

379
N81
No. 7478

CLASSIFICATION OF DENIAL IN SEX OFFENDERS:
AN INVESTIGATION OF RESPONSE STYLES

THESIS

Presented to the Graduate Council of the
University of North Texas in Partial
Fulfillment of the Requirements

For the Degree of

MASTER OF SCIENCE

By

Keith R. Cruise, B.A., M.L.S.

Denton, Texas

May, 1998



Cruise, Keith R., Classification of denial in sex offenders: An investigation of response styles. Master of Science (Psychology), May, 1998, 122 pp., 31 tables, references, 50 titles.

Standard psychological assessment instruments have not produced consistent results by which decisions can be made regarding the appropriate placement and legal disposition of an individual who has committed a sexual offense. The purpose of the present study was to systematically investigate deception and dissimulation as measured by three assessment instruments commonly utilized with sex offenders. A denial classification system was utilized in order to classify offenders into categories based on their level of admission to the legal system. The four group classification system did not produce significant differences on all measures of deception and dissimulation. Contrary to previous research, admitters were found to respond more defensively than deniers on one of the assessment instruments. In addition, partial deniers were identified as responding significantly differently from both admitters and deniers on a separate instrument. The differences found suggest that sex offenders' level of deception is multifaceted. Difficulties in identifying classificatory strategies and implications for theoretical conceptions of denial within this population are discussed.

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CHAPTER I

INTRODUCTION

Sexual offending behavior continues to be a pervasive social problem that presents unique challenges to persons responsible for assessment, intervention, and legal disposition of sex offenders. Mental health professionals are often called upon to answer questions about the psychological characteristics (or profile) of a sexual offender and to evaluate an offender's likelihood of committing the same or similar offending behaviors in the future. The lack of a reliable method for making such predictions has led professionals to support the use of restrictive legal sanctions (i.e., incarceration, probation, and parole) while a sexual offender participates in treatment. Compounding the importance of this problem, evaluation error by a psychologist could ultimately lead to an offender committing further sexual offenses. This creates a special difficulty for professionals who treat sexual offenders in that psychologists must take into account two competing interests. The first is the goal of treating the offender. A second goal is the protection of society from further victimizing behavior.

Deception and dissimulation among sex offenders during psychological assessment is considered a pervasive problem that highly confounds accurate treatment and recidivism prediction (Abel, Gore, Holland, Camp, Becker, & Rathner, 1989; Happel, & Auffrey, 1995; Lanyon, 1993a; Lanyon, Dannenbaum,

& Brown, 1991; Marshall & Eccles, 1991; Miner, Marques, & Day, 1990; O'Donohue & Letourneau, 1993). The purpose of the present study was to examine the relations between deception scales on three psychological instruments commonly used with sex offenders. The Minnesota Multiphasic Personality Inventory (MMPI) is an objective personality inventory. The test involves the individual completing 550 statements with the results intended to reflect an objective assessment of abnormal functioning. Scores are computed for 10 clinical scales. Importantly, four validity scales are derived which seek to assess the test taking attitude of the participant. Relevant test taking attitudes include efforts at impression management, namely underreporting and overreporting of psychopathology.

The Multiphasic Sex Inventory (MSI) is a self-report measure similar in format to the MMPI, but developed to assess psychosexual characteristics. The development and validation of the MSI has been an ongoing process since the first experimental version was put in use in 1984 by Nichols and Molinder. Since that time, the MSI has been updated with the MSI-II recently being published (Nichols & Molinder, 1996). The authors of the inventory state that currently 3,000 private clinicians, clinics, universities, hospitals, and institutions use the MSI (Nichols & Molinder, 1996). The MSI-II provides scale score information on sexual history, paraphilias, and the use of denial and minimization of sexually offending behavior.

The MMPI and MSI both purport to measure deception and dissimulation. Each instrument has indices of deception that may or may not be related to each other (minimization of clinical symptomatology on the MMPI, minimization of

deviant sexual thoughts and behaviors on the MSI). A related issue is the identification of patterns of deception by sex offenders on these assessment instruments. This area warrants further investigation to determine whether deception is a broad strategy that an offender will utilize regardless of the assessment task or whether the use of deception is more selective based on characteristics of the offense and specific patterns of denial.

The third assessment procedure commonly used with sex offenders is a measure of physiological sexual arousal commonly called penile plethysmography (PPG). This assessment technique involves the presentation of both audio and visual stimuli depicting various types of sexual interactions (consensual intercourse, nonconsensual intercourse, fondling, and rape). Both male and female representations are used in an effort to obtain an indication of a particular offender's sexual arousal to different gender and age groups. Hall (1996) argues that behavioral assessment is a useful method of determining environmental conditions that elicit behavior and that obtaining measures of penile response to deviant sexual stimuli is the most widely used analog of the conditions under which sexually aggressive acts occur. Numerous researchers have noted that dissimulation is possible even with phallometric assessment (Hall, 1996; Malcolm, Davidson, & Marshall, 1995; Sewell & Salekin, 1996).

The remaining parts of this document provide a review of the theoretical construct of denial and research that has utilized specific self report and physiological assessment techniques as ways of investigating denial with sex offenders. For the purpose of the present study, a number of a priori hypotheses and research questions are also outlined. The document then provides a full

description of the present study's participants, procedures and, results of all hypothesis tests and exploratory research questions, and finally, an interpretative discussion. The discussion centers around an interpretation of the specific results found in the present study and implications both for psychometric and for theoretical issues concerning the denial construct within a sex offender population. Throughout the discussion, limitations of the present methodology are addressed and suggestions for future research in this area are outlined.

Construct of Denial

An integrated component of cognitive-behavioral treatment used with sex offenders is the restructuring of cognitive distortions through confrontation and challenge (Bumby, 1996). One element of cognitive distortions is the denial that the offending behavior was committed. Rogers and Dickey (1991) compared competing models of deception in sex offenders. The authors noted conceptual parallels between defensiveness and malingering. Both malingering and defensive response styles involve "deliberate dissimulation in the service of an external goal; however, defensiveness is the polar opposite of the symptom exaggeration found in malingerers." They described minimization in sex offenders in the context of three existing models of malingering: pathogenic, criminogenic and adaptational. The pathogenic model would explain deception in sex offenders as repression and suppression of unacceptable sexual impulses. The criminogenic model seeks to explain deception by association with antisocial personality disorder. Rogers (1990) offered a concise explanation of the criminogenic model as a "bad person" (antisocial) in a "bad situation" (forensic evaluation) acting "badly" (uncooperative). In examining deception and

denial with sex offenders, Rogers and Dickey (1991) pointed out that assessment of denial in sex offenders who warrant the diagnosis of antisocial personality disorder compared to sex offenders without the diagnosis is an empirical issue that warrants further investigation. Drawing parallels with their preferred "adaptational" model of malingering, Rogers and Dickey related defensiveness in sex offenders to the three assumptions of the adaptational model: dissimulation is more likely to increase in an adversarial setting; dissimulation is chosen as the best alternative in difficult circumstances; and the greater anticipated benefit from dissimulation, the greater the likelihood of its occurrence. The use of dissimulation in a psycholegal context involves all three of these assumptions. In particular, sex offenders view the assessment of their deviant sexual behavior as adversarial in nature. Second, the nature of the situation under which they are being evaluated creates a "no-win" situation for the offender in that honest self-disclosure and defensiveness are likely to result in a negative report. Finally, the anticipated benefits from the use of deception may vary according to the type of legal intervention that is forthcoming.

Sewell and Salekin (1997) have proposed another model of dissimulation among sex offenders they labeled the socioevaluative model. These authors posit that during the process of a psycholegal assessment the sex offender seeks to constrict the evaluation process. The socioevaluative model differs from the adaptational model in that the former does not entail a cost/benefit analysis on the part of the sex offender being evaluated. Due to previous negative experiences in evaluative contexts, under the socioevaluative model, the sex offender "constricts" the evaluation process and gives no thought to the

ramifications of the outcome of the evaluation. Although Sewell and Salekin note the similarity to the adaptational model proposed by Rogers and Dickey (1991), they note two distinct differences. First, the socioevaluative model does not require an inherent adversarial setting but can occur under any evaluation situation. Second, the process of dissimulation does not include a weighing of the potential risks involved; but is an automatic process based on previous negative evaluative experiences.

Treating the construct of denial as an empirical issue has been approached on two fronts: (1) initial classification, and (2) measurement through assessment. Kennedy and Grubin (1992) focused on the former. These researchers investigated rates of admitting and non-admitting behavior in a group of 102 incarcerated sex offenders and argued that admitting or not admitting to one's sexual offending behavior is not an "either-or" phenomenon. Kennedy and Grubin (1992) outlined five degrees of admission in sexual offenders: admitting all, admitting the offense but denying anomalous sexual preferences, admitting the offense and anomalous preference but claiming special circumstances, denying the offense but admitting anomalous preferences, and denying everything. One third of their sample denied any involvement in a sexual offense. Of the offenders who admitted to their offense, about one-half were unwilling to accept full responsibility. Kennedy and Grubin labeled this group "rationalizers." This group was more likely to admit to a variant sexual preference, was least likely to blame an abnormal mental state, and was most likely to claim to have helped the victim. A group of "externalizers" was also found. This group was most likely to blame the victim or third parties, to

deny harming the victim, and to be dissatisfied with the way the legal system has dealt with their type of offense. A third group of "internalizers" was identified with this group composed of offenders who were most likely to admit fully to the offense as charged, to accept the courts' disposition, to accept that they had harmed the victim, and to be unlikely to blame the victim; however, this group was most likely to blame an abnormal mental state for the offense as well as blaming third parties.

Comparing the rationalizer with outright denier groups, the rationalizer group had a larger proportion of men who gave histories meeting the criteria for DSM-III-R paraphilias. The rationalizer group also reported higher rates of blaming toward victim and claims of an abnormal internal mental state at the time of the offense (e.g., intoxication). Kennedy and Grubin (1992) also compared the group classification according to victim characteristics and offense behavior. The absolute deniers contained the highest proportion of men who offended against adults. The rationalizers were less likely to have offended against females and most likely to have offended against someone unknown to them. The rationalizers were also more likely to have offended against males under 16 years old. The externalizers and internalizers tended to offend against females under the age of 16 and were more likely to be related to the victim in some way.

Kennedy and Grubin's denial classification scheme offers researchers a way to systematically evaluate a particular offender's use of denial. One can see connections between this scheme and Rogers and Dickey's (1991) adaptational explanation for denial in sex offenders. First, the cost benefit analysis, central to

the adaptational explanation of denial, resembles characteristics of the internalizer group. Admitting to the behavior but offering an explanation that resembles an excuse (e.g., I did it because I was severely depressed) might represent an effort to reduce the severity of upcoming legal sanctions leveled against an offender. The socioevaluative model offered by Sewell and Salekin (1997) does not appear consistent with any of the Kennedy and Grubin (1992) denial groups. According to Sewell and Salekin, offenders “constrict” against the evaluation process without the cost benefit analysis component of the adaptational model. Offenders in the externalizing group were more likely to blame a victim or proximate party for the accusation of misconduct and/or deny harming the victim apparently in an effort to divert attention away from their own behavior toward that of the victim or third party. Although offenders in the externalizing group admitted to the offense at some level, this explanation appears to be a partial constriction in that the offender seeks to circumvent any inquiry into his sexual arousal/deviance through the externalizing explanation. The offenders making up the rationalizer group is not consistent with either theoretical explanations due to the fact that these offenders were more likely to acknowledge that their offense was related to their sexual preference. This is inconsistent with either explanations and warrants further theoretical exploration. If one thinks of denial on a continuum, the rationalizer group lies more toward the level of admission than outright denial. However, this group's admission is unique in that the offender may feel that the offense should not be against the law or that the offender did not harm the victim. This group's use of denial of responsibility is not an effort at “constriction” due to the fact that the offender

admits to the commission of the act but likely does not feel that their behavior is sexually deviant.

One caveat warrants mention in this context. Identifying connections between the theoretical explanations and denial classifications becomes problematic because of variations in timing of the offenses and evaluations. For example, the rationalizer group was more likely to admit to an abnormal sexual preference. However, this group was identified by Kennedy and Grubin (1992) post-conviction among incarcerated sex offenders. The incarcerated offender might be more likely to engage in a "cost-benefit analysis" in this setting, given that admitting to an abnormal sexual preference could get the offender into a treatment setting which is less restrictive or with better living conditions than the typical prison setting. In other evaluative contexts, such as an initial investigation, use of denial might be more aligned with the full denial, externalizer, and internalizer groups. In this contrast, a socioevaluative model might better apply, or perhaps an adaptational model with a different cost-benefit analysis. Furthermore, Kennedy and Grubin's investigation was cross-sectional; it is possible that the shift from one classification group to another across time occurs in connection to the benefits an offender may perceive to be available

Kennedy and Grubin (1992) concluded that decreasing denial and accepting responsibility is the primary goal of sex offender rehabilitation. Recognition of different patterns of denial may be helpful in constructing a supervision and treatment program that is consistent with a particular offender's current use of denial. It should be noted that this strategy for measuring denial is based only on specific offense information and the offender's perceptions related

to that offense. Despite finding statistically significant differences between the groups, this classification scheme has not been used to differentiate response patterns on psychological assessment measures. The focus will now turn to researchers who have investigated denial through psychological assessment instruments.

The MMPI and Denial

Murphy and Peters (1992) noted that the MMPI "is the most widely used psychological test in the country and has been used extensively with sexual offenders" (p. 25). The present review will focus on studies using the MMPI specifically related to the investigation of denial in sex offenders. Similar to the classification scheme outlined by Kennedy and Grubin (1992), most studies utilizing the MMPI have sought to identify sex offenders on the basis of their admission status.

Lanyon and Lutz (1984) hypothesized that subjects who were known to have fully denied their offense or partially denied their offense would achieve higher scores on MMPI indices of defensiveness than no-denial subjects. Exploratory analysis of the MMPI clinical scales were also conducted. The researchers identified that past denial research had an "artificial" conception of defensiveness or used subjects who had real-life experiences that promoted defensive responding. The authors noted the importance of independent confirmation that subjects were or were not being defensive. The methodology employed in this study sought to overcome this obstacle by using both historical interview information to indicate the presence of denial and objective legal evidence that the act had occurred. This was achieved by the confirmation of

the offense through substantiated evidence that the offense had occurred.

Participants for the study were 90 males over age 21 who had been indicted or convicted for a felony sex offense. The majority of the offenses were for child molestation. Based on police report information and clinical interview, subjects were divided into no denial, part denial, or full denial groups.

In the Lanyon and Lutz (1984) study, the means on 16 MMPI scales were compared between the full denial and part denial groups with the groups showing a small significant difference. Given the slight differences, the two denial groups were combined and contrasted with the no denial group. Group differences were found on L, F, and K and on each of the three derived validity indices (L+K, L+K-F, and F-K). Orthogonal contrasts revealed that the full denial group and part-denial groups differed only on the derived L + K with the denier groups producing higher L + K scores. When combining the denial groups, differences were found on all six validity scales and derived indices. The denier groups produced higher L and K scores and larger negative F - K scores. In addition, the denier groups produced larger L + K - F scores. The no denial group produced higher F scales than the denial groups. Group differences on the clinical scales included *Mf*, *Sc*, and *Si* with the no denial group scoring higher on all three clinical scales than the denial groups. In addition, group differences were found on clinical scales *Mf*, *Pa*, *Pt*, *Sc*, and *Si* with the no denial group scoring higher on all mentioned clinical scales. Using the 16 scales and indices as predictors of denial, the best individual correlation with the criterion was the validity index L+K-F ($r = .64$). The six validity scale predictors showed an overall hit rate of 83%. The authors concluded that when a valid criterion of denial was

used, a specific association of distorted MMPI profiles was found with deniers producing lower scores on clinical scales. In addition, the validity scales and indices were successful in identifying the type of denial.

Grossman and Cavanaugh (1990) also investigated denial in sex offenders using the MMPI. Offenders who denied deviant sexual behavior were significantly more likely to minimize psychopathology than were those who admitted to deviant sexual behavior. Of particular interest was the relation between status as an admitter or denier and the offender's status with the legal system. Offenders facing no active legal charges showed significantly more psychopathology than did those facing legal charges. Although this appears to be a significant result, the authors did not elucidate the differences between not facing legal charges and facing legal charges in the report of the study. A plausible explanation is that offenders who did not deny deviant sexual behavior and were being evaluated post-conviction were more likely to show elevated clinical symptoms as a reaction to their conviction. Another explanation is consistent with Rogers and Dickey's (1991) adaptational model: the absence of the forensic context allowed offenders to more honestly admit to their problems. The results of this study carries great importance in utilizing a sample of sex offenders who have received a sentence of probation with court-ordered sex offender treatment. Offenders may receive a deferred adjudication, meaning the normally imposed sentence for the crime is deferred in lieu of the offender successfully completing the terms of probation. Offenders can also receive adjudicated probation, meaning that probation is the actual sentence for the crime. Offenders facing the prospect of the original sentence being reinstated if

they fail to complete the terms of their probation might seek to present themselves in the most favorable light (nonendorsement of psychopathology). On the other hand, offenders sentenced to probation might perceive that the legal evaluation of their behavior has diminished, allowing them to acknowledge psychopathology.

In summary, the status of involvement in the court system can create a demand characteristic to minimize clinical symptoms. Conversely, in treatment, sex offenders might seek to artificially elevate clinical symptomatology in order to provide an alternative rationale for their offending behavior (e.g., "I was depressed and that is why I did it"). An equally plausible hypothesis is that the post-adjudication offender understands that part of his probation is the successful completion of sex offender treatment. Knowing this, a particular offender might seek to present himself as free from both psychopathology and sexual deviance during assessment.

Another approach to denial and the MMPI has been to investigate the relation between MMPI scores and penile plethysmography (PPG) data. McAnulty, Adams, and Wright (1994) examined the correspondence between MMPI scores and PPG profiles among alleged child molesters. Participants were classified as having either deviant or non-deviant profiles on the basis of PPG data. The authors utilized raw K-corrected MMPI scale scores entered into a discriminant function analysis to predict group membership. The direct entry of all MMPI scale scores did not reach statistical significance. However, a stepwise entry of variables produced a significant function with seven steps. Scales K and 7 (Pt) made the greatest contributions to the function. Group differences were

also found on Scales 8 (Sc), 0 (Si) and F. The authors did not include these scales in the final discriminant function because of redundancy. Overall the discriminant function had a classification rate of 71.4% with 63.3% of the deviant arousal group correctly classified. The authors concluded that MMPI scores were statistically related to PPG profiles; however, the clinical utility of the results was limited. The patterns of MMPI scores separated child molesters with deviant arousal but misclassified one-third of the offenders in the study. One possible contribution to this result was the elimination of a significant number of participants due to invalid PPG profiles. Thirteen records were eliminated due to missing data or failure to produce a valid PPG profile (the exclusion criterion was failure to achieve greater than 10% erection to any stimuli presented). In addition, 25 cases were excluded due to invalid MMPI profiles based on elevated scores on L, K, or failure to answer over 20 items. This presents an interesting research question in that sex offenders who produce invalid MMPI profiles may also produce PPG profiles that are significantly different from sex offenders who admit to their offending behaviors. More specifically, it is unknown if an invalid profile is related to a nonarousal PPG profile.

Most of the research utilizing the MMPI has been with the original version. With the restandardization and release of the MMPI-2, Mann, Stenning, and Borman (1992) questioned the utility of the MMPI-2 with pedophiles due to the higher education and socioeconomic status of the new standardization sample. A sample of 109 incarcerated male pedophiles were administered the MMPI-2 as part of their sex offender treatment program. Similar to past research with the MMPI, there was no single consistent MMPI-2 profile that emerged from the

sample. However, the researchers noted that the MMPI-2 resulted in a higher frequency of unelevated profiles and overall lower elevations in T-scores than other MMPI studies. The most consistent result found was the elevation of Scale 0. The researchers concluded that this elevation is consistent with the etiology of pedophilic behavior and the sample studied. Men who have difficulty relating to adult females and have limited social skills are blocked from appropriate sexual outlets. Although it was the most consistent elevation in the sample, only 18.39% of the sample had a Scale 0 elevation in either a spike or a two-point code type. Although the researchers did not draw direct comparisons, they reported validity scale results using the MMPI-2 that were similar to past MMPI research. The sample showed moderate elevations on the L Scale and lower scores on the K Scale. The authors concluded that the balancing indicated by the L and K Scale scores reflected defensiveness and impression management in the sample. Overall, Mann et al. (1992) concluded that this sample of pedophiles produced profiles similar to samples evaluated with the original MMPI. They stated that when the MMPI-2 is used, the validity scales should be interpreted with caution. Specifically, they recommended considering the education and socioeconomic status of the offender, noting that these two variables can influence the obtained T-scores on L and K. In addition, the authors outlined the need for normative data on sex offenders who are court ordered into mandatory treatment and sexual offenders who volunteer for treatment.

The MSI and Denial

The MSI is another self report measure commonly used with sex offenders (Nichols & Molinder, 1984). Kalichman, Henderson, Shealy, and Dwyer (1992) investigated the psychometric properties of the MSI and its relation to MMPI scales in a sample of 84 men incarcerated for sexual offenses against children. The researchers found several correlations with the MMPI F and K Scales. Specifically, the Cognitive Distortions and Immaturity Scale and Justification Scale on the MSI showed significant correlations with F ($r = .50$ and $.32$ respectively, $p < .01$). The MSI validity scales mentioned also showed significant negative correlations with the K Scale ($r = -.56$ and $-.29$ respectively). The Cognitive Distortions and Immaturity Scale was also found to be correlated with 7 out of the 10 MMPI clinical scales. However, the only clinical scale that was found to correlate with the Child Molest Scale from the MSI was the Mf Scale ($r = .32$).

Kalichman et al. (1992) carried out the same correlational design with a sample of 113 men being evaluated post-conviction for child sexual offenses. All offenders had victimized female children exclusively. In comparing the incarcerated and post-conviction samples, the researchers found some convergent results. The Child Molest Scale showed a similar correlation with the Mf scale ($r = .37$). This led the researchers to conclude that nontraditional male sex roles increase as sexual interest in children increases. However, this appears to be a traditional interpretation of elevations on the Mf Scale. In addition, nontraditional male sex roles were not adequately defined by the researchers; therefore, caution is warranted in interpreting this result. A similar

correlation pattern was found between the MSI Validity Scales and the F and K scales on the MMPI. However, the correlations consistently were smaller in magnitude. In addition, the Justification scale from the MSI resulted in a positive correlation with the K scale in the nonincarcerated sample ($r = .33$) as opposed to the negative correlation found in the incarcerated sample ($r = -.29$).

Haywood, Grossman, Kravitz, and Wasyliv (1994) examined the relations between MMPI and MSI indices in 59 men accused of child molesting. The researchers used the MMPI F-K and O-S as indicators of response style. All MSI validity indices correlated as expected with the F-K and O-S (r s ranging from .40 to .76) except for Social Sexual Desirability and Lie for Incest. These two comparisons resulted in nonsignificant correlations ($r = -.01$ and $-.06$ respectively). Once again the Cognitive Distortion and Immaturity produced the correlation of highest magnitude with O-S, ($r = .77$, $p < .001$). Haywood et al. (1994) also drew comparisons between admitters ($n = 32$) and nonadmitters ($n = 27$). Nonadmitters scored significantly different from admitters on all MSI indices except Sexual Obsessions, Social Sexual Desirability, and Cognitive Distortion and Immaturity Scales. The nonadmitter group produced higher scores on the Justifications, Child Molest Lie, and Incest Lie Scales indicating a tendency to endorse justifications and use greater denial on the Child Molest and Incest Scales. The admitter group scored higher on the Treatment Attitudes Scale indicating an acknowledgment of the need and potential benefit of treatment. Although concluding that the MSI has concurrent validity with the MMPI, Haywood et al. concluded that the MSI should be used cautiously with nonadmitters given the susceptibility to defensive minimization.

Simkins, Ward, Bowman, and Rinck (1989) utilized the MSI in an attempt to differentiate offenders based on their level of denial. They investigated 103 sex offenders who were clients at a community sexual abuse treatment program.

First it should be noted that Simkins et al. (1989) made no reference to legal action taken against the sex offenders who made up their sample, victim characteristics were also unclear. The sample was divided into three groups: complete deniers (subjects who completely denied all abusive activities) and partial deniers (subjects who admitted to their abusive activities but either minimized the actual extent of these activities or were evasive in discussing the details of the molestation). Finally, a third group of no denial was included for those offenders who completely acknowledged their responsibility and commission of the act. Univariate analyses revealed significant differences on 10 of the MSI scales. The denial groups produced higher Lie Scale scores than the No Denial group. One interesting finding was the nonsignificant difference between on the Cognitive Distortion/Immaturity Scale with the Partial Denial and No Denial groups producing similar scores and the Complete Denier group producing the lowest mean score. Although this scale has produced strong correlation with MMPI validity indices, the scale does not appear to discriminate between levels of denial. Simkins et al. (1989) concluded that the pattern of results suggested that those who admitted to their abusive activities had higher scores on scales measuring molestation activities than those who engaged in any denial. Admitters had higher treatment motivation scores, were more likely to endorse normal heterosexual drives and interest, yet were also more willing to report fantasizing about children as erotic objects.

A stepwise discriminant function analysis collapsing the two denier groups (due to low sample size) was performed using the admitter and newly formed denier groups as the criterion. The discriminant function was significant ($\chi^2 = 44.32, p < .0001$) with four variables entering into the function. The general results indicated that deniers scored lower on Justification, Treatment Attitude, and Sexual Assault. The analysis correctly classified 77.6% of the admitter group and 71.7% of the denier group for an overall classification rate of 75.4%.

Penile Plethysmography

Quinsey and Earls (1990) noted that although the self report is a common and helpful method to measure an individual's sexual behavior and preferences, sex offenders may simply deny that they have inappropriate sexual preferences on such measures. The use of phallogometric testing has been investigated and supported by many as a more objective measure of sexual arousal (Earls & Quinsey, 1985; Freund, 1981; Marshall & Christie, 1981). The support of such testing relies on the premise that an objective physiological measure of changes in penile tumescence in relation to deviant and nondeviant sexual cues will assist the examiner in identifying a particular individual's sexual arousal pattern when other self-report measures might indicate denial or dissimulation. Simon and Schouten (1991) described the working assumption of phallogometric testing and stated that the assessment of sexual deviance assumes a natural operational linkage between stimulus-specific penile arousal patterns and overt sexual acts. They noted that the assumption of an arousal-behavior link is central to any behavior modification treatment paradigm which emphasizes direct attempts to modify arousal patterns associated with deviant sexual behavior.

The interpretation of deviant sexual arousal with the penile plethysmography continues to be a controversy. Quinsey and Earls (1990) pointed out the difficulty in defining deviant sexual arousal. There are generally two accepted methods used in this domain. The first method calculates individual arousal levels, independent of responses to other stimuli, usually in terms of percentage of full erection or millimeters of penile circumference change. The second method involves calculating specific arousal levels relative to responses to other stimuli (usually via a deviancy quotient or a z-score). The definition of normal versus deviant sexual arousal depends upon how males in general respond to various descriptions or depictions of sexual behavior. Earls and Quinsey (1985) noted that although considerable progress has been made in the comparison of arousal levels between subgroups of sexual offenders and nonoffenders, the relations between different patterns of sexual arousal and the need for treatment is not completely clear.

Historically, it appears that the use of penile plethysmography was intended only as a research instrument to compare deviant and nondeviant sexual arousal. Nonetheless, Malcolm, Andrews, and Quinsey (1993) noted that phallometry has emerged as the method of choice for identifying deviant sexual preferences in populations of convicted child molesters. Sewell and Salekin (1997) provided a recent review of the use of phallometric testing and dissimulation. These authors concluded that just because some measure can distinguish sex offenders from persons who are not sex offenders does not mean that the same measure can reliably distinguish an individual sex offender who is lying about the offense from an admitting sex offender. In addition, Malcolm,

Davidson, and Marshall (1985) pointed to research that illustrates offenders' ability to bring arousal under voluntary control, although still influenced by stimulus content.

Noting that dissimulation of the PPG is a distinct possibility, researchers have investigated the discriminant and predictive validity of phallometric testing. Malcolm et al. (1993) used a sample of 172 incarcerated male sexual offenders being evaluated for placement in a sex offender treatment program in Canada. In an effort to investigate the discriminant validity, the researchers formed groups based on sexual offense type, the age and gender of the victim, and the offender's relationship to the victim. Phallometric testing used visual stimuli only. Each visual category is made up of slides depicting both male and female subjects at various ages ranging from very young children to adults. Similar to past research, participants who did not attain a peak response of at least 10% full erection to at least 1 of the 16 stimulus presentations were excluded from the analysis. Both age and gender preference indices were calculated. These indices are obtained by calculating mean millimeter arousal, standard deviations, and mean percentage arousal for each visual category. From these calculations age and gender preference is identified noting the highest level of arousal. Discriminant validity of the gender preference index for groups based on victim gender indicated that offenders responded more to slides representing the gender of the victim in their latest offense. In addition, group differences were found with respect to the age preference index with a combined child molester groups showing greater preference for children than did the other sex offenders.

Malcolm et al. (1993) also investigated the sensitivity and specificity of the calculated age preference index. Using the sample of individuals convicted of sexual offenses, the sensitivity was .53 with 53% of child molesters correctly classified; specificity was .82 with 82% of non-child molesters correctly identified as non-child molesters. The researchers proposed that a more stringent specificity cutoff that would correctly classify 95% of the non-child molesters would result in lowering the sensitivity of the test to .41. Finally, the researchers noted a number of qualifications to their findings, placing particular emphasis on the fact that the arousal indices of groups formed on the basis of victim age (adult, pubescent, and prepubescent) were averaged across participants in the groups. The averaged data might have misrepresented the preference of individual participants. A further qualification by the researchers added to this concern in that 48% of the data collected were excluded due to insufficient erectile responding. In this study, low responding was defined as not achieving above 10% erection to any stimuli. The researchers argued that recent data indicates discriminant validity among very low responders comparable to that of high responders (Harris, Rice, Quinsey, Chaplin, & Earls, 1992).

Other studies on the efficacy of phallometric testing have investigated methods to maximize the discriminant validity. As Simon and Schouten (1991) noted, a lack of precision in the use of laboratory assessment creates difficulties in phallometric testing. Little research exists on the effectiveness of modalities (e.g., visual, audio) or the impact of erotic cues within stimuli. Harris et al. (1992) found that discrimination was maximized by using stimuli that emphasized force and coercion and that stimuli describing injury to the victims showed

greater discrimination between both rapists and child molesters from non-sex offender groups. Exacerbating this problem is the ability of offenders to influence the results of phallometric testing. Hall (1996) noted that nearly 80% of sexual offenders are capable of inhibiting sexual arousal. This author correctly has concluded that any given sexual-arousal finding is not necessarily diagnostic. Nearly 80% of offenders can inhibit arousal; and approximately 20% of normals exhibit deviant sexual arousal (Hall, Proctor, & Nelson, 1988). It appears conclusive that efforts at maximizing discriminate validity of phallometric testing has many procedural difficulties to overcome as well as the susceptibility of the result to faking. A careful analysis of the samples used in these studies is paramount -- specifically identifying whether participants denied their offense, admitted to the offense, and the context of the evaluation.

Chaplin, Rice, and Harris (1995) further elaborated on past research by investigating the discriminant validity of sexual responses to stories of child sexual assault when told from the point of view of a male perpetrator versus that of a female child victim, varying the level of immediate physical and psychological trauma suffered by the victim. The stimuli for this study were 12 scenarios describing sexual interactions between a man and a girl of approximately 8 years of age, varying from passive nontraumatic sexual experiences to extremely traumatic experiences. Fifteen men comprised the treatment group, of which 11 had been convicted of sexual assault with a child. Fifteen men comprised a comparison group recruited through a local employment center. None of the fifteen men in this latter group reported arrests for illegal sexual activity or institutionalization in a mental health facility. In order

to make comparisons between participants, raw arousal scores were transformed into z-scores. The researchers found a significant main effect for participation group and stimulus category as well as a significant interaction. Thus, there were very different profiles for the child molester and nonoffender respondents. Child molesters responded the highest to scenarios depicting sexual activity with a child from the child's point of view. They showed a preference for the passive stories but showed little to no inhibition of their responses even when the stories contained graphic details of pain and traumatic assault from the victim's point of view. Overall, the results of these studies suggest that characteristics of the stimuli and presentation modality produce varying results. This makes comparison of plethysmography results across studies and generalization to criterion groups difficult when stimuli are not adequately described.

Finally, Chaplin et al. (1995) calculated a deviance differential for each participant by subtracting his largest mean z-score response to a deviant category from his mean z-score response to the adult consenting sex category. The deviance differential resulted in a high correlation with group membership ($r = .85, p < .0001$). Sensitivity was reported as .93 and specificity of 1.00. The reported effect size ($d = 4.10$) was obtained with the stimuli emphasizing victim suffering from the victim's point of view. From this the researchers concluded that all categories of stimuli used for the testing yielded excellent discrimination between the child molester and nonoffending groups, noting that the best discrimination occurred when coercive and brutal stimuli were used. A number of implications were suggested. First, men who engaged in sexual activities with

female children exhibited an absolute preference for stories involving sexual activity with female children over those involving sexual activity with adults. Second, when appropriate stimuli and procedures are used, child molesters' sexual responses are very different from controls. Despite the interesting findings from this study, the clinical implications are minimal. Chaplin et al. noted that the statistical significance and large effect size must be interpreted in light of the small sample and the novelty of the experimental stimuli used. In addition, the scenarios were presented using an audio format only. The excellent discrimination found only for the stimuli depiction, rather than for heinous acts against children, suggested that the commonly held belief that child molesters care for the children they offend against may not be true. However, it should be noted that there are no available studies in the plethysmograph literature specifically investigating the relation between level of denial and phallometric indices.

The Present Study

Research in the area of denial in sex offender assessment has progressed along two fronts, namely theory and instrumentation. Across both these areas is the mutual agreement that dissimulation among sex offenders is a pervasive problem. Although cogent explanations have been proffered, the construct of denial within this population remains empirically elusive. One potential explanation for the empirical elusiveness of this construct is that researchers have not adequately operationalized sex offenders' use of denial. The present study attempted to implement a classification scheme based upon Kennedy and Grubin (1992) that operationalized denial into five dimensions.

This was attempted to allow for a more sensitive examination of group differences on procedures commonly utilized in sex offender assessment. Past research seeking to improve on the discriminant validity has focused only on predictors from a single inventory. The present study utilized predictors from the three most common assessment procedures; the MMPI, MSI, and PPG, in an effort to maximize the discriminant validity of denial assessment with sex offenders.

Proposed Hypotheses

The following a priori hypotheses were tested using denial group membership as the independent variable and MMPI scales, MSI scales, and a calculated PPG Deviance Differential as dependent variables.

1. There will be a significant main effect for group on the MMPI validity scales.
 - A. Both the Deniers and Externalizers will produce higher scores on Scale L and K than the Rationalizers, Internalizers, and Admitters.
 - B. Both the Admitters and Internalizers will produce higher scores on Scale F than the Deniers, Externalizers, and Rationalizers.
2. There will be a significant differences between groups on the MMPI clinical scales.
 - A. The Admitters will produce higher scores than all other groups on the standard clinical scales.

3. There will be a significant main effect for group on the MSI scales.
 - A. Deniers and Externalizers will score higher on both the Social Sexual Desirability and Cognitive Distortions and Immaturity Subscales than the Rationalizers, Internalizers, and Admitters.
 - B. Admitters and Rationalizers will score higher on the Justifications Scale than the Deniers, Externalizers, and Internalizers.
4. There will be a significant main effect for group on progress in treatment and treatment attendance.
 - A. Admitters and Internalizers will show better progress and higher participation than the Deniers, Externalizers, and Rationalizers.
5. There will be a significant main effect for group on PPG Deviance Differential scores.
 - A. Admitters and Internalizers will show higher Deviance Differential scores than the Deniers, Externalizers, and Rationalizers.
6. Using representative scales from the MMPI and the MSI, significant predictors will be found to predict the criterion variable of denial group membership.

Research Questions

1. Using the basic hypotheses outlined above, are changes in denial across legal investigation and treatment associated with different assessment results?
2. Is there evidence of convergent validity for response style indices across the self-report inventories utilized in this study?

CHAPTER II

METHOD

Participants

Data for the present study were archival records of 228 male sex offenders participating in a court-ordered sex offender treatment program in Tarrant County, Texas. Approval for the project was obtained from the Tarrant County Probation Office, Research Division, and the University of North Texas Institutional Review Board. Compared to previous research, this project used a relatively homogenous group of sexual offenders. Two hundred twenty eight files were reviewed over a 1 year period. Out of the 228 files reviewed, only files that represented individuals charged with sexual offenses with children as victims were selected for purposes of this analysis. The rationale for this elimination of data was to produce a more homogenous sample of sexual offenders; due to low numbers of individuals who committed sexual crimes against adults, it was decided to retain data on offenders with victims under the age of 18. Sixteen of the 228 files reviewed were listed as sexual crimes with adults as victims. Twenty-nine files involved the offense of Indecent Exposure where the victim was either an adult or the age of the victim could not be determined. Using the child victim selection criteria, 189 files were identified

from the overall sample. The following is a breakdown of the official charge: Indecency with a child ($n = 82$), Aggravated Sexual Assault of a Child ($n = 71$), Indecent Exposure to a Child ($n = 16$), Sexual Assault of a Child ($n = 19$), and Injury to a Child ($n = 1$). Across all offense categories, mean victim age was 11.64 years ($SD = 3.61$) with 164 female victims and 25 male victims.

From the 189 files selected for analysis, the first step was to categorize the files into appropriate denial groups based on the Kennedy and Grubin (1992) denial classification system previously described. Cases were categorized based upon information obtained from the probation files. The most common sources of information used in making the denial categorization were victim statements ($n = 144$), Mirandized statements made by the offender ($n = 96$), and Preliminary Sentencing Investigation reports ($n = 74$). Noting that victim statements were the most common source of information in making denial group classification, raters reviewed other witness statements in 118 files in order to assess the consistency across victim and witness report of the offense. Out of 118 files containing both victim and witness statements, raters indicated consistency across 113 files. Table 1 reports reliability (percentage agreement) between three raters on the Kennedy and Grubin (1992) questions that were used to classify the individuals into denial categories. Over 90% agreement was achieved on 5 out of 7 questions. The remaining two questions had agreement rates above 80%. It should be noted that when disagreements occurred on questions with lower percentage agreement, these disagreements were usually

based on the relative lack of information to make the judgement. On the question concerning externalizing responsibility for the offense disagreements were between coding the question as “no information available” or using the actual classification code of “no blame of third party or victims”. Based upon the available information, 125 files were classified into 1 of 4 denial groups. Sixty-four files could not be classified due to the lack of available information. In addition to this loss of data, the Rationalizer group was also eliminated from the classification scheme due to a lack of data on the necessary questions that make up the decision criteria. Notably, only 5 out of the 189 files reviewed contained statements by the offender indicating that his actions had helped the victim of the offense in some way. From the 189 files, the breakdown of denial group membership was as follows: Deniers ($n = 33$), Admitters ($n = 38$), Internalizers ($n = 25$), Externalizers ($n = 29$). Table 2 is a summary of demographic information for the denial groups. One-way ANOVAs revealed no significant differences for age, monthly income at intake, number of job changes, and longest job position held. Chi-square analysis of categorical demographic variables revealed a number of nonsignificant differences across demographic variables including marital status and race.

Table 3 is a summary of offense related variables across the four denial groups. One-way ANOVA revealed significant differences across denial groups for victim age, $F(3, 118) = 3.99$, $p = .01$. Duncan’s multiple range post hoc test indicated that the Externalizer group mean was significantly different from both

the Admitter and Denier groups. Number of victims did not differ significantly across the four groups. Results of categorical offense related variables reported in Table 4 indicate a significant relationship between denial group membership and relationship with the victim of the offense. An examination of the cross-tabulation matrix indicated that the Admitter group was more likely to have an intrafamilial victim; and the Externalizer group was more likely to have an extrafamilial victim (see Table 5).

Procedures and Instruments

All information was gathered through a two-step file review procedure. The first step in data collection included gathering file information from each offender's main probation file. This included demographic status, recidivism, and minimal treatment information. Demographic variables of interest included: age, ethnicity, education, occupation, income, number of job changes since beginning probation, income at intake, income at file review, military service, current marital status, and age and gender of children (see Appendix B). All probation files were reviewed at the Tarrant County probation office. Each probation officer kept his or her caseload of files in a locked file cabinet. File review began in one office with all files reviewed for that particular probation officer before moving on to the next set of files. The completed demographic information included two numbers for identification purposes. One number was a research subject number and the second number was the individual probationer's Tarrant County identification number. This latter number was copied onto the demographics file

in order to identify and locate that particular offender's treatment file once data collection was initiated at the treatment site. No names were included on either demographic or assessment data collection sheets to insure confidentiality of the offenders. Data collection was completed by a graduate student and a number of undergraduate research assistants trained in the file review procedure.

Probation file information was reviewed to obtain status information regarding the offense leading to the current probation and history of past offending behavior. This information was available in the form of police reports, pre-sentence investigations done by the probation office, and criminal records check. The criminal history of each offender contained both juvenile and adult criminal history if applicable. Current offense information included: the legal charge, offense classification as violent or nonviolent, the status of the offense as deferred or adjudicated, age and gender of victim(s), relationship status of the victim to the offender (intrafamilial, extrafamilial unknown to the offender, and extrafamilial known to the offender), and terms of probation set by the court (restitution, community service, and sex offender treatment). Each offender's criminal history was reviewed noting prior adjudications for violent and/or nonviolent sexual offenses and violent and/or nonviolent nonsexual offenses. In addition, the number of previous probations and paroles were noted.

A number of supervision variables were also examined: frequency of contact with the probation officer, use of surveillance, and use of drug testing. If drug testing was used with a particular offender, the number of drug tests and

outcomes were noted. Length of probation and the presence of a motion for probation revocation was documented from the file when noted.

An important part of the probation data collection procedure was careful review of the official investigation reports regarding the offense. When available, summaries of all contacts with the victim, other witnesses, and the defendant were reviewed. When given, this information included a Mirandized statement given by the defendant. When available, the official Pre-Sentence Investigation (PSI) was also reviewed. The PSI contained a large amount of information regarding the official account of the offense, the victim's account of the offense, and the defendant's account of the offense. All this information was reviewed in order to assign each offender to a denial classification as outlined by Kennedy and Grubin (1992).

The second step in the file review process was gathering assessment information from the treatment site. As part of their participation in the sex offender treatment program, each offender completed a comprehensive psychological battery. This battery included the MMPI, MSI, and PPG. Individual items from the MMPI were entered into a computerized database. Subscale scores and item endorsements from the MSI were also documented. For the PPG, auditory and visual stimuli means, standard deviations, and percentage arousal scores were documented.

Two other variables were extracted from the treatment files, progress in treatment and attendance. The main treatment site where the data were

gathered utilized a standard treatment plan that had the same categories of goals outlined for each offender. On a quarterly basis, each offender's progress toward the treatment plan goals were evaluated and quantified by the treatment provider. Therefore, progress in treatment was obtained for each offender at six time periods, 4 months, 8 months, 12 months, 18 months, 21 months, and 24 months. The treatment program also monitored attendance of each offender carefully as attendance is an important factor for successfully completing treatment within the time frame given by the court and for compliance with the probation program. For each month, a summary report was reviewed noting the number of groups the offender was scheduled to attend and the number of groups that the offender missed. Similar to the progress time frame outlined, attendance was calculated for each time period.

MMPI

Individual items from the MMPI were recorded using a laptop computer. This allowed for calculation of all clinical, supplemental, and validity scales of interest. Again, the county identification number were included with the data in order to match the assessment and demographic information prior to the statistical analysis of the data.

A review of the literature has revealed little information on the reliability and/or validity of the MMPI with sex offenders. Langevin, Wright, and Handy (1990a, 1990b) reported on reliability and criterion validity of the MMPI with sex offenders. They utilized a sample of 157 sex offenders with the sample being

divided along a number of dimensions including admitter versus nonadmitter, violent versus nonviolent, previous sexual offenders versus first offenders, alcohol involvement in the offense versus no alcohol involvement in the offense, and the presence of CT brain abnormalities versus normal scan. The researchers identified 125 scales measuring sexual behavior, substance abuse, violence, personality, defensiveness, and brain damage. Of the 125 scales examined, 70% resulted in modest internal consistency ($r_s > .60$) with 80% of the scales discriminating sex offenders from controls at better than chance levels. Nineteen of the 50 defensiveness scales resulted in alpha coefficients greater than .80. These two articles explored derived scales; no reliability information was reported for standard validity and clinical scales.

A meta-analysis conducted by Parker, Hanson, and Hunsley (1988) reported an average stability coefficient for MMPI scales across a variety of samples to be .74. Graham (1993) reported test-retest correlations for normal, psychiatric, and criminal samples over three test intervals (one day, one to two weeks, and one year or more). Actual range and typical ranges are reported for the samples. In general, higher correlations were reported for the one day or less samples ($r_s .70$ to $.85$ = typical range) with higher correlations being found in the normal and psychiatric population. The one to two week test-retest interval produced correlations ranging from .60 to .85 with higher correlations found in the psychiatric group than the other two groups. Greene (1991) reported results about test-retest reliability of the MMPI validity scales from

research conducted by Dahlstrom, Welsh, and Dahlstrom (1975). Test-retest reliability coefficients for the L scale tended to be slightly lower than those reported for Scales F and K. Reliability coefficients for intervals up to one week range from .70 to .85. Test-retest reliability for the F scale range from .80 to .97 for an interval up to two weeks and range from .45 to .76 for intervals from eight months up to three years. Test-retest correlations for the K scale range from .78 to .92 for an interval up to two weeks and .52 to .67 for intervals from eight months to three years.

MSI

The MSI (Nichols & Molinder, 1984) is a self report measure developed to assess psychosexual characteristics including sexual history, paraphilias, and the use of denial and minimization of sexually offending behavior. The measure was developed to be consistent with the authors' conceptualization of the motivation and behavioral characteristics in sex offenders. The MSI scales inquire about sexually deviant acts, cognitive processes, behavioral aspects of offenses, and deceptive styles of dishonesty and denial. There are six validity scales of particular interest for this study; they include: Parallel Items, Sexual Obsessions, Cognitive Distortions and Immaturity, Social Sexual Desirability, Lie, and Justifications.

Simkins, Ward, Bowman, and Rinck (1989) reported reliability estimates from Nichols and Molinder (1984) in their study with product moment correlations of stability over time ranging from $r = .58$ to $.92$ across scales, with a majority of

the correlations in the .80 range or higher. The test-retest correlation for the entire MSI was reported as .89. Kalichman, Henderson, Shealy, and Dwyer (1992) also discussed the psychometric properties of the MSI. Using a sample of 248 men convicted of sexual assaults against women, standardized alpha coefficients were calculated as a measure of internal consistency. Coefficients ranged from .50 to .90 indicating moderate to high reliability for all scales. The Child Molest, Rape, Bondage, Sexual Obsessions Justifications, and Social-Sexual Desirability Scales demonstrated the highest levels of internal consistency. Exhibitionism, Sexual Inadequacies, Cognitive Distortions and Immaturity, and Sexual Knowledge and Beliefs Scales demonstrated the most heterogeneous item content.

Simkin et al. (1989) found adequate test-retest reliability and internal consistency for a number of MSI scales. However, caution is warranted in generalizing these reliability results to all types of sex offenders. Kalichman et al. (1992) were careful to note that the reliability coefficients were for a sample of incarcerated rapists only and did not include child molesters. The same article discussed various analyses involving three other samples of both incarcerated and nonincarcerated child molesters; the absence of reported reliability and validity information from these samples is interesting. A critical interpretation of this absence suggests that the potential results were not as promising and were therefore not included in the final report of their study. No explanation was given in the article about why such information was not included.

Despite the previous discussion, the MSI is used widely in the clinical assessment of sex offenders. Simkins, Ward, Bowman, and Rinck (1989) utilized the MSI in an effort to predict treatment progress and therapy outcome of child sexual abuse perpetrators. The overall results suggested that the MSI predicted between 30% to 47% of the treatment variance depending on the criterion measure used. The authors also conducted a factor analysis on the MSI and found a four factor solution: assault, sexual fantasy, denial/dysfunction and normal arousal. The authors concluded that the MSI could differentiate among abusers who molest males, females, and both sexes. In addition, the MSI also differentiated between deniers and non-deniers of abuse. However, Nichols and Molinder (1984) cautioned against the use of the MSI in evaluations where the offender has not admitted to the sexual offense.

PPG

Penile plethysmography data were also coded from the offender's treatment file. This aspect of the data collection included both mean arousal and percentage arousal for audio and visual stimuli. Audio stimuli information included the following categories: mutual consent adult, mutual consent child, child nonconsent, fondling, child rape, child sadism, child physical assault, neutral stimuli. Data for both male and female stimuli for these categories were coded when available (see Appendix C). For each offender, the PPG data were recalculated from the mean millimeter arousal for each category using the Deviance Differential z-score transformation outlined by Chaplin (1995). All raw

mean millimeter scores were first converted into z-scores with the deviance difference being calculated by subtracting the offender's largest mean z-score response to a deviant category from his mean z-score response to the adult consenting sex category.

Annon (1988) provided a review of reliability and validity of penile plethysmography in rape and child molestation cases. He reviewed research by other investigators who concluded that measures of erectile change are reliable in the sense that they are stable over time when measured repeatedly in a short period. Annon reviewed another study by Davidson and Malcolm of the test-retest reliability of the differential arousal responses of 90 rapists to rape and non-rape cues over a 48 hour period; Annon stated that the highest reliability was obtained for offenders experiencing 30 percent or more of a full erection. Despite positive acknowledgment of the stability of PPG test results, the author does not provide clear references to the above mentioned studies; nor does he report reliability in terms of appropriate correlations. Earls and Marshall (1983) and Wormith (1986) found reliability coefficients for phallometric scores ranging from .38 to .94. It appears that few studies have addressed reliability of phallometric testing adequately. Wormith (1986) reported widely disparate reliability coefficients for a large sample of sex offenders and non-sex offenders across male, female, adult, and child stimuli. In addition to differences across the stimuli, the researcher noted that reliability can vary with different scoring methods.

Hall (1996) provided a recent review of psychometric issues in scoring PPG protocols. Raw scores are an inappropriate method of comparison due to physical differences in penis size. The use of ratios is problematic in that an offender exhibiting 1 mm of penile tumescence in response to adult consenting stimuli and a 2 mm of tumescence in response to pedophilic stimuli would have the same .50 ratio as a second subject exhibiting 20 mm and 40 mm to the respective categories. The first offender's ratio likely would be attributed to measurement error whereas the second offender's mm change might better be categorized as deviant arousal to pedophilic stimuli. Similar issues in clinical interpretation occur when raw scores are transformed as is also common (i.e., deviance differentials, and z -score transformations). However, using raw scores, or ratios based on raw scores, does not allow for appropriate group comparisons due to the differences in magnitude. The deviance differential was chosen for this study in order to standardize individual scores and provide an individual measure of the magnitude of arousal that could be utilized for group comparison purposes. Although PPG testing remains the benchmark for assessment of sexual deviance, there remains a number of areas that warrant careful scrutiny of this type of assessment data. First, different procedures have been found to produce different results; second, the paucity of research available on reliability; and three, choice of scoring techniques and interpretation of available indices.

CHAPTER III

RESULTS

To test Hypothesis 1, stating that there will be a main effect for denial on MMPI validity scales, a multivariate analysis of variance (MANOVA) was carried out using denial group status as the independent variable and all MMPI validity scales as dependent variables. Table 6 is a summary of descriptive statistics for MMPI validity scale raw scores. The multivariate analysis of variance (MANOVA) with denial group as the independent variable and the three standard validity scales as dependent variables produced a nonsignificant main effect for denial group, Wilks lambda = .87, $p > .50$. Due to the nonsignificant main effect, subhypotheses were not examined.

Table 7 is a summary of descriptive statistics for all MMPI clinical scales. To test hypothesis 2, stating that there will be a main effect for denial on MMPI clinical scales, a series of univariate F -tests were run using denial group status as the independent variable and all MMPI clinical scales as dependent variables. Results of the f -tests were all nonsignificant. Due to the nonsignificant results, the subhypothesis was not examined.

To test Hypothesis 3 stating that there will be a significant main effect for denial on the MSI scales a multivariate analysis of variance (MANOVA) was carried out using denial group status as the independent variable and specific

MSI scales as dependent variables. Table 8 is a summary of descriptive statistics for MSI validity scales. To test hypothesis #3 a multivariate analysis of variance (MANOVA) was run using denial group status as the independent variable and MSI validity scales as the dependent variables. Results of the MANOVA revealed a nonsignificant main effect for denial group, Wilks lambda = .95, $p > .50$. Subhypotheses were not examined due to the nonsignificant main effect.

To test Hypothesis 4, stating that there will be a main effect for denial group membership on treatment attendance and progress, a MANOVA was carried out using denial group status as the independent variable and treatment attendance and progress as dependent variables. Attendance was calculated for the first year of treatment by totaling the number of groups attended and the number of scheduled groups. For each subject, a quarterly percentage was then calculated by dividing the number of groups attended by the number of groups scheduled. Table 9 a is descriptive summary of attendance for the first year of treatment. Results of the MANOVA revealed a nonsignificant main effect for attendance, Wilks lambda = .68, $p = .28$. Similar results were found for treatment goals. Table 10 is a summary of descriptive information for the mean number of treatment goals completed by the various denial groups within the first year of sex offender treatment. The MANOVA revealed a nonsignificant main effect for denial group, Wilks lambda = .24, $p > .50$. Due, to the nonsignificant main effect, subhypotheses were not examined.

To test Hypothesis 5, stating that there will be a main effect for denial group membership on PPG audio and visual indices, denial membership was used as the independent variable and audio and visual deviance differential used as dependent variables in separate ANOVAs. Prior to calculating the differential scores, the veracity of the PPG results across the denial groups was tested. Using the report writer's indication of the validity of the PPG (a dichotomous rating of valid or invalid) a chi-square was calculated using the validity indicator and denial group. The resulting chi-square was of nonsignificant $\chi^2(3) 4.07, p = .25$. However, when the possible dissimulation category was added to the cross-tabulation matrix a significant chi square was obtained $\chi^2(6) = 12.76, p = .04$. In order to gain a better understanding of this relationship, the valid and possible dissimulation validity indicators were compared. The resulting chi-square was also significant $\chi^2(3) = 9.75, p = .02$ (see Table 11). The pattern across the Kennedy and Grubin groups indicated that Admitters and Internalizers were more likely to be associated with valid PPG profiles and the Deniers and Externalizers resulting in profiles evaluated as possible dissimulation. Only a small number of PPG profiles were rated as invalid ($n = 6$) by the report writer. Deviance differential variables were then calculated by first converting all raw scores for all categories in standardized scores. For each offender, the difference between the standardized score of the adult consensual sex category (adult consensual sex for the audio differential and adult female for the visual differential) and the highest elevated deviant category was calculated. Table 12

is a summary of descriptives for both audio and visual deviance differential scores for the denial groups. Two ANOVAs were calculated to test hypothesis 5. Results of the ANOVA for the audio deviance differential were nonsignificant $F(3, 76) = .02, p > .50$. Similar results were found for the visual differential $F(3, 85) = .33, p > .50$. As above, due to the nonsignificant main effect, subhypotheses were not examined.

Exploratory Analyses: Reconceptualizing the Denial Construct

Hypothesis 6, stating that significant predictors from the MMPI and MSI would be utilized to predict denial group membership, was not analyzed due to the null results found for hypotheses 1 through 5 (i.e., the denial classification appears to have little relation to the assessment instruments). Due to the null results found, other indicators of denial available to the researchers were then utilized in order to re-examine hypotheses 1-5 (i.e., the denial classification appears to have little relation to the assessment instruments investigated). In addition to the denial ratings which were utilized in making the Kennedy and Grubin ratings, sex offender treatment staff noted in each treatment file the denial status of the offender during the treatment intake process. This denial indicator did not correspond directly to Kennedy and Grubin denial groups but was noted as three levels (denier, admitter, and partial). Denier and admitter categories correspond to the operational definitions for similarly named Kennedy and Grubin groups. The partial category is conceptually related to the Internalizer and Externalizer groups in that some element of denial was noted by

the treatment staff conducting the intake. Out of the 189 files reviewed, this denial variable was noted in 96 of the files with the following breakdown (denier $n = 27$, admitter $n = 59$, partial $n = 10$). This treatment denial status variable was used as a new independent variable and all five main hypotheses re-analyzed. Similar nonsignificant results were obtained for the MMPI hypotheses. A MANOVA for the MMPI validity scales resulted in a nonsignificant main effect, Wilks lambda = .93, $p > .50$ (see Table 11). Using the MMPI clinical scales as dependent variables all scales resulted in nonsignificant results except Scale 1, $F(2, 64) = 3.95$, $p = .02$ (see Table 14). Post hoc analysis utilizing a Duncan's multiple range test indicated that the Deniers ($M = 8.58$) scored significantly higher than both the Admitters ($M = 4.68$) and the Partial Admitters ($M = 6.43$).

A different result was obtained in analyzing MSI validity scales with the new denial scheme. Table 15 reports descriptive information for MSI validity scales for treatment denial groups. Using treatment denial as the independent variable resulted in a significant main effect, Wilks lambda = .83, $p = .03$. Univariate F -tests indicated significant results for the Denial Scale $F(2, 93) = 6.18$, $p = .003$. Duncan's post hoc analysis of the Denial Scale indicated that the Partial Group scored significantly higher on the Denial Scale than either the Denier or Admitter Groups.

In re-examining the treatment attendance and progress hypotheses, a nonsignificant main effect was found for treatment denial status for attendance, Wilks lambda = .86, $p = .38$ (see Table 16) An examination of the Univariate F -

tests indicated that attendance for the Quarter #3 was significant, $F(2, 58) = 3.40, p = .04$. Duncan's multiple range test indicated that Denier group had significantly lower attendance ($M = .89, SD = .07$) than either offenders in the Partial group ($M = .96, SD = .03$) and Admitters ($M = .94, SD = .06$). A nonsignificant main effect was found for treatment denial group status on number of quarterly treatment goals completed, Wilks lambda = .65, $p = .23$ (see Table 17)

Similar nonsignificant results were found for the PPG deviance differential scores calculated for Hypothesis 5 (see Table 18). Using the new treatment denial status as the independent variable and audio differential as the dependent variable resulted in a nonsignificant result, $F(2, 69) = .31, p > .50$. The ANOVA for the visual differential was also nonsignificant, $F(2, 67) = 1.49, p = .23$.

Noting that the treatment denial classifications resulted in contrary results to those found for the Kennedy and Grubin denial groups, the consistency across individual offenders between the classifications was calculated. A new variable (denial agreement) was created with two levels, consistent versus inconsistent, denial category classification. For example, if an offender was classified as an admitter from the legal information via the Kennedy and Grubin system and an admitter by the treatment staff, then this offender was classified as consistent. If the classification was different across the two variables, the offender was placed in the inconsistent category. A particular problem in creating this variable was the number of offenders with missing data in the individual

categories. Out of the 189 offenders, Kennedy and Grubin denial group classifications could not be established for 64 offenders. Similarly, treatment denial status was unavailable for 93 offenders. Using only those offenders where both denial classifications were available, the following n s were obtained; Consistent Deniers ($n = 14$), Consistent Admitters ($n = 13$), and Inconsistent ($n = 36$).

Similar nonsignificant results were obtained in reexamining Hypothesis 2 concerning MMPI clinical scales (see Table 20). Only Scale 7 resulted in a significant F -test, $F(2, 64) = 3.23, p = .03$. Post hoc analysis using a Duncan's multiple range test indicated that the Consistent Deniers ($M = 19.50$) scored significantly higher than either the Consistent Admitters ($M = 8.40$) and the Inconsistent group ($M = 12.67$). However, a significant MANOVA for the validity scales was found, Wilks lambda = .78, $p = .029$ (see Table 19). In addition, a nonsignificant main effect was found for MSI validity scales with the new denial variable, Wilks lambda = .95, $p > .50$ (see Table 21).

In re-examining treatment attendance and progress in treatment variables, A significant main effect was found for treatment progress, Wilks lambda, = .11, $p = .001$ (see Table 21). Univariate F -tests for the quarterly treatment goal variables indicate that none of the individual variables reached statistical significance. Extremely small cell sizes and little variability in the Consistent Deniers for Quarter #1 appears to have contributed to this significant main effect. In re-examining treatment attendance using the Denial Consistency as the

independent variable a similar nonsignificant result was obtained, Wilks lambda = .754, $p = .15$ (see Table 23).

Similar nonsignificant results were found for the PPG deviance differential scores calculated for Hypothesis 5 (see Table 24). Using Denial Consistency as the independent variable and audio differential as the dependent variable resulted in a nonsignificant result, $F(2, 21) = 1.94$, $p = .12$. An ANOVA for the visual differential was also nonsignificant, $F(2, 21) = 1.35$, $p = .28$.

Once again noting the dissimilar results found across all hypotheses, the denial variable was again reclassified into two groups, Consistent Admitters and Consistent Deniers. The rationale behind this final reclassification was that by eliminating the group of offenders who were inconsistent across their presentation to the legal system and treatment site, two extreme groups would likely be formed. The resulting n s for these two extreme groups were Consistent Deniers $n = 11$ and Consistent Admitters $n = 12$. No differences were found for MSI variables, Wilks lambda = .67, $p > .50$ (see Table 25). In examining the MMPI validity scales, a significant main effect emerged for the two group Denial classification, Wilks lambda = .840, $p = .034$. Table 26 provides descriptive statistics for the three MMPI validity scales for the two group Denial classifications. Results of univariate F -tests indicated a significant difference for the K Scale $F(1, 16) = 7.37$, $p = .015$ with the Consistent Admitters having higher K raw scores than the Consistent Deniers.

Utilizing the two group comparison resulted in a number of significant univariate F -tests for the MMPI clinical scales (see Table 27). Scale 1, 7, and 9 were significant, $F(1, 79) = 3.25, p = .04, F(1, 79) = 4.80, p = .01,$ and $F(1, 79) = 3.44, p = .04$ respectively. On both Scales the Consistent Deniers produced significantly higher raw scores than the Consistent Admitters. Scales 6 and 8 were marginally significant ($p < .10$).

In examining treatment progress and attendance variables, a significant main effect was found for the two group denial classification for treatment progress, Wilks lambda = .194, $p = .002$ (see Table 28). Similar to the result found using the three group classification, Univariate F -tests revealed nonsignificant results for individual treatment quarters. Although a main effect was found, the extremely small cell size and lack of variability in Quarter 1 appears to have contributed to the significant main effect. Analysis of attendance variables using the two group Denial classification as the independent variable produced nonsignificant results, Wilks lambda = .850, $p = .29$ (see Table 29).

Nonsignificant results were also obtained for PPG audio and visual deviance differential scores across the two groups. Visual deviance differentials were nonsignificant $F(1, 15) = .40, p > .50$. Audio deviance differentials were also nonsignificant $F(1, 15) = 3.39, p = .09$ (see Table 30).

On an exploratory basis, two stepwise discriminant function analyses were completed analyzing both the three group and two group Denial classifications.

The validity scales from both the MSI and the MMPI served as potential discriminant variables. Due to the extreme number of offenders with missing data from either of these tests only 47 cases were included in the first discriminant function analyzing the three group Denial classification. Results of the stepwise discriminant function yielded a significant function, Wilks lambda = .70, $\chi^2(2, 21) = 7.42$, $p = .02$. The canonical correlation was .55, indicating that the function accounted for a total of 30.25% of the variance in the three group Denial classification. The overall classification rate for the function was 54.17%. Although the function produced a statistically significant result, only one variable (K Scale) entered the function with the overall classification rate being modest at best.

Similar results were found for the two group Denial classification. Based on the results from the previous discriminant function analysis, it was expected that a similar significant function would be obtained with a higher classification rate. Results of this stepwise discriminant function yielded a significant function, Wilks lambda = .68, $\chi^2(1, 16) = 5.87$, $p = .01$. The canonical correlation was .56 indicating the function accounted for 31.36% of the variance in the two group Denial classification variable. The overall classification rate was 77.78%. Similar to the previous function, only the K Scale entered this function.

As a final effort at gaining a better understanding of the patterns across the validity scales of the MMPI and the MSI, a correlation matrix was generated (see Table 31). In order to get the most accurate picture, cases without data

were removed using a listwise deletion. Sixty-nine offenders had complete MSI and MMPI and were utilized for this analysis. In general, L and F showed significant correlations with the K Scale. The L Scale correlated only with the SSD Scale on the MSI; however, F and K significantly correlated with the CDI, Ju, and Dn scales from the MSI. The PPG audio and visual deviance differentials were also correlated with the MMPI and MSI validity scales. Correlations with the visual differential were all nonsignificant (correlations ranged from $r = -.15$ to $r = .01$). Similar nonsignificant correlations were found for the audio differential (correlations ranged from $r = -.26$ to $r = .15$).

CHAPTER IV

DISCUSSION

The results of the present study will be discussed by reviewing the specific hypotheses and exploratory research questions, organized by specific assessment instruments studied. This approach is utilized to ease interpretation and integration of the data. Hypotheses and research questions from the MMPI, MSI, and PPG will be discussed first. Treatment outcome variables will then be reviewed. Methodological and statistical limitations will then be addressed, with the final portion of the discussion devoted to the clinical implications of the results and suggestions for future research in this area.

MMPI

Lanyon and Lutz (1984) reported that when a valid criterion of denial was utilized, validity scales and indices were successful in identifying the type of denial. In the present study, no significant differences were found when offenders were divided into Kennedy and Grubin (1992) denial groups. The present study focused solely on differences in the three validity scales L, F, and K. Specifically considering each validity scale, little variance was found across the L scale (means across the four groups ranged from 5.43 to 6.50) with the Internalizers and Externalizers producing higher L raw scores than either Deniers

or Admitters; however, these scores were not significantly different. A similar pattern was found for the F scale (means ranged from 6.69 to 8.64) with Internalizers and Externalizers producing higher F raw scores. Although the main effect was not found, the hypothesized pattern of results was found concerning the F scale. A different pattern of results emerged for the K scale. Admitters and Externalizers produced the highest K raw scores (18.06 and 17.00 respectively). Contrary to the hypothesized direction, the Denier group produced the lowest K mean of 14.50. Substantial overlap was noted across the four groups with standard deviations ranging from 5.22 to 6.06.

Similar nonsignificant results were found when the Kennedy and Grubin classification scheme was broken down into three groups based on level of denial as presented to the treatment site and the two group consistency classifications. The three group denial classification produced similar nonsignificant results. However, when offenders were divided into Consistent Admitters and Consistent Deniers, significant differences were found. Results of the univariate analyses indicated that the Consistent Admitters had higher K raw scores than the Consistent Deniers.

The results found here are in direct contrast to the results found by Lanyon and Lutz (1984) concerning the three validity scales. First, the four group denial classification as outlined by Kennedy and Grubin (1992) showed nonsignificant differences across the three validity scales. Significance in the present study was only reached for the K scale when Consistent Deniers were

compared to Consistent Admitters. Even then, the results are counterintuitive and in the opposite direction of the original hypotheses. The first distinction that can be drawn from the present study and the Lanyon and Lutz (1984) study is that derivative validity indices were not investigated in this study. Lanyon and Lutz reported that the best discriminator between deniers and admitters was the validity index of $L + K - F$; however significance was achieved on all validity scales and derived indices. On an exploratory basis the $F-K$ index was measured across the Kennedy and Grubin and reconceptualized denial groups. Results of univariate analyses across the four denial independent variables produced nonsignificant results. A possible explanation for the results found here is that individuals who admit to their sexual offense may be more prone to responding defensively on the MMPI in order to present themselves as "normal" as possible under the circumstances. The perception may exist that endorsing psychopathology on the MMPI may result in further unwanted intervention and supervision within this population. However, the possibility of a random result, specific to the present population cannot be ruled out.

Lanyon (1993) investigated validity scales and specially derived indices of sexual deviance on the MMPI. Similar patterns of validity scores were found between admitters and nonadmitters in the Lanyon (1993) study compared to this sample concerning the L scale but not for scales F and K. Lower F scales and higher K scales were found for this sample compared to the Lanyon (1993) sample. An interesting result was obtained in the Lanyon (1993) study when

MMPI scales of admitters, nonadmitters, and controls were subjected to a factor analysis. A three factor solution emerged. The first factor was interpreted as reflecting admission versus denial; the second factor was interpreted as representing sexual deviance; and the third factor was specific to the L scale on the MMPI. Importantly, the K scale cross-loaded on all three factors. Lanyon (1993) interpreted the significant cross loadings of the K scale to indicate that sexual deviance was also susceptible to defensiveness on the MMPI. This result would assist in explaining the counterintuitive results found for the K scale between the consistent admitters and consistent deniers. Even when offenders admit to sexual deviance, defensiveness may be a prominent concern.

No specific hypotheses were supported for the MMPI clinical scales. Similar to the results of the validity scales, no significant differences were found across the Kennedy and Grubin (1992) groups on all clinical scales. An examination of the means and standard deviations in Tale 6 indicates very similar means across the four groups on all 10 clinical scales. The largest difference was obtained on Scale 7 with deniers producing raw scores 4 points higher than admitters with both Internalizers and Externalizers falling between these two groups. The denial reclassifications into the three group and two group comparisons produced similar nonsignificant results. In general the results found here are consistent with the conclusions reaching by Yanagida and Ching (1993) that no specific clinical profile can be identified for sex offenders. Similar results were obtained by Hall, Shepherd, and Mudrak (1992) in that

profiles did not differ as a function of arrests for sexual versus nonsexual offending. The Lanyon and Lutz (1984) study found significant differences on clinical scales *Mf*, *Pa*, *Pt*, *Sc*, and *Si*. The Lanyon and Lutz (1984) results indicate that admitters resulted in higher scores on these scales. In the McAnulty, Adams, and Wright (1994) study, which sought to predict group membership based on elevated and nonelevated PPG profiles, significant differences were also found on scales 7, 8, and 0. Results across these two studies appear to indicate that admitters and offenders who show deviant sexual arousal via plethysmography show heightened levels of anxiety compared to offenders who deny the offense or show nonelevated PPG indices. The opposite direction was found in the present study. Consistent Deniers produced the highest mean raw score on Scale 7. These results appear to represent one more differential result in the ongoing struggle to identify a clinical profile for sexual offenders on the MMPI (e.g., Murphy & Peters, 1992). In consideration of the results found for the *K* scale, it is possible that the elevation of this scale was context specific with the deniers expressing higher anxiety due to perceived pressures of court order treatment and probation. Results reported by McAnulty, Adams, and Wright (1994) indicated that higher *K* scores were associated with lower scores on Scale 7. A similar pattern was found in the present study. Considering the relation between *K* and Scale 7, it is possible that differences found on Scale 7 are a function of defensiveness.

MSI

Varying results were also obtained when examining specific a priori hypotheses for the MSI. It was hypothesized that group differences would be found between the Kennedy and Grubin (1992) denial classification groups on the Social Sexual Desirability, Cognitive Distortions and Immaturity, Denial, and Justifications scales. A significant main effect was not found across the four Kennedy and Grubin (1992) groups. The predicted pattern of scores was only found to exist in the hypothesized direction for the Social Sexual Desirability scale. However, an examination of the means reported in Table 7 for the SSD scale indicates that the differences between the four groups on these measures is negligible. When treatment indicators of denial were utilized as the independent variable, a significant main effect was found. Significant differences were found on the Denial Scale with the group of partial deniers (equated similar to the Kennedy and Grubin Externalizers and Internalizers) producing significantly higher Denial scale scores than both the Deniers and Admitters. When MSI validity scales were compared across the three group classification of Consistent Admitters, Consistent Deniers, and Inconsistent Deniers, no significant differences were obtained. Similarly when Consistent Deniers were compared to Consistent Admitters no significant differences were found.

The results found here, specifically for the Partial denial groups, appear to indicate that acknowledgment of involvement in the offense affects elevations on certain MSI indices. When offenders admit to participation in the offense, or to

certain elements of the offense, their overall level of denial (as expressed through the MSI Denial scale) is higher than offenders who openly admit or fully deny their offense. All three denial groups as classified via the treatment site indicators resulted in very similar Social Sexual Desirability scores. The MSI-II handbook (Nichols & Molinder, 1996) report that both the Denial and Social Sexual Desirability Scales are indicators of the reliability of the offender's self report on this inventory, with the SSD scale indicative of defensiveness. Within this sample there is very little differentiation in defensiveness across the groups. Noting that all three groups appeared to be responding in an equally defensive manner, it is not surprising that the specific scales of Cognitive Distortions and Immaturity and Justifications produced no significant differences across the groups.

Other researchers have noted significant differences based on level of denial on the scales used in the present study. Haywood et al. (1994) reported significant elevations of admitters over nonadmitters on the Justifications scale. However, Haywood et al. found no significant differences on either the SSD or CDI. The results found here are also generally consistent with results obtained by Simkins et al. (1989). Simkins et al. also found significant differences on the Justifications scale with the Admitters producing higher Justification scores than Deniers. Intuitively, it would seem that when an offender admits to commission and responsibility for the sexual offense, a heightened level of justifications might be endorsed to buffer social reprisal. Within the present study, admitters scored

more similarly to deniers (mean 3.54 and 3.04 respectively) on the Justification scale. However, the partial denial group produced a mean of 6.20. This result appears to indicate that when an offender presented at the treatment site and acknowledged some level of participation in the offense, then more justifications were offered to moderate the perceived culpability. The lack of differences found across the Kennedy and Grubin classification appears to indicate that denial presented to the legal system appears to have little effect on validity indices on the MSI. In general, the conclusion reached by Haywood et al. appears appropriate to apply to this sample, in that little differentiation in defensiveness is seen between admitters and nonadmitters. However, the partial admitters attempt to offer more justifications for the participation in the sexual offense.

Discrete denial indicators show mixed effectiveness in elucidating clear validity patterns across both the MSI and MMPI. An examination of the correlation table (Table 29) does provide some interesting indicators of the relations between the standard validity scales on the MMPI and validity patterns on the MSI. Nichols and Molinder (1996) provided a correlation matrix for MMPI and MSI variables from the restandardization sample for the MSI-II; similar correlations were found in the present study concerning the variables L, F, K, SSD, and CDI. First, Nichols and Molinder (1996) reported significant correlations between the MMPI F and K scales with the MSI CDI. Similar relations were found in the present study (see Table 29). The negative correlation between K and CDI and the positive correlation between F and CDI

appear to indicate a complex relation between admission of psychopathology and sexual deviance as measured by the CDI. Nichols and Molinder (1996) interpreted this pattern as follows: "the less defensive a sex offender is, the more likely the MSI scales reflecting his sexual pathology will be elevated" (p. 57). However, in the present study, similar negative correlations were also found between the two MMPI scales (F and K) and two other MSI indices (the Dn and Ju scales). Thus, these results appear to indicate that defensiveness, as measured by the MMPI K scale, is related to the following sexual offending indices: denial that a sexual offense took place (Dn scale), and also to the fact that cognitive distortions (CDI scale) and justifications (Ju scale) are offered. The reverse seems to hold for willingness to report psychopathology (i.e., MMPI F scale). When offenders produced higher F scores, higher scores were also found on the CDI, Dn, and Ju scales.

PPG

As noted in the introduction, phallometric testing is the preferred method of obtaining an "objective" measure of sexual arousal to varying stimuli. Most of the research with penile plethysmography has focused on differentiating between sexual offenders versus controls or deviant versus nondeviant profiles. Little is known about how level of denial influences PPG results. This study represents one of the first attempts to systematically examine this variable with both audio and visual results from plethysmograph assessment. It was hypothesized that a significant main effect would be found for the Kennedy and Grubin (1992) denial

classification groups with the Admitters and the Internalizers producing higher deviance differentials. When utilizing the Kennedy and Grubin classification scheme, neither the audio or visual deviance differentials differed across the four groups.

In interpreting the z -score differentials in Table 10, the larger z -score represent a larger deviance differential. A negative value indicates that the highest deviant category was larger than the mean arousal to adult consensual categories. Across the audio differential the pattern of results conforms to the hypothesized direction for the Internalizer group. Although Admitters produced higher mean audio differential than the Deniers, the Externalizer group mean was also greater than the Admitters. The visual differential produced very different results from the audio differential. Although the magnitude of the differential was similar across audio and visual categories for the Internalizers and Externalizers, the mean visual differential was positive. Admitters produced a similar visual differential in the same direction as the audio differential. The Deniers showed a very small visual differential. Denial presentation at the treatment level was not related to deviant arousal. Similarly, when denial was reclassified based on consistency into both the three group and two group classifications, nonsignificant results remained.

One possible explanation for the results is that denial presentation does not have an effect on the overall level of arousal during PPG assessment. Thus, the rationale presented by Quinsey and Earls (1990) may hold true that PPG

represents the best measure of sexual arousal even when other self-report measures indicate denial or dissimulation. However, Malcolm, Davidson, and Marshal (1985) have argued that offenders have the ability to bring their level of arousal under voluntary control. Unless the examiner is able to “catch” the offender at attempts to manipulate the test (see Sewell & Salekin, 1996), the only indication of possible dissimulation is the resulting PPG profile. Depending on the research question being asked, most researchers generally exclude PPG profiles from the analyses when less than 10% arousal is achieved (e.g., Grossman & Cavanaugh, 1990; Simkins et al., 1993); however, this quite possibly is excluding the very group that one is most interested in researching; namely deniers or partial deniers. Therefore, the present study did not exclude any profiles from the analyses. On an exploratory level, frequency tables for percentage arousal were examined for the adult categories across both the visual and audio categories. Across all offenders, 60% of the sample had lower than 10% arousal to the adult female visual category. Opposite results were found for the audio female adult consensual sex category. Over 60% of the sample had arousal over 10%. Thus, in interpreting the deviance differential results, the overall low level of arousal to the visual stimuli is a caveat that warrants further exploration.

Other researchers have attempted to focus on finding variables that predict elevated versus nonelevated profiles. McAnulty et al. (1994) was able to correctly classify deviant from nondeviant PPG profiles at 63.3% based on MMP!

scales. As previously mentioned Scales K and 7 contributed significantly to this significant discriminant function; however, the moderate classification rate and misclassification of 1/3 of the child molesters warrants caution in using such a function. Once again, offenders in the McAnulty et al. (1994) study were excluded from the analyses when less than 10% arousal was achieved.

The present study sheds little light onto the relationship between denial status and PPG results. The deviance differential quotient was chosen as the best scoring alternative in that the magnitude of the difference between the adult consensual categories and deviant categories would adequately reflect elevated and nonelevated arousal. However, null results were obtained. The only other indication of a potential relationship between denial group status and PPG patterns was the significant chi-square indicating a relationship between the Kennedy and Grubin (1992) groups and the examiners indication of validity of PPG results classified into three categories (valid, invalid, and possible dissimulation). The resulting crosstabulation matrix indicated that Admitters and Internalizers were more likely to have a rating indicating a valid profile. Deniers and Externalizers were more likely to have profiles rated as either invalid or with possible dissimulation. The criteria that appear to be utilized in making a determination of either possible dissimulation or invalidity are either less than 10% arousal or higher arousal response to the neutral visual stimuli. Another problem exacerbating this relation is that there is no other physiological measure of sexual arousal by which to judge the veracity of the PPG results. Thus, there

is no available criterion for distinguishing a denier who produces a nonelevated profile as invalidity based on dissimulation or truly nondeviant sexual arousal.

Treatment Variables

None of the research reviewed in the introduction of the present study specifically addressed denial status and treatment variables. The present study utilized information available from the offender treatment files to examine treatment progress as measured by the number of treatment goals completed per quarter (3 month time period). In addition, attendance was calculated for each quarter by documenting the number of groups attended divided by the number of groups scheduled. It was hypothesized that there would be a significant main effect for the Kennedy and Grubin groups for both attendance and progress in treatment. Separate analyses were run for progress in treatment and attendance with nonsignificant results found for both when the Kennedy and Grubin denial grouping were utilized. Examining the data reported in Table 8 reveals that attendance rates across the four groups never fell below 80% across the four measured treatment quarters. Surprisingly, across all four quarters, the Externalizers maintained the highest level of treatment attendance. The lack of significant differences across this variable is likely due to mandated attendance associated with this population. Offenders are court ordered into treatment with monthly attendance summaries sent by the treatment provider to the offenders supervising probation officer. Strong sanctions including probation revocation can result from the offender not attending treatment; therefore, regardless of

their level of admission or denial, maintaining attendance is likely viewed as very important to all the offenders. Supporting this idea, similar nonsignificant results were found when treatment denial was utilized as the independent variable. In addition, neither the three group consistency classification or the two group comparison of Consistent Admitters and Consistent Deniers produced significant results concerning the attendance variable.

It was hypothesized that the number of treatment goals completed per quarter would be a more sensitive measure of treatment participation and an indirect measure of treatment progress. When the Kennedy and Grubin denial groups were utilized as the independent variable, a nonsignificant result was obtained for progress in treatment across six quarters. Table 9 indicates that across the first three quarters of treatment, the number of treatment goals completed by each group was relatively equal. Contrary to the hypothesized direction, the Deniers and Internalizers completed more treatment goals in the 5th and 6th quarters than either Admitters or Externalizers; however, this result was not statistically significant. It is plausible that this result may be due to external scrutiny by the offenders' supervising probation officer, or threatened treatment termination by the treatment provider for lack of progress. Out of the four groups, the Externalizers appear to have completed goals more slowly than did the other three groups. When the treatment denial variable was utilized a significant main effect was found with the Admitters completing significantly more treatment goals in the first quarter of treatment than either the Deniers and

Partial Deniers. Although the next two quarters were nonsignificant, the same pattern was evident. These results are fairly consistent and intuitive concerning the treatment denial indicators. Individuals who admit to their offense appear more likely to begin work on their treatment plan than offenders who deny their offense.

Limitations of the Present Study

Across all the hypotheses tested, many of the main hypotheses were not confirmed by the statistical analyses. In addition, when significant results were found, some were in the opposite direction from that was hypothesized. A number of methodological limitations warrant review in order to gain further perspective on the results of the present study. First, the crux of this study was the careful assessment of the variables which contributed to the Kennedy and Grubin classification scheme. Although percentage agreement on the ratings for the questions were all above 80% with the majority being above 90%, a large number of the files did not have the requisite materials from which to gather this information. To investigate whether the availability of materials varied as a function of the various denial groups, chi-square analyses were run examining the relationship between the denial groups and the availability of CPS reports, Mirandized statements, and pre-sentence investigations. The presence of a Mirandized statement by the offender was significantly related to the data collectors ability to make the denial classifications.

A separate issue is whether the inability to make the denial classifications for many cases served as a confound for the findings regarding cases on which denial classifications were possible. The critical question is as follows: Are there systematic differences between offender files where denial classifications were unable to be made compared to offender files where the classifications were made. Similar chi-square analyses were completed to address this question. In developing two groups of offenders (denial rating available and denial rating unavailable) significant differences were found between the two groups concerning the PSI and Mirandized statements by the offender. Files that lacked the PSI and Mirandized statement were more likely to be eliminated because the denial classification could not be made. The question remains whether there were systematic reasons why these materials were missing from the files. It cannot be ruled out that the lack of this information represented some fundamental difference between the cases on which denial classification could versus could not be made. If so, the present findings might not be broadly applicable across the admission-denial spectrum.

Further reducing the sample, for many offenders who the Kennedy and Grubin classifications were made, assessment data was either missing from the file or made unavailable due to circumstances outside the control of either the researcher or the treatment provider. One can trace across the various reclassifications of the denial groups a consistent decrease in the n_s per cell. Although the F -statistic is robust to violations of normality, when cells sizes drop

below 20, caution is warranted in interpreting the results. Although moderate cell sizes were achieved for the Kennedy and Grubin denial groups, cell sizes below ten were common for the denial reclassification groups. This raises caution in making conclusive interpretations of the data, limiting the generalizability of the results found here.

Another limitation of this study that also relates to the clinical relevance of the present study is the operationalization of the Kennedy and Grubin (1992) groups and this denial conceptualization's applicability within this population. Aside from the issues concerning the availability of materials from which the classifications were based on, the original conceptualization by Kennedy and Grubin was a five group classification scheme. Among this sample and based on the availability of materials made available to the data coders, a group of Rationalizers was not found. It appears that within this population, this form of denial is not likely to be found. Kennedy and Grubin stated that rationalizers were more likely to admit to their offense but offered varied rationalizations for why the offense took place (e.g., "I was teaching my daughter how to have sex"). Arguably, considering the legal context in which this study took place, an admission at this level means acknowledging legal culpability as well as creating a perception of sexual deviance. A related issue is the original sample utilized by Kennedy and Grubin in creating this classificatory system. The sample they utilized was a heterogenous group of incarcerated sex offenders who had committed sexual offenses against both adults and children. One of the main

differences found across the original study was that gender and age of the victim appeared to vary across the five groups. The present study used a fairly homogenous group of sex offenders who had committed offenses against children. The rationale for limiting the sample was partially based on the characteristics of the available data; however, by restricting the variability of the population, it was hypothesized that type of denial would become a more salient discriminator. The last issue of concern in the applicability of the Kennedy and Grubin classification scheme is the temporal delay involved in making the denial determination. The researchers interviewed the incarcerated sex offenders in the original sample, post adjudication. In the present study, the materials from which the ratings were made, essentially dealt with pre-adjudication reports. Using Rogers and Dickey adaptational model approach, reasons for dissimulating at the pre-adjudication stage may be primarily to avoid prosecution and imposition of legal sanctions. However, once the legal sanction has been applied, reasons for engaging in denial may be more geared to denying deviant sexual preference as a way to avoid treatment or the social stigma of being labeled a sexual offender.

If any conclusion can be drawn concerning the results of this study, it is as follows: pre-adjudication admission or denial shows no relation with specific validity patterns on the assessment instruments utilized in the present study. It appears that one's level of admission or denial, regardless of the type of denial utilized, may be too far removed from the assessment process in order to exert

systematic influence on the response style of the offenders. Significant differences were found when indicators of denial during the initial treatment intake were utilized. On a broad level this suggests that temporal proximity may play a more important role in the assessment of denial. Specifically, treatment indicators of denial appear related to validity scales on the MSI. Partial admitters were more likely to endorse a significantly higher number of denial statements than either Admitters or Deniers. It appears that given their level of admission concerning the offense, the partial deniers responded to items on this scale in such a way to reflect their level of defensiveness. Using an adaptational explanation, the offenders may have endorsed items from the Denial scale that was consistent with their version of the offense in an effort to reflect consistency across their admissions during the treatment intake interview and actual assessment.

The temporal proximity issue becomes more complex in considering the results represented by comparing Consistent Admitters and Consistent Deniers on the MMPI. Consistent Admitters produced higher K scores than Consistent Deniers. Finding no differences between K scores across the Kennedy and Grubin groups may represent the lack of sensitivity of K to defensiveness within this population when quality of denial is the important issue. However, it seems counterintuitive that offenders who consistently admitted to the commission and responsibility of their offense would respond in a defensive manner on this inventory. A possible explanation for this includes examining K in relation to the

SSD from the MSI. Within this sample, all offenders elevated the SSD scale, indicating a tendency to present as a sexually appropriate individual. Individuals who consistently admitted to their offense may perceive more risk involved in endorsing pathological characteristics on the MMPI. This perspective is consistent with the socioevaluative model offered by Sewell and Salekin (1997). This model posits that offenders will “constrict” against the evaluation process and not engage in a cost/benefit analysis concerning their level of denial. Once the admission has taken place in multiple contexts, individuals who admit to their offense respond defensively across the two self-report inventories involved in the present study; however, they only appear significantly different on the K scale of the MMPI.

Suggestions for Future Research

There are a number of obvious limitations that could be overcome in efforts at replicating and extending this study. In first considering replication, the Kennedy and Grubin classification scheme should not be abandoned completely. The lack of significant results may be due to lack of availability of information and the homogeneous group of offenders tested. Future studies could utilize the Kennedy and Grubin model keeping the following caveats in mind. First, denial level as classified by the Kennedy and Grubin system should be measured at multiple time periods, during the legal investigation, at initial referral for treatment/assessment, and at a designated reference point in the treatment process. A temporal investigation of this nature should also involve a more

heterogenous group of offenders consisting of both offenders with child victims and offenders with adult victims. Issues of consistency in denial status could then be systematically investigated as well as isolating at what points the change takes place. This would also provide further evidence to differentiate the adaptational model from the socioevaluative model. Lack of change in admission or denial would appear to support the socioevaluative model, whereas multiple changes in denial stance may reflect the adaptational model.

The second caveat to consider in extending this study would be to update and expand the types of measures utilized. Considering the issue of defensiveness, the MSI appears to have limited ability to differentiate admitting from nonadmitting offenders. More sensitive measures of defensiveness need to be considered in relation to this instrument. Second, the MMPI has a rather dark history regarding its clinical utility with sex offenders. Other measures of psychopathology, whether they be self-report multiscale inventories, interviews, or observational measures, should be considered and their clinical utility explored.

Conclusions

There are four main conclusions that may be drawn from the present study. First, there does not appear to be specific response styles as measured by the MMPI and MSI associated with the Kennedy and Grubin denial classification groups. Second, the type of denial utilized (full denial, blaming external factors, or blaming internal factors) also does not appear to be

associated with specific response style on these inventories. Third, type of admission and consistency in denial status does appear to be related to level of denial on the MSI and defensiveness on the MMPI. Fourth, both the adaptational model offered by Rogers and Dickey (1991) and the socioevaluative model offered by Sewell and Salekin (1997) appear useful in conceptualizing denial when considering both the type of admission and denial consistency.

APPENDIX A
TABLES

Table 1

Percentage agreement on Kennedy & Grubin Denial Classification questions across three independent raters

<u>Question</u>	<u>Agreement</u>	<u>Disagreement</u>	<u>% Agreement</u>
Offense	25	1	96.15%
Responsibility	24	2	92.31%
Internal Attribution	21	5	80.77%
External Attribution	23	3	84.61%
Preference	26	0	100.00%
Effect	24	2	92.31%
Social Sanction	24	2	92.31%

Note. Ratings on each variable are listed in Appendix B.

Table 2

Summary of demographic information for denial groups

	<u>Denier</u> n = 33	<u>Admitter</u> n = 38	<u>Internalizer</u> n = 25	<u>Externalizer</u> n = 29
Age	34.27 (10.38)	34.90 (8.38)	34.63 (8.47)	31.00 (9.08)
Monthly reported Income at probation intake	1153.63 (988.75)	2012.11 (4035.18)	1506.71 (1150.06)	877.38 (985.76)
Highest grade completed	11.34 (2.30)	12.17 (2.88)	11.89 (3.14)	11.56 (1.50)
Number of job changes	2.54 (2.56)	3.31 (2.99)	3.05 (6.52)	3.88 (4.52)
Longest job held (in months)	37.50 (37.91)	29.34 (24.55)	32.26 (21.85)	30.04 (22.49)

Note. Standard deviations reported in parentheses below means.

Table 3

Summary of offense related variables across denial groups

	<u>Denier</u> n = 33	<u>Admitter</u> n = 38	<u>Internalizer</u> n = 25	<u>Externalizer</u> n = 29
Victim age	10.48 (4.23)	10.54 (3.67)	12.16 (3.29)	13.07 (2.48)
Number of victims	1.18 (.46)	2.42 (4.35)	1.24 (1.24)	1.62 (2.78)

Note. Standard deviations reported in parentheses below means.

Table 4

Summary of categorical offense variables by denial group

	χ^2	df	p
Offense	13.30	12	.34
Victim gender	1.67	3	> .50
History of extrafamilial victim	.91	3	> .50
History of intrafamilial victim	2.83	3	> .50
Relationship with current victim	7.95	3	.05

Table 5

Frequencies for victim status by denial group

<u>Victim Status</u>	<u>Denier</u> n = 33	<u>Admitter</u> n = 38	<u>Internalizer</u> n = 25	<u>Externalizer</u> n = 29
Intrafamilial (n = 72)	18	27	16	11
Extrafamilial (n = 53)	15	11	9	18

Table 6

Descriptives and F-values for MMPI validity scales by denial group

	<u>Denier</u> n = 16	<u>Admitter</u> n = 16	<u>Internalizer</u> n = 9	<u>Externalizer</u> n = 14	F	df	p
L Scale	5.43 (2.39)	5.88 (3.34)	6.11 (2.71)	6.50 (2.71)	.36	3, 51	> .50
F Scale	6.81 (3.65)	6.69 (4.47)	8.56 (5.94)	8.64 (6.80)	.57	3, 51	> .50
K Scale	14.50 (5.89)	18.06 (5.22)	16.44 (5.60)	17.00 (6.06)	1.10	3, 51	.36

Note. L Scale = Lie Scale; F Scale = Atypical Response; K Scale = Defensiveness. Standard deviations reported below the means. Wilks lambda from overall MANOVA = .87, $p > .50$

Table 7

Descriptives and F-values for MMPI clinical scales by denial group

	<u>Denier</u> n = 16	<u>Admitter</u> n = 16	<u>Internalizer</u> n = 9	<u>Externalizer</u> n = 14	F	df	p
Scale 1	6.93 (6.69)	6.00 (4.26)	7.22 (4.87)	6.43 (4.07)	.14	3, 51	> .50
Scale 2	23.94 (7.18)	22.31 (5.28)	22.55 (3.57)	23.78 (3.74)	.35	3, 51	> .50
Scale 3	23.31 (5.64)	22.56 (3.10)	22.55 (4.33)	23.78 (5.28)	.22	3, 51	> .50
Scale 4	20.25 (5.80)	20.81 (4.46)	20.55 (3.88)	22.64 (6.21)	.58	3, 51	> .50
Scale 5	29.37 (3.83)	28.44 (3.22)	27.11 (5.67)	26.71 (4.07)	1.27	3, 51	.29
Scale 6	13.75 (4.40)	12.31 (2.52)	12.33 (4.58)	13.00 (3.90)	.45	3, 51	> .50
Scale 7	14.56 (10.12)	10.19 (6.74)	12.67 (10.14)	12.36 (8.20)	.67	3, 51	> .50

(Table Continues)

Table 7

Descriptives and F-values for MMPI clinical scales by denial group (continued)

	<u>Denier</u> n = 16	<u>Admitter</u> n = 16	<u>Internalizer</u> n = 9	<u>Externalizer</u> n = 14	F	df	p
Scale 8	15.06 (13.37)	13.31 (8.12)	16.56 (10.43)	14.36 (11.38)	.18	3, 51	> .50
Scale 9	16.87 (5.14)	15.86 (3.61)	18.00 (5.29)	17.28 (5.98)	.39	3, 51	> .50
Scale 0	31.19 (10.18)	29.06 (7.99)	30.11 (10.78)	27.64 (7.78)	.40	3, 51	> .50

Note. Scale 1 = Hypochondriasis; Scale 2 = Depression; Scale 3 = Hysteria; Scale 4 = Psychopathic Deviate; Scale 5 = Masculinity-Femininity; Scale 6 = Paranoia; Scale 7 = Psychasthenia; Scale 8 = Schizophrenia; Scale 9 = Hypomania; Scale 0 = Social Introversion. All standard deviations reported in parentheses below means.

Table 8

Descriptives and F-values for MSI validity scales by denial group

	<u>Denier</u> n = 19	<u>Admitter</u> n = 17	<u>Internalizer</u> n = 14	<u>Externalizer</u> n = 17	<u>F</u>	<u>df</u>	<u>p</u>
SSD	20.16 (8.79)	20.29 (8.36)	21.21 (6.61)	21.06 (7.48)	.07	3, 63	> .50
CDI	5.56 (3.83)	5.82 (3.52)	4.93 (4.60)	5.59 (5.64)	.11	3, 63	> .50
Dn	7.52 (5.18)	7.26 (4.63)	8.21 (4.19)	7.94 (4.07)	.14	3, 63	> .50
Ju	4.58 (6.11)	3.29 (4.06)	3.86 (5.10)	4.59 (3.71)	.31	3, 63	> .50

Note. SSD = Social Sexual Desirability; CDI = Cognitive Distortion and Immaturity; Dn = Denier; Ju = Justification. Standard deviations reported in parentheses below means. Wilks lambda from overall MANOVA = .95, $p > .50$.

Table 9

Descriptive and F-values for group attendance by denial group

	<u>Denier</u> n = 12	<u>Admitter</u> n = 14	<u>Internalizer</u> n = 8	<u>Externalizer</u> n = 9	<u>F</u>	<u>df</u>	<u>p</u>
Quarter 1	.77 ^a (.18)	.89 ^b (.07) ^c	.87 ^b (.13)	.90 ^b (.10)	2.87	3, 39	.04
Quarter 2	.87 (.11)	.92 (.07)	.91 (.10)	.94 (.07)	1.41	3, 39	.25
Quarter 3	.91 (.09)	.89 (.10)	.95 (.07)	.94 (.06)	.90	3, 39	.45
Quarter 4	.92 (.09)	.89 (.12)	.93 (.07)	.92 (.10)	.31	3, 39	> .50

Note. Standard deviations reported in parentheses below means. Wilks lambda from overall MANOVA = .68, $p = .28$. Superscripts denote significant differences between groups.

Table 10

Descriptives and F-values for number of quarterly treatment goals completed by denial group

	<u>Denier</u> n = 5	<u>Admitter</u> n = 6	<u>Internalizer</u> n = 5	<u>Externalizer</u> n = 2	F	df	p
Quarter 1	4.60 (2.19)	3.17 (2.04)	3.40 (2.30)	4.50 (.71)	.55	3, 14	> .50
Quarter 2	3.20 (1.48)	3.17 (2.04)	3.60 (2.41)	4.50 (.71)	.27	3, 14	> .50
Quarter 3	5.00 (2.83)	5.67 (2.66)	3.80 (2.59)	4.00 (1.41)	.53	3, 14	> .50
Quarter 4	8.20 (4.92)	8.50 (3.73)	7.00 (1.58)	4.50 (.71)	.73	3, 14	> .50
Quarter 5	12.00 (4.30)	9.00 (3.69)	10.20 (4.92)	8.00 (1.41)	.66	3, 14	> .50
Quarter 6	13.40 (6.15)	11.67 (6.95)	13.40 (5.81)	8.50 (2.12)	.38	3, 14	> .50

Note. Standard deviations reported in parentheses below means. Wilks lambda from overall MANOVA = .24, p > .50.

Table 11

Frequencies for PPG validity indicators by denial group

<u>Validity Indicator</u>	<u>Denier</u> n = 25	<u>Admitter</u> n = 23	<u>Internalizer</u> n = 16	<u>Externalizer</u> n = 20
Valid (n = 43)	9	18	9	7
Invalid (n = 6)	2	0	2	2
Possible Dissimulation (n = 35)	14	5	5	11

Table 12

Descriptives and F-values for standardized audio and visual deviance differential scores by denial group

	<u>Denier</u> n = 23	<u>Admitter</u> n = 23	<u>Internalizer</u> n = 14	<u>Externalizer</u> n = 20	<u>F</u>	<u>df</u>	<u>p</u>
Audio	-.24 (1.52)	-.28 (1.78)	-.36 (1.64)	-.32 (1.62)	.023, 79		> .50
Visual	-.03 (1.71)	-.26 (1.62)	.23 (1.47)	.13 (1.91)	.333, 79		> .50

Note. Standard deviations reported in parentheses below means.

Table 13

Descriptives and F-values for MMPI validity scales by treatment denial

	<u>Denier</u> n = 19	<u>Admitter</u> n = 41	<u>Partial</u> n = 7	E	df	p
L Scale	5.21 (2.25)	6.43 (2.61)	5.86 (3.34)	.03	2, 64	> .50
F Scale	7.26 (6.35)	7.22 (5.44)	6.71 (4.68)	1.02	2, 64	.36
K Scale	16.11 (6.78)	18.00 (4.74)	15.71 (6.87)	1.47	2, 64	.24

Note. L Scale = Lie Scale; F Scale = Atypical Response; K Scale = Defensiveness. Standard deviations reported below the means. Wilks lambda from overall MANOVA = .93, $p > .50$.

Table 14

Descriptives and F-values for MMPI clinical scales by treatment denial

	<u>Denier</u> n = 19	<u>Admitter</u> n = 41	<u>Partial</u> n = 7	F	df	p
Scale 1	8.58 ^a (6.89)	4.78 ^b (3.76)	6.43 ^b (4.28)	3.95	2, 64	.02
Scale 2	24.58 (6.94)	21.90 (4.15)	22.57 (3.95)	1.81	2, 64	.17
Scale 3	25.05 (6.17)	22.80 (3.85)	23.57 (2.88)	1.58	2, 64	.21
Scale 4	21.95 (5.84)	20.80 (5.08)	19.86 (3.13)	.52	2, 64	> .50
Scale 5	28.05 (4.50)	28.07 (3.98)	27.57 (3.65)	.05	2, 64	> .50
Scale 6	13.11 (4.90)	12.20 (3.14)	11.86 (2.91)	.48	2, 64	> .50
Scale 7	13.95 (9.94)	9.43 (7.23)	10.6 (7.23)	1.31	2, 64	.28
Scale 8	15.21 (13.64)	12.43 (8.22)	17.21 (9.73)	.71	2, 64	.49
Scale 9	17.21 (4.58)	15.63 (4.32)	17.00 (4.86)	.93	2, 64	.40
Scale 0	31.10 (10.04)	28.34 (8.40)	27.71 (7.97)	.72	2, 64	.49

Note. Scale 1 = Hypochondriasis; Scale 2 = Depression; Scale 3 = Hysteria; Scale 4 = Psychopathic Deviate; Scale 5 = Masculinity-Femininity; Scale 6 = Paranoia; Scale 7 = Psychasthenia; Scale 8 = Schizophrenia; Scale 9 = Hypomania; Scale 0 = Social Introversion. All standard deviations reported in parentheses below means.

Table 15

Descriptives and F-values for MSI validity scales by treatment denial

	<u>Denier</u> n = 27	<u>Admitter</u> n = 59	<u>Partial</u> n = 10	E	df	p
SSD	20.60 (8.04)	22.71 (6.86)	19.70 (6.15)	1.29	2, 93	.28
CDI	5.67 (4.44)	4.49 (3.52)	5.60 (3.98)	1.03	2, 93	.36
Dn	7.44 ^a (5.03)	6.42 ^a (3.58)	11.20 ^b (3.05)	6.18	2, 93	.003
Ju	3.04 (4.16)	3.54 (4.23)	6.20 (4.32)	2.13	2, 93	.13

Note. SSD = Social Sexual Desirability; CDI = Cognitive Distortion and Immaturity; Dn = Denier; Ju = Justification. Standard deviations reported in parentheses below means. Wilks lambda from overall MANOVA = .83, $p > .03$.

Table 16

Descriptives and F-values for treatment attendance by treatment denial

	<u>Denier</u> n = 8	<u>Admitter</u> n = 16	<u>Partial</u> n = 4	F	df	p
Quarter 1	.89 (.09)	.87 (.15)	.84 (.07)	.52	2, 58	> .50
Quarter 2	.92 (.07)	.92 (.08)	.90 (.08)	.18	2, 58	> .50
Quarter 3	.89 (.08)	.94 (.06)	.96 (.03)	3.34	2, 58	.04
Quarter 4	.91 (.07)	.93 (.09)	.95 (.06)	.41	2, 58	> .50

Note. Standard deviations reported in parentheses below means. Wilks lambda from overall MANOVA = .86, $p = .38$. Superscripts denote significant differences between groups.

Table 17

Descriptives and F-values for quarterly treatment progress by treatment denial

	<u>Denier</u> n = 9	<u>Admitter</u> n = 16	F	df	p
Quarter 1	4.87 (1.73)	3.37 (1.93)	3.34	1, 22	.07
Quarter 2	4.50 (2.93)	3.50 (2.00)	.97	1, 22	.33
Quarter 3	5.13 (3.44)	4.75 (2.46)	.09	1, 22	> .50
Quarter 4	7.75 (5.15)	7.13 (3.58)	.12	1, 22	> .50
Quarter 5	10.88 (5.71)	8.58 (4.38)	1.08	1, 22	.31
Quarter 6	14.38 (6.21)	10.31 (6.10)	2.33	1, 22	.14

Note. Standard deviations reported in parentheses below means. Wilks lambda from overall MANOVA = .65, p = .23.

Table 18

Descriptives and F-values for standardized audio and visual deviance differential scores by treatment denial

	<u>Denier</u> n = 16	<u>Admitter</u> n = 44	<u>Partial</u> n = 10	F	df	p
Audio	-.03 (1.75)	-.39 (1.72)	-1.21 (1.63)	1.49	2, 67	.23
Visual	-.09 (1.41)	.08 (1.75)	-.38 (2.28)	.31	2, 67	> .50

Note. Standard deviations are reported in parentheses under means.

Table 19

Descriptives and F-values for MMPI clinical scales by 3 group denial consistency

	<u>Consistent</u> <u>Denier</u> n = 11	<u>Consistent</u> <u>Admitter</u> n = 11	<u>Inconsistent</u> n = 23	F	df	p
Scale 1	10.00 (7.93)	4.80 (3.08)	6.00 (5.83)	2.16	2, 64	.10
Scale 2	25.50 (6.32)	21.70 (5.06)	24.17 (6.33)	1.60	2, 64	.20
Scale 3	25.50 (6.32)	23.10 (2.77)	20.00 (4.86)	1.49	2, 64	.22
Scale 4	22.87 (4.79)	21.20 (5.67)	18.83 (5.45)	.75	2, 64	.52
Scale 5	29.37 (4.66)	27.50 (3.44)	28.50 (2.51)	.29	2, 64	.82
Scale 6	15.25 (5.94)	11.60 (2.41)	12.50 (1.05)	1.71	2, 64	.17
Scale 7	19.50 ^a (11.56)	8.40 ^b (5.36)	12.67 ^b (4.36)	3.23	2, 64	.03
Scale 8	21.37 (13.64)	11.60 (8.22)	19.50 (9.73)	1.94	2, 64	.07
Scale 9	17.21 (4.58)	15.63 (4.32)	17.00 (4.86)	.93	2, 64	.40
Scale 0	34.50 (10.04)	26.20 (8.40)	33.67 (7.97)	1.98	2, 64	.12

Note. Scale 1 = Hypochondriasis; Scale 2 = Depression; Scale 3 = Hysteria; Scale 4 = Psychopathic Deviate; Scale 5 = Masculinity-Femininity; Scale 6 = Paranoia; Scale 7 = Psychasthenia; Scale 8 = Schizophrenia; Scale 9 = Hypomania; Scale 0 = Social Introversion. All standard deviations reported in parentheses below means.

Table 20

Descriptives and F-values for MMPI validity scales by 3 group denial consistency

	<u>Consistent Denier</u> n = 11	<u>Consistent Admitter</u> n = 11	<u>Inconsistent</u> n = 23	F	df	p
L Scale	5.64 (2.06)	6.90 (3.30)	6.18 (2.71)	.62	2, 42	> .50
F Scale	6.45 (4.48)	6.55 (5.04)	7.49 (6.16)	.68	2, 42	> .50
K Scale	14.36 (7.11)	18.82 (4.87)	16.39 (5.06)	1.76	2, 42	.18

Note. L Scale = Lie Scale; F Scale = Atypical Response; K Scale = Defensiveness. Standard deviations reported below the means. Wilks lambda from overall MANOVA = .78, p = .03.

Table 21

Descriptives and F-values for MSI scales by 3 group denial consistency

	<u>Consistent Denier</u> n = 14	<u>Consistent Admitters</u> n = 13	<u>Inconsistent</u> n = 36	F	df	p
SSD	19.21 (9.40)	20.31 (9.70)	21.44 (7.76)	.43	2, 60	> .50
CDI	4.78 (4.56)	4.62 (2.36)	5.58 (4.41)	.36	2, 60	> .50
Dn	7.93 (4.57)	7.46 (4.11)	7.81 (4.46)	.04	2, 60	> .50
Ju	3.36 (5.01)	2.52 (3.43)	4.58 (5.07)	.82	2, 60	.44

Note. SSD = Social Sexual Desirability; CDI = Cognitive Distortion and Immaturity; Dn = Denier; Ju = Justification. Standard deviations reported in parentheses below means. Wilks lambda from overall MANOVA = .95, $p > .50$.

Table 22

Descriptives and F-values for treatment attendance by 3 group denial consistency

	<u>Consistent Denier</u> n = 8	<u>Consistent Admitter</u> n = 11	<u>Inconsistent</u> n = 20	F	df	p
Quarter 1	.87 (.10)	.89 (.13)	.86 (.13)	.53	2, 36	> .50
Quarter 2	.88 (.08)	.93 (.05)	.91 (.08)	.83	2, 36	.44
Quarter 3	.91 (.10)	.92 (.05)	.93 (.08)	.41	2, 36	> .50
Quarter 4	.90 (.10)	.89 (.12)	.95 (.05)	.21	2, 36	.08

Note. Standard deviations reported in parentheses under means. Wilks lambda from overall MANOVA = .75, p = .15.

Table 23

Descriptives and F-values for treatment progress by 3 group denial consistency

	<u>Consistent Denier</u> n = 3	<u>Consistent Admitter</u> n = 6	<u>Inconsistent</u> n = 9	<u>F</u>	<u>df</u>	<u>p</u>
Quarter 1	6.00 (0.00)	3.17 (2.04)	3.44 (2.02)	2.65	2, 15	.10
Quarter 2	3.33 (2.93)	3.17 (2.00)	3.67 (2.06)	.13	2, 15	> .50
Quarter 3	5.00 (2.65)	5.67 (2.66)	4.11 (2.47)	.68	2, 15	> .50
Quarter 4	7.00 (5.20)	8.50 (3.73)	7.11 (3.02)	.31	2, 15	> .50
Quarter 5	12.33 (5.51)	9.00 (3.69)	10.00 (4.02)	.66	2, 15	> .50
Quarter 6	16.33 (6.50)	11.67 (6.95)	11.33 (4.87)	.87	2, 15	.44

Note. Standard deviations are reported in parentheses under means. Wilks lambda from overall MANOVA = .11, p = .001.

Table 24

Descriptives and F-values for standardized audio and visual deviance differential scores by 3 group denial consistency

	<u>Consistent Denier</u> n = 8	<u>Consistent Admitter</u> n = 8	<u>Inconsistent</u> n = 6	F	df	p
Audio	.22 (1.28)	-1.17 (1.72)	.25 (1.84)	1.22	2, 67	.30
Visual	-.18 (1.81)	-.75 (1.82)	.67 (.75)	.91	2, 67	.44

Note. Standard deviations are reported in parentheses under means.

Table 25

Descriptives and F-values for MSI scales by denial agreement

	<u>Consistent Denier</u> n = 11	<u>Consistent Admitters</u> n = 12	F	df	p
SSD	18.81 (10.22)	19.67 (9.84)	1.79	1, 97	.17
CDI	5.82 (4.64)	4.50 (2.43)	.29	1, 97	.30
Dn	7.54 (5.12)	7.08 (4.05)	.04	1, 97	> .50
Ju	4.00 (5.62)	2.67 (3.57)	.44	1, 97	> .50

Note. SSD = Social Sexual Desirability; CDI = Cognitive Distortion and Immaturity; Dn = Denier; Ju = Justification. Standard deviations reported in parentheses below means. Wilks lambda from overall MANOVA = .67, $p > .50$.

Table 26

Descriptives and F-values for MMPI validity scales by denial agreement

	<u>Consistent Denier n = 12</u>	<u>Consistent Admitter n = 11</u>	F	df	p
L Scale	5.25 (2.05)	7.40 (3.03)	1.93	2, 79	.13
F Scale	7.50 (4.60)	6.40 (5.30)	.13	2, 79	> .50
K Scale	11.41 (6.25)	19.00 (5.10)	4.92	2, 79	.01

Note. L Scale = Lie Scale; F Scale = Atypical Response; K Scale = Defensiveness. Standard deviations reported below the means. Wilks lambda from overall MANOVA = .84, $p = .03$.

Table 27

Descriptives and F-values for MMPI clinical scales by denial agreement

	<u>Consistent Denier</u> n = 8	<u>Consistent Admitter</u> n = 10	F	df	p
Scale 1	10.00 (7.93)	4.80 (3.08)	3.25	2, 79	.04
Scale 2	25.50 (6.32)	21.70 (2.77)	1.82	2, 79	.17
Scale 3	25.00 (6.32)	23.10 (2.77)	.73	2, 79	.48
Scale 4	22.87 (4.79)	21.20 (5.67)	.72	2, 79	.48
Scale 5	29.38 (4.66)	27.50 (3.40)	.43	2, 79	> .50
Scale 6	15.25 (5.95)	11.60 (2.41)	2.59	2, 79	.08
Scale 7	19.50 (11.56)	8.40 (5.36)	4.80	2, 79	.01
Scale 8	21.37 (16.32)	11.60 (7.17)	2.77	2, 79	.07
Scale 9	20.00 (3.42)	16.40 (3.72)	3.44	2, 79	.04
Scale 0	34.50 (10.59)	26.20 (4.80)	2.05	2, 79	.14

Note. Scale 1 = Hypochondriasis; Scale 2 = Depression; Scale 3 = Hysteria; Scale 4 = Psychopathic Deviate; Scale 5 = Masculinity-Femininity; Scale 6 = Paranoia; Scale 7 = Psychasthenia; Scale 8 = Schizophrenia; Scale 9 = Hypomania; Scale 0 = Social Introversion. All standard deviations reported in parentheses below means.

Table 28

Descriptives and F-values for treatment progress by denial agreement

	<u>Consistent Denier</u> n = 3	<u>Consistent Admitter</u> n = 6	F	df	p
Quarter 1	6.00 (.00)	3.17 (2.04)	2.61	2, 22	.10
Quarter 2	3.33 (.58)	3.17 (2.04)	.43	2, 22	> .50
Quarter 3	5.00 (2.65)	5.67 (2.66)	.43	2, 22	> .50
Quarter 4	7.00 (5.20)	8.50 (3.73)	.39	2, 22	> .50
Quarter 5	12.33 (5.51)	9.00 (3.69)	.70	2, 22	> .50
Quarter 6	16.33 (6.50)	11.67 (6.95)	1.15	2, 22	.09

Note. Standard deviations are reported in parentheses under means. Wilks lambda from overall MANOVA = .19, $p = .002$.

Table 29

Descriptives and F-values for treatment attendance by denial agreement

	<u>Consistent Denier</u> n = 6	<u>Consistent Admitter</u> n = 10	F	df	p
Quarter 1	.84 (.09)	.92 (.05)	1.19	2, 62	.31
Quarter 2	.86 (.08)	.95 (.04)	2.46	2, 62	.09
Quarter 3	.88 (.11)	.92 (.05)	.86	2, 62	.43
Quarter 4	.86 (.09)	.89 (.13)	2.30	2, 62	.11

Note. Standard deviations reported in parentheses under means. Wilks lambda from overall MANOVA = .85, p = .29.

Table 30

Descriptives and F-values for standardized audio and visual deviance differential by denial agreement

	<u>Consistent Denier</u> n = 8	<u>Consistent Admitter</u> n = 8	F	df	p
Audio	.22 (1.27)	-1.17 (1.72)	1.39	2, 120	.12
Visual	-.18 (1.81)	-.75 (1.82)	.96	2, 120	.39

Note. Standard deviations reported in parentheses under means.

Table 31

Correlation matrix of MMPI and MSI validity scales

	<u>L</u>	<u>F</u>	<u>K</u>	<u>SSD</u>	<u>CDI</u>	<u>Dn</u>	<u>Ju</u>
<u>L</u>	1.00	.15	<u>.40**</u>	<u>-.48**</u>	-.19	.02	.06
<u>F</u>		1.00	<u>-.38**</u>	-.14	<u>.56**</u>	<u>.27</u>	<u>.33*</u>
<u>K</u>			1.00	-.02	<u>-.65**</u>	<u>-.27</u>	<u>-.40*</u>
<u>SSD</u>				1.00	-.05	<u>-.32**</u>	-.12
<u>CDI</u>					1.00	<u>.40**</u>	<u>.35*</u>
<u>Dn</u>						1.00	<u>.36*</u>
<u>Ju</u>							1.00

Note. L = MMPI Lie Scale; F = MMPI F Scale; K = MMPI K Scale; SSD = MSI Social Sexual Desirability; CDI = MSI Cognitive Distortions and Immaturity; Dn = MSI Denial Scale; Ju = MSI Justifications Scale. Significant correlations $p < .05$ are underlined.

* = significance $p < .005$

** = significance $p < .001$

APPENDIX B
DATA COLLECTION FORMS

Kennedy and Grubin (1992)
Denial Classification Questions and Ratings

Offense

- 0 Fully admits offense as charged
- 1 Partial denial - claims victim consented
- 2 Denies offense completely
- 9 No information to rate

Responsibility

- 0 Accepts full responsibility
- 1 Accepts partial responsibility only e.g. was led on by victim or under peer pressure
- 2 Denies responsibility completely
- 9 No information to rate

Internal Attribution

- 0 Accepts internal responsibility - no mitigating internal factors
- 1 Claims offense out of character
- 2 Denial of internal responsibility e.g. drunk, under stress, depressed
- 9 No information to rate

External Attribution

- 0 No blame of third parties
- 1 Blames remote factors e.g., upbringing
- 2 Blames proximate factors e.g., wife, employer
- 9 No information to rate

Preference

- 0 Says offense arose from sexual preferences
- 1 Admits paraphilic interest, but denies relevance to offense
- 2 Denies any deviant preference
- 9 No information to rate

Effect

- 0 Acknowledges harm to victim
- 1 Denies harm to victim
- 2 Claims to have helped victim
- 9 No information to rate

Social Sanction

- 0 Regards offense as deserving sentence like that received
- 1 Believes sentences generally too harsh for type of offense
- 2 Believes type of offense should not be against law
- 9 No information to rate

SEX OFFENDER ARCHIVAL DATA COLLECTION SHEET

(use -9 for any missing data)

- _____ 1. Date file reviewed _____
- _____ 2. File Status (1=active; 2=closed)
- _____ 3. Study code number
- _____ 4. County identification number
- _____ 5. Probation supervisor code
- _____ 6. Offender gender (1=male; 2=female)
- _____ 7. Offender age at time of intake (in years)
- _____ 8. Ethnicity (1=European-American; 2=African-American; 3=Asian-American; 4=Hispanic; 5=Other _____)
- _____ 9. Last grade completed (list grade level)
- _____ 10. Last calendar year in school
- _____ 11. Attended technical school (1=yes; 2=no)
- _____ 12. Attended college (1=yes; 2=no)
- _____ 13. Occupation _____
- _____ 14. Number of job changes noted in file
- _____ 15. Longest position held (in months; -9=unable to determine from file review)
- _____ 16. Income at intake (per month)
- _____ 17. Income at review (per month)
- _____ 18. Military service (1=yes; 2=no; -9=unknown)
- _____ 19. If military service =1; Type of Discharge (1=honorable; 2=dishonorable; -9=unknown or no military service)
- _____ 20. If military service =1; Months of service
- _____ 21. If military service =1; Age at discharge
- _____ 22. Current marital status (1=Married; 2=Divorced; 3=Separated; 4=Single)
- _____ 23. Current cohabitation with non-spouse (1=yes; 2=no)

- _____ 24. Number of marriages
- _____ 25. Number of male children
- _____ 26. Age of youngest male child
- _____ 27. Age of oldest male child
- _____ 28. Number of female children
- _____ 29. Age of youngest female child
- _____ 30. Age of oldest female child
- _____ 31. Number of male children living with offender at time of offense
- _____ 32. Number of female children living with offender at time of offense
- _____ 33. Number of changes in residence since beginning probation

Status Information

- _____ 34. Offense _____ (list the offense charged)
- _____ 35. Offense classification (1=violent; 2=nonviolent)
- _____ 36. Status of offense (1=deferred; 2=adjudicated)
- _____ 37. Age of victim
(1)_____ (2)_____ (3)_____ (4)_____ (5)_____
- _____ 38. Gender of victim (1=male; 2=female)
(1)_____ (2)_____ (3)_____ (4)_____ (5)_____
- _____ 39. Relationship status of victim to the offender (1=intrafamilial;
2=extrafamilial)
(1)_____ (2)_____ (3)_____ (4)_____ (5)_____

- _____ 40. If #39 = extrafamilial (1=known to the offender; 2=unknown to the offender)
(1)_____ (2)_____ (3)_____ (4)_____ (5)_____
- _____ 41. Number of victims (all known victims)
- _____ 42. Age of youngest male victim
- _____ 43. Age of oldest male victim
- _____ 44. Age of youngest female victim
- _____ 45. Age of oldest female victim
- _____ 46. History of intrafamilial victim (1=yes; 2=no)
- _____ 47. History of extrafamilial victim (1=yes; 2=no)
- _____ 48. History of extrafamilial victim not known to the offender (1=yes; 2=no)
- _____ 49. Offender ordered to pay restitution (1=yes; 2=no)
- _____ 50. Offender ordered to complete community service (1=yes; 2=no)
- _____ 51. Offender ordered into sex offender treatment (1=yes; 2=no)
- _____ 52. Prior adjudication(s) for violent sexual offense(s) (1=yes; 2=no)
- _____ 53. Prior adjudication(s) for nonviolent sexual offense(s) (1=yes; 2=no)
- _____ 54. Prior adjudication(s) for nonsexual violent offense(s) (1=yes; 2=no)
- _____ 55. Prior adjudication(s) for nonsexual nonviolent offense(s) (1=yes; 2=no)
- _____ 56. Prior indication (adjudicated or not) of nonsexual child maltreatment (1=yes; 2=no)
- _____ 57. Currently on parole (1=yes; 2=no)
- _____ 58. Currently on probation (1=yes; 2=no)
- _____ 59. Number of previous probations at intake.
- Supervision
- _____ 60. Date probation began_____
- _____ 61. Frequency of contact with probation officer (number of contacts per month)
- _____ 62. Use of surveillance (1=yes; 2=no)
- _____ 63. If surveillance =1; Type of surveillance used_____

- _____ 64. Use of drug testing (1=yes; 2=no)
- _____ 65. Number of drug tests in file
- _____ 66. Number of positive outcomes
- _____ 67. Positive ETOH (1=yes; 2=no)
- _____ 68. Positive Marijuana/has (1=yes; 2=no)
- _____ 69. Positive Other (1=yes; 2=no)
- _____ 69a. Number of previous probations at intake
- Recidivism Information
- _____ 70. Charged with new offense (1=yes; 2=no)
- _____ 71. Offense charge_____
- _____ 72. Offense classification - violent sexual offense (1=yes; 2=no)
- _____ 73. Offense classification - nonviolent sexual offense (1=yes; 2=no)
- _____ 74. Offense classification - violent nonsexual offense (1=yes; 2=no)
- _____ 75. Offense classification - nonviolent nonsexual offense (1=yes; 2=no)
- _____ 76. Offender reported recidivism during tx. (1=yes; 2=no).
- _____ 77. Offense classification - violent sexual offense (1=yes; 2=no)
- _____ 78. Offense classification - nonviolent sexual offense (1=yes; 2=no)
- _____ 79. Offense classification - violent nonsexual offense (1=yes; 2=no)
- _____ 80. Offense classification - nonviolent nonsexual offense (1=yes; 2=no)
- Treatment Information
- _____ 81. Status in treatment (1=primary; 2=aftercare)
- _____ 82. Length of treatment (in months)
- For #84 - 90 note actual scale rating from file (1=poor to 5=excellent; - 9=not available)
- _____ 83. Rating Source (1=treatment program; 2=data collector)
- _____ 84. Attendance rating
- _____ 85. Treatment participation
- _____ 86. Prognosis

- _____ 87. Progress
- _____ 88. Responsibility for offense
- _____ 99. Victim blaming
- _____ 90. Cognitive distortions
- _____ 91. Presence of primary social support for offender (1=yes; 2=no)
- _____ 92. Nature of social support (1=spouse; 2=sibling; 3=adult child; 4=parent; 5=friend; 6=other; -9 if presence of primary social support for offender = no)
- _____ 93. "Substance abuse" (1=yes; 2=no; 3=po suggests)
- _____ 94. "Drug abuse" (1=yes; 2=no; 3=po suggests)
- _____ 95. "Mental retardation" (1=yes; 2=no)
- _____ 96. "Health problems" (1=yes; 2=no)
- _____ 97. "Emotional problems" (1=yes; 2=no)
- _____ 98. "Language deficiency" (1=yes; 2=no)
- _____ 99. "Injuries" (1=yes; 2=no)
- _____ 100. Prior sexual treatment noted (1=yes; 2=no)
- _____ 101. Prior substance treatment noted (1=yes; 2=no)
- _____ 102. Prior other psychological treatment noted (1=yes; 2=no)

Assessment Information from Treatment Sites (-9 if no evidence in file of completion of individual assessments)

- _____ 103. Name of treatment site_____
- _____ 104. MMPI (1=yes; 2=no)
- _____ 105. MMPI version (1=MMPI; 2=MMPI-2)
- _____ 106. MSI (1=yes; 2=no)
- _____ 107. Abel Arousal Indices (1=yes; 2=no)
- _____ 108. PPG (1=yes; 2=no) IF PPG file is in the probation file code the following
(otherwise code -9)
- _____ 108a. Age Preference (1=child; 2=adolescent; 3=adult; 4=mixed child and
adolescent; 5=mixed child and adult; 6=mixed adolescent and child)
- _____ 108b. Gender Preference (1=male; 2=female; 3=mixed)
- _____ 108c. Rape (1=yes; 2=no)
- _____ 108d. Number of PPG assessments in file_____
- _____ 108e. Number of PPG assessments rated as valid_____
- _____ 108f. Deviant Arousal (1=yes; 2=no; 3=mixed)
- _____ 108g. Validity Rating

PPG Data

Visual

Female	Mean	%	Male	Mean	%
Adult	_____	_____	Adult	_____	_____
15-17	_____	_____	15-17	_____	_____
11-14	_____	_____	11-14	_____	_____
7-10	_____	_____	7-10	_____	_____
1-6	_____	_____	1-6	_____	_____
Neutral	_____	_____	Neutral	_____	_____
Female			Male		
Mutual Consent Adult	_____	_____		_____	_____
Child	_____	_____		_____	_____
Fondling Child	_____	_____		_____	_____
Nonconsent Child	_____	_____		_____	_____
Rape Child	_____	_____		_____	_____
Sadism Child	_____	_____		_____	_____
Phys. Assault Child	_____	_____		_____	_____
Hi	_____		Male	_____	
Low	_____		Female	_____	

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