result of participating in this research. Because these things can happen, you can seek help from the clinic staff. If you feel upset at any point, you can ask to stop participating.
- (2) We want to caution you that if you discuss any past crimes with us, you should limit answers to crimes you have been convicted. If you discuss other crimes which nobody knows about, we must notify the authorities.
- (3) If your crime is still before the courts, you should consider not participating. We suggest that you consult your lawyer before participating.
- (4) There is a social risk that other client, clinic staff, friends, or members of your family might discover that you participated in research about sex offenders. Because of the nature of the research, this might prove embarrassing to you.
- (5) As mentioned above, there is a legal risk that your research data could be subpoenaed by the courts. We would make it known that the data is intended for researching group responses only and that the data is not for individual clinical assessment. Keep in mind that the possibility of being subpoenaed is unlikely because the results will not be part of your clinical record.

I believe that I have been fully informed about this research in language that is understandable to me. I have asked any questions that I may have about the research and the investigator has answered these questions to my satisfaction.

My signature below indicates my consent to participate in this research.

PARTICIPANT:

Name (please print): _____

Signature: _____

Date: _____

WITNESS:

Name (please print): _____

Signature: _____

Date: _____

FOR FEDERAL PARTICIPANTS:
("Statement of Informed Consent" and "Consent for Release of Information")

**STATEMENT OF INFORMED CONSENT FOR PARTICIPATION IN THE STUDY
ENTITLED:
"Assessing Clients Charged for Sexual Offenses"**

Sandy Jung, M.A. (Graduate Student)
Department of Psychology, University of Victoria

Janet B. Bavelas, Ph.D. (Supervisor)
Department of Psychology, University of Victoria

D. Richard Laws, Ph.D. (Supervisor)
Forensic Psychiatric Services

What is the Purpose of the Study?

Many sex offenders are referred for sex offender programs as part of their custodial sentence or probation/parole order. Because of this, it is very important to identify what the client's needs may be. We need this information to decide what services to give each individual.

The purpose of this research is to learn what a particular client's needs are. If we can do this, then the services can be most helpful to our clients.

What Will I Do In This Study?

You have been referred to the principal investigator, Sandy Jung, to participate in this research.

The study will be asking for your perception about the sexual offense(s) you have been charged with and convicted for. We will be interviewing you and asking you to complete some questionnaires. The interview will not be tape-recorded. We will be asking some personal questions about your sex offending and how you feel about sex offending. Because of this, you can stop at any time if it is upsetting. We will also review pertinent files containing personal information relevant to this research (e.g., includes psychological files, case management, health care, IPSO files).

How Much Time is Required To Participate?

You can expect participation to last for approximately 3 to 4 hours including breaks. The interview will be no longer than 1 hour. Completing the questionnaires will take about 2 to 3 hours. It is up to you if you want to complete this in 2 sessions instead of 1.

May I Withdraw From This Study At My Discretion?

Your participation is purely voluntary. You may refuse to participate at any time without penalty or loss of benefits to which you are otherwise entitled. If you choose to withdraw, your data will be disregarded and destroyed.

How Confidential Are My Responses?

All of your responses are confidential, but there are limits to this confidentiality. If the courts subpoena your responses in this research, we cannot guarantee confidentiality. However, we would point out that this is for group research only and not for individual clinical assessment.

All of your responses will be coded with a 3-digit number rather than your name. The list matching your name to the number will be kept in a locked cabinet. The data from this research will NOT be included in the institution's files.

Five years after the project has ended, all of your responses to the questionnaires and the interview will be destroyed.

What Are the Risks and Benefits of My Participation?

Benefits. There will be no direct benefits to you for participating in this research. However, the research is to help us meet the needs of sex offenders. Your contribution may be helpful to individuals like yourself in the future.

Risks. There may be risks and discomforts to you if you participate in this research.

- (1) You may feel anxious, ashamed, depressed or guilty as a result of participating in this research. Because these things can happen, you can seek help from the psychological staff. If you feel upset at any point, you can ask to stop participating.
- (2) We want to caution you that if you discuss any past crimes with us, you should limit answers to crimes you have been convicted. If you discuss other crimes which nobody knows about, we must notify the authorities.
- (3) If you have crimes which are still before the courts, you should consider not participating. We suggest that you consult your lawyer before participating.
- (4) There is a social risk that other clients or institutional staff might discover that you participated in research about sex offenders. Because of the nature of the research, this might prove embarrassing to you.
- (5) As mentioned above, there is a legal risk that your research data could be subpoenaed by the courts. We would make it known that the data is intended for researching group responses only and that the data is not for individual clinical assessment. Keep in mind that the possibility of being subpoenaed is unlikely because the results will not be part of your records.

I believe that I have been fully informed about this research in language that is understandable to me. I have asked any questions that I may have about the research and the investigator has answered these questions to my satisfaction.

My signature below indicates my consent to participate in this research.

Sandy Jung

Name of Participant (please print)

Name of Witness

Signature of Participant

Signature of Witness

Date

Date

Correctional Service Canada / Service correctionnel du Canada

PROTECTED / PROTÉGÉE A [X] B [] C [] L []

FORM COMPLETED / UNE FOIS REMPLIE

CONSENT FOR DISCLOSURE OF PERSONAL INFORMATION - (INMATE)

CONSETEMENT POUR DIVULGATION DE RENSEIGNEMENTS PERSONNELS - (DÉTENU)

NOTE: Reference documents = The Privacy Act and the Treasury Board Guide.

NOTE: Documents de références = Loi sur la vie privée et le Guide du Conseil du Trésor.

Completing Operational Unit - Unité opérationnelle ayant rédigé le rapport

Current Institution or Address - Adresse ou établissement actuel

PERSONAL INFORMATION BANK - FICHIERS DE RENSEIGNEMENTS PERSONNELS

PUT AWAY ON FILE / CLASSER AU DOSSIER

FPS Number / Numéro SED

Family name / Nom de famille

Given name(s) / Prénom(s)

Date of birth / Date de naissance

I hereby consent to the disclosure by the Correctional Service of Canada of the personal information pertaining to myself which may be described as:

Je consens à la communication par le Service correctionnel du Canada de renseignements personnels me concernant lesquels peuvent être décrits comme étant:

Pertinent files containing personal information relevant to this research (e.g., includes psychology files, case management, health care, IPSO files).

(Description des renseignements)

to the following individual(s) or organization(s)

à/aux personne(s) ou organisme(s) suivant(s):

Sandy Jung for the purpose of

Nom de la (des) personne(s) ou organisme(s)

Conducting research

(Description de l'usage)

I understand that the refusal to consent to such disclosure will not prejudice me in any way or result in any adverse consequence in connection with the particular primary administrative purpose(s) being served by collection.

Il est entendu que le refus de consentement à la communication n'entraînera aucune décision préjudiciable quant aux fins particulières visées par la collecte de renseignements.

This consent shall be and remain in full force and in effect until

Le présent consentement demeure en vigueur jusqu'au

Jan 31 19 2001 unless due notice in writing of its revocation shall have been given

19 à moins qu'un avis écrit de révocation ne soit donné.

It shall be noted that this form will be part of my file(s) which I have a right to examine and request correction as followed by Section 12 of the Privacy Act.

Je sais que cette formule fera partie de mon(mes) dossier(s) lequel(lesquels) j'ai le droit de consulter et demander des corrections en vertu de l'article 12 de la Loi sur la Protection des renseignements Personnels.

IN WITNESS WHEREOF I have hereunto set my signature and

EN FOI DE QUOI j'ai apposé ma signature et mon sceau

seal this day of 19, SIGNED.

ce jour de 19 fait et signé

SEALED AND DELIVERED BY (Name of individual)

par (Nom de la personne) en présence de

Signature of individual - Signature de la personne

AFFIDAVIT OF WITNESS

AFFIDAVIT DU TÉMOIN

I Sandy Jung of the Victoria

Je de (Nom du témoin) de (Ville)

in the province of B.C.

dans la province de

make oath and say: 1. That I was personally present and did see the annexed instrument duly signed sealed and executed by

déclare sous serment: 1. Que j'étais personnellement présent et que j'ai vu

(Name of individual) the party thereto;

(Nom de la personne) apposé sa signature sur le

2. That the said instrument was executed by the said at

document ci-annexé en qualité de partie; 2. Que ledit document a été signé par ledit à dans

in the province of British Columbia and that I am the subscribing witness to the said instrument;

la province de et que je suis témoin audit document;

3. That I know the said (Name of individual) and he/she is in my belief of legal age.

3. Que je connais ledit (ladite) (Nom de la personne) et je crois qu'il(elle) est majeur(e).

Signature of witness - Signature du témoin

CSC/SCC 487 (R-95-01) 7530-21-895-1071

DISTRIBUTION Original = Originator (file) Original = Auteur (dossier)

Copy = Individual/Organization requesting information Copie = Individuel/Organisation faisant la demande pour l'information

Copy = Inmate Copie = Détenu

Appendix N:
Procedural Guidelines

**RESEARCH PROJECT:
Assessing Clients Charged for Sexual Offenses**

Procedural Guidelines

REVIEW PARTICIPANT'S CLINIC FILE

Document (1) Gender, (2) Birthdate (hence, age), (3) Education, (4) Usual occupation

INTRODUCTIONS

I'm a Ph.D. student at UVic supervised by Drs. Bavelas and Laws (give card to him).

STUDY INFORMATION

"I'm trying to identify what a client's needs may be and use this information to decide what services to give each individual.

The information that you share in this project will not be shared with your probation officer or with the clinic. This will, in total, take 3 hours.

There will be an interview which will last, at the most, 1 hour.

The questionnaires, a few before the interview and a booklet after the interview, will take, at the most, 2 hours."

If applicable, introduce the second interviewer.

"If it is alright with you I would like to have (second interviewer's name) attend our session. This is solely for two purposes: first, to make sure that while I am asking questions that I'm not missing anything important; second, to ensure that what I record is the same as what someone else is recording and therefore, prevent myself from being biased.

STATEMENT OF INFORMED CONSENT

Discuss the Statement of Informed Consent

Ensure participants understand it and have them sign it

DEMOGRAPHIC INFORMATION

Have participant complete the Offense Description.

INTERVIEW PROTOCOL (open-ended interview)

If not already documented: (1) Gender, (2) Birthdate (hence, age), (3) Education, (4) Usual Occupation

1. CHARGES

Descriptions of sexual offense charges

- What were you charged for?

What was heard about the victim's perspective

- What did the victim say happened?

- Who was the victim? Describe

- How did it happen? (was it planned?)

2. OFFENDER'S PERSPECTIVE ON THE OFFENSE

In their own words, describe what happened?

- What actually happened?

- How was the offense(s) discovered?

3. COURT PROCESS

Process of being charged

- What happened after the incident - how did you come about getting charged?

Process of trial

- What happened in the trial?

Process of sentencing

- What did you get?

- How did you serve it?

- If applicable - What was your experience like in jail?

- How did you plea?

- How do you feel about the police and the criminal system?

- What do you think about your sentence?

- Do you have a condition to complete treatment? How do you feel about that?

4. HISTORICAL OFFENSES

When more than one offense has occurred, treat each as a separate incident and give an accurate account of each.

- Ever done anything like this on other occasions / in the past?

Sexual Charges

- Are you heterosexual/homosexual? Attracted to children and adults?

Non-sexual charges

- Were you involved with other criminal acts not resulting in charges?

5. CURRENT STATUS

Victim current status (What is the victim's present status? How has this affected her/him/them?)

- Attitude

- Mental Status

- How do you think this has affected her?

Family, Probation, Victim(s) and victim's family, Social Support

(What was it like after you were sentenced / served your time in jail?)

6. OTHER REASONS

Why do you think you did this? (Looking for external, internal attributions)

- Alcohol

- Marital difficulties

- Past abuse

How do you feel about what's happened?

- What you did?

- Did you feel cheated or manipulated?

What is the likelihood of this ever happening again?

- And why?

QUESTIONNAIRES

1. Shipley Institute of Living Scale (timed administration)
2. Self-Monitoring Scale
3. Rosenberg Self-Esteem Scale
4. Balanced Inventory of Desirable Responding Version 6
5. RAPE Scale
6. MOLEST Scale
7. Revised Cognition Scale
8. Appropriate Sexual Fantasies Scale
9. Sex Role Stereotyping, Adversarial Sexual Beliefs, Sexual Conservatism scales

BEHAVIOURAL OBSERVATIONS

(Document while participants are completing questionnaires)

*How did the offender behave?
Did he show any physical signs of anxiety? What were they?
Did he take on a victim's stance?
Was he defensive?
Were his responses relevant?
How focused was he?*

SCORING THE CID-SO

After the session (interview and questionnaires) and the participant has left, score the participant based on the interview information and my behavioural observations

Appendix O:
Debriefing

At this point I would like to give you further information in addition to what I've told you at the start of the study. I would like you to keep in mind that we are not looking at individual responses, but rather average responses on each of the questionnaires that you have filled out and on the questions I have asked you during the initial interview. So, in other words, I won't be looking at your responses by itself, but as a whole with all the participants' data. Is that clear?

What we are looking at here is the extent to which you have taken responsibility for your sexual offending and how you view the sexual offenses for which you have been charged for. Many people have different views of their offending and I am not here to judge you specifically, but what we would like to do with your data is to target what needs you might have and how we can examine them at our clinic. This is based on your responses to my questions during the interview and in the questionnaires you've filled out. This type of information may be useful for our staff to use prior to anybody entering our sex offender management group that we hold in our clinic. We are hoping to find that the interview that we went through and the questionnaires you filled out will be a useful screening tool to see who may benefit from individual treatment and group treatment.

I would like to remind you at this point that your probation officer and other people at this clinic will not have access to your data. Only my supervisors, Dr. Bavelas and Dr. Laws, will have access to this information and this will not have any affect on your status at this clinic. However, you have been already told that this information can be subpoenaed by the courts, so it is not completely confidential.

Do you have any questions about your participation or about the study at this point?

If you are interested in the results of the overall study, please feel free to contact me at the clinic number, 387-1465 (they will be given a card with this number). Once we have completed the research, overall results (and not individual ones) will be available for those who have participated in the research.

Thank-you for your participation in this study.