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Cognitive Behavioural Relapse Prevention Treatment

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**Changes in the Coping Strategies of Extrafamilial Child Molesters
Following Cognitive Behavioural Relapse Prevention Treatment**

Geris A. Serran

Thesis submitted to the
Faculty of Graduate and Postdoctoral Studies
in partial fulfillment of the requirements for the
Ph.D. degree in Clinical Psychology

School of Psychology
Faculty of Social Sciences
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ABSTRACT

Despite the important role of effective coping in cognitive-behavioural treatment programs for sexual offenders to reduce sexual recidivism, research that explores changes in coping strategies is lacking. The purpose of this study was to examine the changes in coping strategies identified by child molesters following cognitive-behavioural relapse prevention treatment. Treated incarcerated child molesters were compared to a group of incarcerated child molesters on a waiting list. Groups completed various measures aimed at identifying coping strategies used in specific high-risk situations, general coping styles, and the use of sexual coping strategies. The results indicated that treated child molesters do show evidence of changes in their selected strategies. Compared to a waiting list group, treated child molesters are able to identify more effective coping strategies in specific high-risk situations. As well, changes are noted in their general coping styles, with an increase in the endorsement of task-focused and social diversion strategies. There were no changes in their endorsement of emotion-focused strategies, distraction strategies, or sexual coping strategies. The changes that occurred are encouraging and suggest that treatment has a positive impact on child molesters' choice of strategies. However, it appears that a more concentrated effort may be required to modify the use of emotion-focused strategies.

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INTRODUCTION

Sexual offending is a serious social problem that affects men, women, and children all over the world. Epidemiological studies suggest that sexual offenses are not rare events. Research statistics indicate that as many as 27% of females and 16% of males in the United States may have been sexually assaulted during their childhood (Finkelhor, Hotaling, Lewis & Smith, 1990). Clearly, the frequencies of sexual abuse and sexual assault are much higher than the reported incidence and prevalence rates, and the majority of these victims experience at least some harmful effects as a result (Katz, in press). Research on child sexual offenders indicates that some perpetrators have multiple victims. Elliot, Browne, and Kilcoyne (1995) found that 30% of the child sex offenders who reported committing sexual offences against children also reported victimizing between 10 and 450 different children. In order to lower the number of children who are sexually victimized, it is imperative to examine the factors associated with offending. As well, it is critical to examine techniques that can be utilized to prevent offenders from committing additional sexual offences. One possible method is treating sexual offenders.

Treatment of sexual offenders is seen as a cost-effective manner of preventing further suffering of victims (Prentky & Burgess, 1991; Marshall, 1992). Treatment methods have evolved over the years, from earlier psychodynamic models of therapy to the nearly exclusive use of cognitive-behavioural treatments today. Further, the number of sexual offender treatment programs in North America has risen from 643 in 1986 to 1784 in 1994 (Freeman-Longo, Bird, Stevenson, & Fiske, 1994).

Effectiveness of Sexual Offender Treatment

Considering the widespread implementation of sexual offender treatment programs in the United States (Freeman-Longo et al., 1994) and Canada (Wormith & Hanson, 1992), it becomes increasingly important to determine their efficacy. Treatment is considered effective if it reduces the likelihood of recidivism. Furby, Weinrott, and Blackshaw (1989), reviewing recidivism among sexual offenders, could find no benefit from treatment. Despite various papers and reviews on the topic, policymakers and researchers continue to debate whether treatment effectively reduces recidivism. A recent large-scale meta-analysis, (Hanson et al., 2002), however, excluded all research studies with methodological problems, and found significant improvements with treatment across 42 studies that included over 9000 subjects. The recidivism rates of treated sexual offenders (9.9%) from both community and institutional settings were lower than untreated sexual offenders (17.3%). This meta-analysis also suggested that treatment programs adopting a cognitive-behavioural approach were the most effective in reducing both sexual and general recidivism. These findings should encourage sexual offender therapists to adopt treatment models based on current research, and to conduct their own evaluations of their programs.

Although the observed recidivism rates are relatively low, recidivism rates continue to increase gradually with extended follow-up periods (Hanson, Steffy, & Gauthier, 1993). Even more concerning is that when a child molester reoffends, he often victimizes more than one child. Essentially, recidivism rates are the only outcome measure of true relevance, as it is reoffending that the public must be concerned about. However, for many researchers, the typical comparison study using recidivism as an outcome is not an optimal design for several reasons. Specifically, Hanson and Bussiere

(1998) found the average sexual offense recidivism rate for untreated sexual offenders was 13% over 4 or 5 years. Such a low base rate means that outcome studies using official crime statistics need to include large numbers of subjects who are followed after release for many years. Very few treatment programs are able to generate a sufficient number of at-risk subjects for a sufficiently long period to permit a proper evaluation. As well, detected recidivism, which is the most credible treatment outcome for sexual offenders, does not take into account sexual assaults not reported to police (Bonta & Hanson, 1994). Hanson (1997) proposes that within-treatment change on dynamic risk factors is one approach that will contribute to our understanding of treatment effectiveness. Evidence of within-therapy changes on clinically relevant variables (factors targeted during treatment) may be used to improve upon current sexual offender treatment programs. One such factor is the tendency for sexual offenders to cope with stress through sexual fantasies (Cortoni & Marshall, 2001; McKibben, Proulx, & Lusignan, 1994) and through emotion-focused strategies (Marshall, Serran, & Cortoni, 2000).

Given these research findings, it appears that coping strategies should be a relevant target of current programs. However, no research has been conducted to examine whether coping strategies actually change following treatment. The current study will attempt to determine whether child molesters will endorse more effective coping strategies following cognitive-behavioural sexual offender treatment.

Relapse prevention model

Relapse prevention (RP; Marlatt, 1985) was initially employed in the treatment of substance abusers in order to maintain treatment gains. Although the RP model was

demonstrated to be effective with addicts, there have been challenges to the way it has been employed with sexual offenders (Laws, Hudson, & Ward, 2000).

Marques (1987) was the first to provide an outline of how this approach may be applied to sexual offenders. Since then, numerous programs for sexual offenders have applied the RP model in their services. In fact, these comprehensive cognitive-behavioural programs have become the most popular approaches in North America for the treatment of sexual offenders (Pithers, 1990; Wormith & Hanson, 1992), as well as in other English-speaking countries, such as Australia (Cull & Wehner, 1998), New Zealand (Hudson, Marshall, Johnston, Ward, & Jones, 1995), and Great Britain (Beckett, 1998; Mann & Thornton, 1998). Although specific content varies, the majority of these programs address acceptance of responsibility, cognitive distortions, empathy for victims, social functioning, deviant fantasies, and the development of relapse prevention plans.

The RP approach described by Pithers, Marques, Gibat and Marlatt (1983) is the most widely used in sexual offender treatment. It assumes that reoffenses or relapses do not occur “out of the blue”, but rather are the product of a variety of events and situations that develop over time. The model also proposes that all sexual offenders will at some point slip or lapse from their state of complete abstinence. Some will recover and return to their abstinence, while others may continue along the path to a reoffense.

In relapse prevention, the aim is to examine past offending in order to identify the points along the way that increased and contributed to the risk of the individual (re)offending. Once these events, situations, and feelings are recognized, the offender generates ways to either avoid or cope with the increased risk. The basic premise of relapse prevention is that if a high-risk situation (the most common being a negative

emotional state or an interpersonal conflict) is experienced, and if the offender fails to cope appropriately, he will have deviant sexual thoughts or fantasies (Laws, 1989). These fantasies are said to be followed by cognitive distortions, conscious planning of a future offense, and, finally, the commission of a reoffense (Pithers, Kashima, Cumming, Beal, & Buell, 1988; Laws, 1989). Once assessment has highlighted the high-risk situations involved in the offenses, the client can be taught to respond appropriately when facing such situations in the future. Traditional relapse prevention treatment programs are concerned with teaching the client adaptive coping strategies with specific skill training, as well as instruction in general problem-solving procedures (Pithers et al., 1983).

In a recent evaluation of the RP model, Ward and Hudson (1996) identified two main criticisms: (1) adaptation from the original model used with addicts resulted in changes that are conceptually confusing; and (2) aspects of the model are not supported by the limited evidence available. Marques, Day, Nelson, and Miner (1989) found that after treatment, clients improved their knowledge of RP concepts (the factors that placed them at risk), and they identified strategies for coping with risk factors. Unfortunately, the data available on the long-term effectiveness of Marques' program is disappointing. In addition, Beckett, Beech, Fisher, and Fordham (1994) measured several community RP programs in England and found similarly disappointing results. In the most successful of these programs, only 57% of the clients demonstrated improved relapse prevention knowledge after treatment, while no changes were observed in three of the programs. Mann (1996) suggested that perhaps the negative findings were a function of the time-limited nature of the programs. She then compared three comprehensive prison-

based programs: a therapeutic community with no cognitive-behavioural or RP component; a cognitive-behavioural program with no RP component; and a cognitive-behavioural program with an extensive RP component. The results supported the usefulness of cognitive-behavioural treatment, with the benefits being clearly attributable to the inclusion of the RP component.

Although RP approaches appear to have potential benefits, recent attempts to improve their effectiveness have focused on the avoidance aspects of the approach. In RP programs, clients are required to identify risk factors and then develop strategies for avoiding these factors. Thus, the target of RP approaches is to develop a set of avoidance plans. Mann, Webster, Schofield, and Marshall (in press), however, point to evidence from the general psychological literature indicating that avoidance goals are very difficult to maintain, whereas approach goals are more readily achieved. For example, the best way to avoid feelings of loneliness is to develop positive relationships. Thus, the goal for offenders in this case will be to acquire the skills necessary to develop enjoyable and satisfying relationships, rather than simply having a goal of avoiding loneliness.

Approach goals are those that identify ways of meeting the basic needs of autonomy, competence, and relatedness (see Ward (2002), for a discussion of these goals) that result in a fulfilling life. Ward's (2002) contention is that a person living such a life will have no reason to offend. In fact, developing positive goals rather than avoidance strategies is simply a change in emphasis. The goal of treatment with sexual offenders, has, for many years, been focused on developing ways of meeting their needs prosocially, with the assumption being that success in these endeavors will remove the motivation to offend.

Good Lives and Self-regulation Models

These concerns with the original RP treatment suggest that working to improve its components have become more critical. Ward (2000) and Ward, Hudson, and Keenan (1998) have developed theories aimed at improving our understanding of the offence process and improving intervention with sexual offenders. Ward, Hudson, and Keenan suggest that rather than traditional relapse prevention's focus on one pathway to offending (a covert pathway) and negative affect states, there are different pathways and affective states to offending. For example, the degree to which planning is present, the extent of coping and social skills deficits, and the particular offending style will differ across offenders. They suggest that knowledge of offending patterns is also particularly useful in identifying problem areas and developing specific coping strategies, as well as understanding high risk situations and coping deficits.

The self-regulation model presented by Ward, Hudson and colleagues is based on the assumption that choice of goals is related to sexual offending. The underregulation pathway is one where the individual wishes to avoid sexual offending but is unable to control his behaviour. He tends to be impulsive and has low self-efficacy about his ability to refrain from offending. He may fail to cope appropriately and place himself in high risk situations. In the misregulation pathway, the individual makes active attempts to avoid offending but uses ineffective strategies. For example, he might masturbate to a deviant fantasy or use pornography as a means of coping with an urge to offend. These two pathways represent avoidance pathways to offending. Approach pathways involve a decision to offend. In some cases, offence-supportive attitudes or goals are triggered by

situational factors. In other cases, self-regulation is intact but the offender engages in explicit planning of the offence and his goal is to sexually offend.

Ward (2000) developed the Good Lives Conception of treatment, which focuses on assisting the sexual offender in improving the quality of his life through the development of healthier, more appropriate goals, skills and knowledge. According to this theory, sexual offenders need to learn to meet their needs in more appropriate ways. This might translate into the development of more appropriate goals and skills training. Rehabilitation focuses on identifying the various obstacles preventing offenders from living a balanced and fulfilling life and to equip them with the skills, attitudes, beliefs, and supports necessary to assist them in achieving these goals.

Risk Factors

Assisting offenders in managing risk, particularly by helping them cope in a manner that reduces stress and problems, will in turn promote a more positive lifestyle. Dynamic (or changeable) risk factors are those that are linked to reoffending. Hanson and Harris (2000) identified various dynamic risk factors that affected sexual offending. Among these dynamic factors were sexual and general self-regulation processes. Inadequate sexual self-regulation includes the use of sexual activity to attenuate negative emotional states and reduce life stressors. Deficits in general self-regulation refers to impulsive behaviours and general lifestyle instability. Acute dynamic risk factors include substance abuse problems, negative mood states, interpersonal problems, and anger or hostility. All of these dynamic risk factors offer treatment-relevant targets to prevent recidivism.

These dynamic factors have been linked to the high-risk situations identified in the research literature as problematic for sexual offenders. These high-risk situations are antecedents to recidivism. Analyses of the relapse episodes reported by sexually aggressive individuals (Pithers et al., 1983) have revealed common patterns of high-risk situations. Seventy-five percent of the relapses were precipitated by situations that evoked a negative mood state or feeling (e.g., boredom, frustration, anger). Interpersonal conflicts preceded an offense in 20% of the cases.

COPING STYLES AND STRATEGIES

Specific Coping Strategies

McCormick and Smith (1995) measured aggression and hostility in a group of substance abusers seeking treatment and examined their coping strategies when facing various situations (e.g., negative or positive emotional states, problems with family or friends, problems at work). The researchers found that subjects who displayed more hostility and aggression were more likely to use escape-avoidance, confrontive, and distancing styles of coping. As well, these clients reported more situations that triggered their use of substances, and expressed less confidence about dealing appropriately with those situations in the future. This was especially true for situations involving unpleasant internal states, rejection, or problems with family and friends. McCormick and Smith (1995) concluded that more hostile and aggressive clients are at highest risk to relapse, as their substance use tends to be triggered by high negative emotional states, and their hostility results in interpersonal conflict and rejection.

If an individual in a high-risk, stressful situation is able to perform an effective coping response (e.g., resolving an argument assertively rather than aggressively), the

probability of a relapse decreases (Pithers et al., 1983). Successful coping increases the individual's sense of self-efficacy and the belief that he can deal effectively with future high-risk situations. If the individual fails to effectively cope with a high-risk situation, he will feel a decrease in his sense of control, will feel more helpless, and will be more likely to relapse.

High-risk situations differ among individual offenders, and in treatment, each offender is required to identify high-risk situations specific to his offense(s). After determining his risk situations (such as background factors, mood, and typical circumstances in which offending occurs), offenders are required to identify alternative actions they may take to deal with unavoidable high-risk situations and prevent offending from occurring. Often, offenders do not have the skills necessary to deal with these risk factors prior to commencing treatment. Coping skills assessment procedures examining specific high-risk situations have been developed for use in various programs, such as substance abuse, school performance, and problem identification in adolescents (Chaney & Roszell, 1985; Davis & Glaros, 1986; Goldfried & D'Zurilla, 1969; Hunter & Kelley, 1986). These tests are useful for identifying coping skills deficits and assessing the impact of interventions on skills training.

In addition, it appears that sexual offenders also have more generic coping difficulties than do other subjects. Barbaree, Marshall, and Connor (1988) examined the problem-solving capacities of sexual offenders and found that sexual offenders could identify many potential solutions to presented problems, but typically chose an inadequate solution. Therefore, sexual offenders appear to have developed inadequate

generic coping styles. Recent research has examined the general coping styles of sexual offenders.

General Coping Strategies

Coping has been defined by Lazarus and Folkman (1984) as constantly changing cognitive and behavioural efforts to manage situations that are taxing or stressful. The coping strategies employed may be efficacious or maladaptive; thus coping may improve the situation and reduce stress, or exacerbate the problem and increase stress.

Researchers differ in how they view an individual's coping behaviour. Some researchers stress the importance of studying the situational context in which coping occurs (Billings & Moos, 1981; Folkman & Lazarus, 1985), while others emphasize the person (trait) variables (Endler & Parker, 1992). The difference between these two approaches can be defined as the interindividual approach (which attempts to identify basic coping styles) versus the intraindividual approach (which attempts to identify the basic coping strategies used in particular types of situations). There appears to have been a lack of interest by most coping researchers in integrating these two approaches; that is, researchers rarely assess both situational and stylistic coping variables in the same study (Parker & Endler, 1996).

Coping styles are referred to in the literature as characteristic or typical manners of confronting stressful situations and dealing with them (Folkman & Lazarus, 1980; 1985). Although some researchers argue that situational factors are more important than consistent styles in determining how well an individual adapts to stress (Cohen, 1987; Compas, Malcarne, & Fondacaro, 1988; Lazarus & Folkman, 1987), more recent evidence suggests that individuals do exhibit stability in their coping styles over time

(Carver, Scheier, & Weintraub, 1989; Endler & Parker, 1990; Miller, 1990).

Specifically, the general coping strategies used by individuals have been found to relate to situation-specific responses made to a particular stressful event. Endler and Parker (1999) point out that there are specific situations (such as emergencies) when particular coping responses are more desirable, but in other situations, where a variety of coping responses are possible, individual coping styles likely play an important role.

Two consistently identified styles of coping have been identified: task or problem-focused coping and emotion-focused coping. Some experts have identified a third general coping style, avoidance-focused coping (Endler & Parker, 1990, 1994). Task-focused coping occurs when the individual believes he or she can change the situation. In this response to stressful circumstances, individuals adopt either behavioural strategies to deal directly with the problem, or cognitive strategies that reconceptualize the problem or minimize its effects. Emotion-focused strategies involve emotional responses to the problem, fantasizing, or self-preoccupation. For example, individuals using these strategies may get angry and take out their anger on others, simply worry about the problem but do nothing, or become depressed. Avoidance-focused coping involves techniques designed to escape or avoid the problem, using either distraction activities (such as watching TV or eating) or social diversion (such as phoning a friend).

Within each category of coping style, specific strategies may be more or less adaptive. For example, hitting or yelling at another person represents a maladaptive emotion-focused response to a situation, while attempting to calm oneself when faced with stress may be more adaptive. Therefore, not all coping strategies reduce stress; some responses are dysfunctional. Evidence suggests that strategies such as self-blame,

wishful thinking, escapism, self-distraction, and giving up on goals are disadvantageous (Bolger, 1990; Carver et al., 1993; Cronkite & Moos, 1984; Folkman & Lazarus, 1985).

Whether an individual possesses effective coping strategies is a major determinant in how well that person adjusts to difficult situations in life or deals effectively with stress. Coping strategies play a major role in an individual's well-being when faced with negative or stressful situations (Endler & Parker, 1989; McCrae & Costa, 1986; Miller, Brody, & Summerton, 1988). Although most stressors may elicit all types of coping in response, task-focused coping is believed to predominate when people feel something constructive can be done, while emotion-focused coping predominates when people feel that the stressor is something that must be endured.

Coping plays an important role in mediating between stressful events and outcomes such as anxiety, depression, psychological distress, and physical problems (Billings & Moos, 1981, 1984; Endler & Parker, 1989). Research indicates that task-focused coping is significantly, if modestly, predictive of positive adaptation (Billings & Moos, 1981; Compas et al., 1988; Endler & Parker, 1999, 1990; Mitchell, Cronkite & Moos, 1983). Emotion-focused coping, however, is related to depression, neuroticism, and may be a predictor of emotional distress. Although Folkman and Lazarus' (1986) concept of emotion-focused coping involves the management, palliation, or expression of negative emotions, emotion-focused strategies which involve the expression of emotion, rather than the management of emotion, may be particularly problematic. The research concerning avoidance-focused coping is less clear. Some research finds no relationship between avoidance-focused strategies and poor outcome, while others suggest that avoidance-focused strategies are problematic (Endler & Parker, 1999). Certainly, some

avoidance strategies (e.g., substance use, denial, overeating) are more problematic than others (e.g., watching television). However, it does make sense that an overall general avoidance style would not be helpful.

Coping among General Offenders

Zamble and Porporino (1988) found no evidence that the problems offenders experienced outside prison were different from the problems faced by most people, but the ways in which offenders dealt with these problems were ineffective and exacerbated rather than solved them. The typical coping response implemented by offenders was characteristically the first response that came to mind, was executed inconsistently, and was followed by avoidance of the problem and its consequences. Planning and persistence were rarely evident among offenders. Since future recidivism could be predicted by the use of coping strategies, Zamble and Porporino hypothesized that offenders are unable to successfully recognize and resolve their problems. In support of this, Loucks and Zamble (1994) found that female offenders displayed poor coping strategies similar to those of male offenders, while the level of coping ability in a community sample differed from offender populations (Hughes & Zamble, 1993).

Zamble and Quinsey (1997) examined the coping ability of a group of criminal recidivists (assault, robbery, and property crimes). A standardized coping inventory was administered to determine coping strategies for different problem situations (e.g., conflict with a spouse, dealing with loneliness). Sixty-six percent of the recidivists indicated that they would have coped with at least one of the problem situations in a way that would have exacerbated the problem. However, the offenders did not appear to recognize the

ineffectiveness of their choice of strategy. Non-recidivists, who reported experiencing fewer problems than the recidivists, also displayed more efficacious coping responses.

Coping among Sexual Offenders

Advocates of a relapse prevention treatment approach claim that the coping strategies used by sexual offenders during stressful situations or while they are in negative mood states are important components of treatment. However, very little research has examined how sexual offenders cope. At this time, only three specific studies have examined general coping strategies in sexual offenders.

In the first study, Neidigh and Tomiko (1991) compared 20 child molesters with 20 non-offenders on the coping strategies used to handle life stress, as well as the coping strategies used to control the urge to sexually abuse children. Neidigh and Tomiko used a coping measure to examine how the subjects coped with life stressors, and adapted this questionnaire to obtain a separate measure of coping with the temptation to molest. The latter was achieved by having each participant read a scenario and imagine how they would cope. The results showed that, compared to non-offenders, child molesters used more self-denigration techniques when attempting to deal with daily stressors and used both more avoidance and self-denigration techniques when attempting to deal with an urge to molest. The authors suggested that the use of self-denigration strategies might actually increase the amount of stress, and such strategies were linked to a failure to control impulses. Both self-denigration and avoidance techniques have been shown to be less effective than behavioural and cognitive strategies (Neidigh & Tomiko, 1991).

Cortoni and Marshall (2001) examined the general coping strategies of 29 rapists, 30 child molesters, and 30 violent offenders, while Marshall, Serran, and Cortoni (2000)

compared 30 child molesters, 24 nonsexual offenders, and 29 non-offenders. In both studies, child molesters were observed to use emotion-focused coping strategies to a significantly greater degree than rapists, nonsexual offenders or community males. The emotion-focused coping strategies employed by the child molesters included self-blame, self-preoccupation, and fantasizing potential reactions. It appears that these strategies are particularly prevalent among child molesters. The coping strategies used by child molesters are clearly inadequate, and because they involve negative self-appraisal and an increased negative mood state, perhaps such strategies increase the probability of offending.

Of relevance to this issue, Roger and Masters (1997) evaluated an emotion-control training program for sexual offenders. These researchers suggested emotional rumination and coping styles might link stress and fantasy to sexual offending. In a pilot study, offenders participated in the emotion-control training program, where they discussed signs and symptoms of stress and learned to release 'bottled-up' emotion in a constructive manner. After completing the program, the offenders showed a significant improvement in task-focused coping and a reduction in emotional coping.

Replicating their pilot study using a comparison group, Roger and Masters (1997) randomly divided 29 sexual offenders and 23 murderers into experimental and wait-list comparison groups. As before, the researchers found a significant reduction in emotional coping and impulsiveness and a significant increase in task-focused coping. Taken together, the results of the studies of Marshall and his colleagues and of Roger and Masters suggest that emotional rumination is a particularly problematic strategy of sexual

offenders, and subsequent treatment should aim to improve the effectiveness of their coping strategies.

Sex as a Coping Strategy

Interestingly, only recently has the possibility that sexual offenders may use sexual activity as a means of coping with stress and negative emotions been considered. Cortoni and Marshall (2001) investigated this possibility, and found the typical responses of sexual offenders (both child molesters and rapists) to stressful situations or negative emotions were to seek either appropriate or inappropriate sexual activity. The use of sex as a coping strategy was found to significantly relate to both emotion-focused and avoidance coping strategies, which highlights the ineffective nature of these strategies. Although ultimately ineffective, if these strategies serve to reduce personal discomfort, it is likely sexual offenders will continue to engage in such activities until they learn of more effective alternatives.

Earlier research suggested that sexual offenders may use sexual activity as a means of coping with their high-risk factors. Proulx, McKibben, and Lusignan (1996) examined the relationship between sexual behaviour, moods and/or emotions following conflict in a group of sexual offenders. A "Fantasy Report" was used, in which conflicts and emotional states (High Risk Situations), deviant and nondeviant sexual fantasies (lapse), and masturbatory activities were assessed over several months. The frequency of deviant and nondeviant sexual fantasies were recorded, as were the emotions experienced. In response to problems, girl-victim child molesters were more likely to report loneliness and humiliation, while boy-victim child molesters reported only loneliness. The presence of conflict in the lives of the rapists in Proulx et al.'s study

generated strong deviant sexual fantasies. Anger, loneliness, and humiliation were the most frequently reported emotions by rapists and child molesters. Negative mood states increased the deviant sexual fantasies of girl-victim child molesters, but not the frequency of nondeviant sexual fantasies. For boy-victim child molesters, conflict and negative mood states were associated with the emergence of deviant sexual fantasies. Proulx et al.'s study, then, suggests that among sexual aggressors, intense negative affect is likely to be associated with the occurrence of some aspects of deviant sexual behaviour.

Looman (1995) interviewed 21 child molesters, 19 rapists, and 19 nonsexual offenders in order to determine whether there was a link between mood state and sexual fantasies. Child molesters reported that they were more likely to fantasize sexually about a child than an adult if they were feeling depressed, had argued with a wife or girlfriend, felt rejected by a woman, or were angry. They were likely to have sexual fantasies about an adult if they were happy, had a good day, or were feeling romantic. Looman suggested that child molesters might use fantasies about children as a means of coping with dysphoric moods, while Proulx et al. (1996) proposed that sexual offenders engage in both deviant and nondeviant sexual fantasies as a means of reducing their levels of distress.

CURRENT STUDY

According to the relapse prevention model, effective treatment of sexual offenders should generate competency in coping with their specific high-risk situations through the development of effective coping responses. Because research has suggested that child molesters also display deficits in their general coping strategies (Marshall, Serran, & Cortoni, 2000), and may use sex as a way of coping (Cortoni & Marshall,

2001), it might be that both situational and stylistic variables influence specific coping responses. Thus, not only is it relevant to determine whether treatment has increased situational competency, it is also necessary to determine whether generic coping strategies have been improved. In addition, we need to determine whether treatment decreases the use of sexual activity as a means of coping with stressful situations. If more effective coping is reported following treatment, then treatment can be said to be beneficial in helping child molesters improve their coping abilities and thereby reduce future risk to reoffend.

Hypotheses

Because coping with high-risk situations is the main treatment target in relapse prevention interventions, offenders should display more effective coping strategies following treatment. The main question of interest is whether child molesters in the Treatment Group display relevant changes on the various measures of coping following intervention. Child molesters who have not completed treatment should not display any significant changes on the coping measures.

Based on previous research and theory, the following hypotheses were identified and tested:

- 1) Treated child molesters will provide more effective strategies to the high-risk situations on the *Sex Offender Situational Competency Test* at post-treatment testing. It is expected that child molesters in the Waiting List group will demonstrate no significant change.

- 2) Treated child molesters will demonstrate an increase in the endorsement of task-focused strategies at post-treatment testing. It is expected that child molesters in the Waiting List group will demonstrate no significant change.
- 3) Treated child molesters will demonstrate a decrease in the endorsement of emotion-focused strategies at post-treatment testing. It is expected that child molesters in the Waiting List group will demonstrate no significant change.
- 4) Treated child molesters will demonstrate a decrease in the endorsement of avoidance-focused strategies at post-treatment testing. Specifically, their use of distraction techniques should decrease following treatment. It is expected that child molesters in the Waiting List group will demonstrate no significant change.
- 5) Treated child molesters will demonstrate a decrease in the endorsement of sex as a coping strategy at post-treatment testing. It is expected that child molesters in the Waiting List group will demonstrate no significant change.

Method

Participants

Sixty adult extrafamilial child molesters incarcerated in the Bath and Warkworth medium-security Canadian penitentiaries or the Millhaven Assessment Unit were recruited. Thirty-three of these participants were involved in cognitive-behavioural sexual offender treatment programming at Bath Institution (Appendix A). The Waiting List Group consisted of 27 participants incarcerated at Bath, Warkworth, or Millhaven. Waiting List participants were evaluated at intake to be appropriate candidates for a moderate or low-moderate intensity sexual offender treatment program.

The mean age of the Treatment Group was 46.45 years ($SD = 10.52$), and for the Waiting List Group it was 46.59 years ($SD = 12.57$). These age differences were not statistically significant $F(1, 58) < 1$. Table 1 displays the age, education level, and marital status for the groups of participants. Chi-square analyses revealed no significant differences between groups for education level and marital status, $\chi^2(3, N = 59) = 4.21, p > .05$ and $\chi^2(6, N = 59) = 7.52, p > .05$, respectively.

Originally, approximately 100 participants were approached and a total of 67 participants were recruited. Of the original volunteers, one participant withdrew from the study (Waiting List Group) and one was removed from the treatment program due to failure to fully accept responsibility for his offense. There were five participants for whom measures on the second administration of data were not achieved (three from the Treatment Group, two from the Waiting List Group).

The following criteria were considered when choosing participants for the study: a conviction for a sexual offense against an unrelated child victim, no previous sexual offender programming, a minimum sentence of 2 years, a moderate or low/moderate risk of sexual reoffending, and at minimum of grade 5 education.

A victim was considered to be a child if he/she was 14 years or younger. Unrelated meant the child was not biologically related to the offender (e.g., biological child, grandchild, sibling, niece, nephew). Those in a parenting role (e.g., stepfather) were still considered for the study.

All participants were those rated as moderate or low/moderate risk to sexually reoffend based on actuarial measures of static factors. An extensive assessment is conducted at the Millhaven Institution Assessment Unit prior to the offender's transfer to his home institution. Actuarial measures of risk to sexually reoffend were the STATIC-99 or the RRASOR.

Offender Criminal History

Previous Offenses

Offenders were compared on previous criminal history in order to ensure the samples were similar. Offenses defined as general offense convictions excluded convictions for violent and sexual offenses. Examples include property offenses such as Break and Enter or Theft. Offenses defined as violent excluded sexual offenses (e.g., Assault). The means and standard deviations for previous general, violent and sexual conviction histories are displayed in Table 1.

The groups did not differ in terms of number of previous general, violent, and sexual offenses ($F_s(1, 52) = 2.22, 1.48, \text{ and } 1.70$, respectively, $p_s > .05$.)

Current Sentence

Index offenses are the offense convictions for which the offenders are currently serving sentences. Often, the offenders will be convicted for more than one offense at a time; however, in this study it was only necessary that they be convicted of a sexual offense. The average sentence length for the index offense was 4.85 ($SD = 2.30$) for the Treatment Group and 5.48 ($SD = 3.76$) for the Waiting List Group. An analysis of variance revealed no significant differences between the two groups, $F(1, 58) < 1$.

Victim Characteristics

Participants were recruited based on current convictions (convictions of sexual offenses against unrelated children, male or female and no previous sexual offender treatment programming). The mean number of victims in the Treatment and Waiting List Groups were 2.88 ($SD = 2.55$) and 2.93 ($SD = 3.07$), respectively. An analysis of variance revealed no significant differences between groups, $F(1, 58) < 1$. In the Treatment Group, 25 participants had only female victims (76%), 5 had only male victims, and 3 had both male and female victims. In the Waiting List Group, 18 participants had only female victims (67%), 8 had only male victims, and 1 had both male and female victims. Since the number of participants with either only male victims or both male and female victims were small, data were not analyzed separately.

Table 1

Offender Age, Education, Marital Status, Offense History, Length of Current Sentence,

Number of Victims and Victim Type

	Treatment	Waiting List
Mean Age (in years)	n =33	n =27
	46.45 (10.52)	46.59 (12.57)
Education	n (%)	n (%)
Grade 8 or less	2 (6.1%)	2 (7.4%)
Some high school	20 (60.6%)	15 (55.6%)
Completed high school	7 (21.2%)	6 (22.2%)
Post-secondary/trade	1 (3.0%)	2 (7.4%)
University degree	2 (6.1%)	2 (7.4%)
Marital Status	n (%)	n (%)
Single	9 (27.3%)	6 (22.2%)
Separated/divorced	12 (36.4%)	9 (33.3%)
Married/common-law	12 (36.4%)	8 (29.6%)
Widowed	0 (0%)	3 (11.1%)
Offense History	Mean (SD)	Mean (SD)
General	3.63 (4.50)	1.83 (4.31)
Violent	.40 (.67)	.21 (.41)
Sexual	.47 (1.07)	.83 (.96)
Current Sentence (years)	Mean (SD)	Mean (SD)
	4.85 (2.30)	5.48 (3.76)
Mean Number of Victims	2.88 (2.55)	2.93 (3.07)
Victim Type	n (%)	n (%)
Female Victims	25 (75.8%)	18 (66.6%)
Male Victims	5 (15.2%)	8 (29.6%)
Male and Female Victims	1 (3.0%)	1 (3.7%)

Note: Percentages do not always add to 100% because not all participants provided the information.

Measures

Data were gathered mainly through the use of self-report measures. All participants completed a brief demographics form (Appendix B). Institutional files were examined to provide demographic information and criminal history information for the participants to ensure accuracy of information. In the case of discrepancies, file information was used (e.g., CPIC for offence history).

Social Desirability

The tendency of participants to present themselves in a socially desirable way is always a problem with the use of self-report measures, particularly when those measures deal with sensitive material. In order to assess self-deception and impression management in self-reports, the *Paulhus Deception Scales* (PDS; Paulhus, 1998) were administered (Appendix C). The PDS constitutes version 7 of the *Balanced Inventory of Desirable Responding*, a 40-item questionnaire that measures one's tendency to provide socially desirable responses on self-report measures. The PDS consists of two subscales: Self-Deceptive Enhancement (SDE – the tendency to give honest but inflated self-descriptions) and Impression Management (IM – the tendency to give inflated self-descriptions to an audience). Respondents rate on a 5-point scale (ranging from “Not True” to “Very True”) the extent to which each statement describes him or her. Higher scores on the inventory indicate a greater tendency to present oneself in a socially desirable manner. Points are only assigned for extreme responses.

This measure was chosen for a variety of reasons. Many other measures designed to examine social desirability (e.g., *Marlowe-Crowne Social Desirability Scale*) are unidimensional, whereas the PDS separates scale content into two subscales, suggesting

that respondents may display different kinds of desirable responding. As well, sample norms have been collected for various comparison groups, including a sample of inmates from Canadian minimum- and medium-security prisons (Kroner & Weekes, 1996), and are part of the standard assessment battery administered to inmates entering the Ontario federal correctional system. The norms for prison inmates are 7.50 (3.50) for the Total Score, 2.20 (2.70) for the SDE subscale, and 5.30 (3.60) for the IM subscale. Internal reliability is highly satisfactory with values ranging from .83 to .86 for the Total Score, .81 to .84 for the IM subscale, and .70 to .75 for the SDE subscale. Paulhus (1998) also summarizes studies demonstrating the validity of the PDS as a measure of social desirability.

The former version of this scale, the BIDR, has been used specifically in sexual offender populations. Looman, Abracen, Maillet, and DiFazio (1998) concluded that the Impression Management subscale of the BIDR was negatively associated with sexual arousal responses to violence against females. Cortoni and Marshall (2001) found that both the Self-Deceptive Enhancement and Impression Management subscales were correlated with other psychometric measures used in their study examining coping behaviour in sexual offenders.

Coping

Sex Offender Situational Competency Test:

The *Situational Competency Test* (SCT; Chaney, O'Leary, & Marlatt, 1978) was designed to assess coping strategies for alcoholics, and the same process was used to develop the *Sex Offender Situational Competency Test* (SOSCT; Day, Miner, Nafpaktitis, & Murphy, 1987) (Appendix D). A literature review was conducted by Day et al. prior to

developing their measure. From this, they determined different types of high-risk situations. Interviews were conducted with sexual offenders and various categories of high-risk situations were drawn from these interview transcripts. Three researchers independently rated the interviews and the overall agreement was $Kappa = .54$. The test consists of fourteen situations drawn from a pool of 58 items. Four versions of this test were developed: a homosexual child molest version, a heterosexual child molest version, a bisexual child molest version, and a rape version (in the present study, only the child molester versions were used). The four tests are of equal difficulty and share certain common items. The overall reliability of the difficulty ratings across eight raters was $\alpha = .85$. The situations were developed by Day et al. to represent six categories of high-risk situations: intrapersonal negative emotional states, intrapersonal negative physical states, testing control, disinhibitors, interpersonal conflicts, and social pressure.

The usual administration of this test involves the use of a tape recorder, and individuals are required to verbally respond to each of the situations. One of the test developers was contacted (personal communication, M. Miner, 1999), and indicated that conducting the test in a written format was acceptable. Therefore, in the current study participants were required to write out what they would normally do in each of the 14 situations. A summary score was calculated and used to determine the effectiveness of the offenders' strategies to cope with high-risk situations. Ratings of the coping strategies were determined in each case by two independent raters (graduate students in a clinical psychology program) using the instruction manual prepared by Miner, Day, and Nafpaktitis (1988). According to the effectiveness rating, each situation was rated on a 5-point scale ranging from 1 (Not Effective) to 5 (Very effective). In order to achieve a

rating of 5, the response had to be clearly specified, involve cognitive factors, be complex, and plausibly prevent the occurrence of a relapse. A strategy would receive an effectiveness rating of 1 if the probability of a relapse remained the same or was likely to increase as a result of the participant's response.

Coping Inventory for Stressful Situations:

General coping styles were assessed using the *Coping Inventory for Stressful Situations* (CISS; Endler & Parker, 1990) (Appendix E). The CISS is a 48-item scale designed to assess the task-focused, emotion-focused, and avoidance-focused coping strategies that were established as the three dimensions of coping (Parker & Endler, 1992). The intercorrelations of the CISS scales provide support for the multidimensionality of the scale. Non-significant or significant-but-low correlations were found comparing the Task, Emotion, and Avoidance scales using various samples (intercorrelations ranged from 0.00 to 0.40), thus, the scales are relatively independent. The measure has 16 items per scale (Task, Emotion, and Avoidance). The Avoidance scale is further divided into two subscales, namely Distraction and Social Diversion. Internal consistency analyses of the Task, Emotion, and Avoidance scales revealed alpha coefficients of, respectively, .90, .87, and .85 for male undergraduates, and .90, .88, and .83 for female undergraduates (Endler & Parker, 1990). Six-week test-retest correlations for the three scales were .73, .68, and .55 for male undergraduates and .72, .71, and .60 for female undergraduates. The alphas for the two Avoidance subscales were also highly satisfactory. The alphas for the Distraction subscale ranged from .79 for female undergraduates to .69 for female psychiatric patients. The alphas for the Social Diversion subscale ranged from .84 for adolescent males to .74 for adult males. Items are answered

on a 5-point scale and scores for each item are summed to obtain a score for each subscale, with scores ranging from 16 to 80 for each subscale.

A number of coping measures are available, however, the CISS was chosen for various reasons. The CISS scales were derived from both theoretical and empirical bases, and have been used in a variety of research and applied settings. As well, most of the current measures include scales that assess the task-focused and emotion-focused dimensions of coping, whereas the CISS also includes the avoidance-focused dimension. This measure was developed due to the psychometric weakness of many existing scales (e.g., relatively low reliabilities, unstable and unsubstantiated factor structure, and lack of empirical support). Normative data (standard deviations in brackets) was collected on 124 inmates in a correctional institution: 51.49 (11.01) for Task; 45.46 (11.16) for Emotion; 42.42 (11.84) for Avoidance; 18.05 (6.56) for Distraction; and 15.44 (4.90) for Social Diversion. This scale was used in previous research with sexual offenders [Cortoni & Marshall, 2001; Marshall, Serran & Cortoni (2000)].

Coping Using Sex Inventory:

The *Coping Using Sex Inventory* (CUSI; F. Cortoni, W. L. Marshall, 2001) (Appendix F) is a 16-item inventory designed to assess whether participants use sexual activities as coping strategies. The inventory contains both consenting and non-consenting sexual items, and includes both adult and child items. These items were designed to assess a wide range of sexual activities, including fantasies, masturbation, pornography use, and actual sexual behaviour with a partner. Subjects are asked to indicate how often they engage in the activity described in each item when they encounter a stressful or difficult situation. The items are answered on a 5-point Likert-

type scale. The item scores are summed to obtain the overall scale score, ranging from 16 to 80.

Cortoni and Marshall (2001) report that the scale has satisfactory internal consistency ($\alpha = .86$). A factor analysis using a sample set of 195 subjects revealed that the CUSI is comprised of three factors consisting of consenting items (Consenting = items 1, 4, 7, 11, 14; $\alpha = .80$); adult sexual violence (Rape = items 3, 8, 10, 12, 15, 16; $\alpha = .83$); and child sexual aggression (Child molest = items 2, 5, 9, 13; $\alpha = .87$). Item 6 of the scale ("Go out and score with a stranger") loaded equally with both the consenting and the adult sexual violence subscales, and was therefore excluded from the current assessment. Test-retest reliability has not previously been determined but was assessed during the current study and will be described in the results section of this document. Cortoni and Marshall (2001) found a significant difference between non-sexual offenders and sexual offenders on this measure. Mean scores (standard deviations in parentheses) were 31.50 (9.22) for child molesters, 28.55 (12.67) for rapists, and 22.27 (5.83) for non-sex offenders. The mean scores (standard deviations in parentheses) for child molesters on the subscales were 15.07 (6.09) for Consenting, 7.50 (2.58) for Rape, and 7.07 for Child Molest (3.62).

Procedure

Data collection was conducted at the Millhaven Assessment Unit, and the medium security institutions Warkworth and Bath. Prior to initiating data collection, the project was submitted to and approved by ethics and the Regional Research Committee of the Correctional Service of Canada. Lists of incarcerated individuals were generated from the national database (Offender Management System, OMS). Institutional psychologists or their assistants identified which offenders met the inclusion criteria and provided the names to the researcher. If an examination of the OMS files revealed any of the following information, participants were excluded: a) participation in previous sexual offender treatment, b) adult victims or related victims, c) offenders identified as high risk to reoffend, and d) denial of the index offense.

Potential participants were approached in groups whenever possible to minimize disruptions to the institutions where data were collected. Once they arrived, the researcher introduced herself and described the purpose and procedures of the study. Those who chose to participate were provided with a consent form describing the study (Appendix G). The researcher answered all questions and participants read and signed the consent form.

Confidentiality was ensured by coding each questionnaire and matching it to a number on a separate envelope for each participant. The participants were advised not to identify themselves other than on the consent form. The coding ensured that participant data could be destroyed if anyone wished. One participant in the Waiting List Group requested his test material be destroyed, and the measures were shredded. Since data was collected on two occasions, consent forms were also coded in order to appropriately

match data. All data were removed from the institution after collection, no data were provided to the institution or placed on the participant's institutional files, and no information was given regarding his participation in the study. At the end of the study, participants were provided with a debriefing form (Appendix H).

Participants in the Treatment Group were approached prior to entering treatment and asked to complete the measures. Within two weeks of completing the program, they were asked to complete the measures again. In general, participants were in treatment for 3.5 months. Participants in the Waiting List Group completed the measures on two separate occasions, prior to entering a sexual offender treatment program and approximately 3 months later.

Results

Social Desirability

The *Paulhus Deception Scales* (BIDR-7) were included to identify the tendency of participants to present themselves in a favourable manner. Missing data were few, and where they occurred the scores were adjusted based on recommendations in the *Paulhus Deception Scales* manual. If more than 5 responses are missing, the administration should be considered invalid, and the scores should not be generated. If 1 to 5 items are omitted, the scores can be adjusted for increased accuracy. Three cases (two from the Treatment Group, one from the Waiting List Group) were adjusted due to missing data, but there were no measures that needed to be discarded. Mean scores are presented in Table 2. Social desirability was measured at both administrations, to ensure that scores remained in the normative range at both administrations.

Pre-treatment/Time 1. At the initial administration, the Treatment Group's mean Total Score was 9.90 ($SD = 4.15$), and the Waiting List Group's mean Total Score at initial administration was 12.24 ($SD = 5.09$). These scores were slightly above average compared to the normative data collected by Paulhus (i.e., 7.50). An analysis of variance revealed no significant differences between the Treatment and Waiting List Groups on the overall score, $F(1, 58) = 3.88, p > .05$. The subscales, Self-Deceptive Enhancement (SDE) and Impression Management (IM), were also examined. On the SDE subscale, the Treatment Group's mean score was 2.70 ($SD = 2.70$), and the Waiting List Group's mean score was 3.70 ($SD = 2.90$). These scores were slightly above average compared to prison entrants in Paulhus' study (i.e., 2.20), but were in the normative range. An

analysis of variance revealed no significant differences between groups on the SDE subscale, $F(1,58) = 1.85, p > .05$.

Table 2

Mean scores for Social Desirability at Time 1 and Time 2

	Treatment (<u>n</u> = 33)		Waiting List (<u>n</u> = 27)	
	Time 1	Time 2	Time 1	Time 2
Total Score	9.90 (4.15)	11.05 (4.85)	12.24 (5.09)	12.54 (4.57)
Self- deceptive enhancement	2.70 (2.70)	3.39 (2.45)	3.70 (2.90)	3.36 (2.74)
Impression management	6.98 (2.73)	7.65 (3.72)	8.72 (4.01)	9.12 (3.10)

Standard deviations in parentheses.

On the IM subscale, the Treatment Group's mean score was 6.98 ($SD = 2.73$), and the Waiting List Group's mean score was 8.72 ($SD = 4.01$). Both mean scores were slightly higher than Paulhus' data (i.e., 5.30), but were still considered to fall in the normative range. An analysis of variance demonstrated no significant differences between groups on the IM subscale, $F(1,58) = 3.98, p > .05$.

Post-treatment/Time 2

At the second administration, the Treatment Group's mean Total Score was 11.05 ($SD = 4.85$) and the Waiting List Group's mean Total Score was 12.54 ($SD = 4.57$). These scores were slightly above average compared to normative data collected by Paulhus (i.e., 7.50). An analysis of variance revealed no significant differences between the groups, $F(1, 58) = 1.50, p > .05$. On the SDE subscale, the Treatment Group's mean score was 3.39 ($SD = 2.45$) and the Waiting List Group's mean score was 3.36 ($SD = 2.74$). These mean scores were somewhat above average compared to normative data collected by Paulhus (i.e., 2.20) but T-scores fell within the normative range. An analysis of variance revealed no significant differences between groups on the SDE subscale, $F(1, 58) < 1$. On the IM subscale, the Treatment Group's mean score was 7.65 ($SD = 3.72$) and the Waiting List Group's mean score was 9.12 ($SD = 3.10$). These scores were slightly above average compared to normative data collected by Paulhus (i.e., 5.30), but were not in a problematic range. An analysis of variance revealed no significant differences between groups on the IM subscale, $F(1,58) = 2.68, p > .05$.

Correlational analyses were computed between the *Paulhus Deception Scales* (PDS) and the dependent measures used in the current study (see Tables 3a and b). At the initial

Table 3a

Correlations between Coping Measures and Social Desirability at Time 1 for Offender Groups

	Treatment			Waiting List		
	Total	SDE	IM	Total	SDE	IM
Situational competency	-.22	-.13	-.18	-.10	-.06	-.04
Task	.45**	.29	.34	.34	.38*	.18
Emotion	-.20	-.40*	.09	-.05	-.09	.12
Avoidance	.26	.02	.40*	.08	.42*	-.10
Distraction	-.17	-.14	-.15	-.01	.43*	-.01
Social diversion	.19	.02	.22	.25	.38	.07
Sexual Coping	-.26	-.27	-.22	-.19	.20	-.30

Note: * $p < .05$. ** $p < .001$

Table 3b

Correlations between Coping Measures and Social Desirability at Time 2 for Offender Groups

	Treatment			Waiting List		
	Total	SDE	IM	Total	SDE	IM
Situational competency	-.07	-.12	-.02	-.17	-.09	-.16
Task	.23	.25	.07	.51**	.56**	.21
Emotion	-.17	-.05	-.18	-.09	-.22	.06
Avoidance	-.09	.07	-.20	.28	.51**	-.12
Distraction	-.14	-.01	-.18	.17	.38	-.15
Social diversion	.01	.08	-.17	.35	.50**	-.01
Consenting Sex	-.13	.04	-.20	.07	.01	.07

Note: * $p < .05$. ** $p < .001$

Note: IM = Impression management
SDE = Self-deceptive enhancement

administration, the Treatment Group's Total Score correlated positively and significantly with the Task scale of the *Coping Strategies for Stressful Situations* (CISS), $r = .45$. The SDE subscale was significantly negatively correlated with the Emotion scale of the CISS, $r = -.40$. The IM subscale correlated positively and significantly with the Avoidance scale of the CISS, $r = .40$. The Waiting List Group's SDE subscale correlated significantly and positively with the Task scale and Distraction subscale of the CISS, $r_s = .38$ and $.43$, respectively. At the second administration, the Waiting List Group's Total PDS score correlated significantly and positively with the Task scale of the CISS, $r = .51$, respectively, and the SDE subscale correlated significantly and positively with the Task scale and Social Diversion subscale of the CISS, $r_s = .56$ and $.50$, respectively.

Covariates

Considering there were positive correlations between the *Paulhus Deception Scales* and several of the dependent measures, the Total Score or subscales were entered as covariates in the analyses of those dependent measures. If both the Total Score and subscales were correlated with dependent measures, the Total Score was used as the covariate. Data were analyzed with and without covariates. Since the results did not differ regardless, only those results without the covariates will be described.

Dependent Measures

Calculations of scores for each measure and its subscales (where applicable) were computed according to the instructions provided by the authors. The initial alpha was set at .05. Adjustments to alpha were made based on the number of comparisons.

Checks for Violations of Assumptions

The univariate and multivariate analyses employed to test the hypotheses are subject to various assumptions. The steps taken to examine the data prior to the analyses are outlined by Tabachnick and Fidell (1996). Prior to analysis, data were examined separately for each group at each test administration for accuracy of data entry, missing values, and assumptions of multivariate analysis (normality, homogeneity of variance/covariance matrices). SPSS Explore and SPSS Frequencies were used to examine data for violations of assumptions.

Missing Data

For this study, the first check was for missing data. On the *Sex Offender Situational Competency Test*, answers left blank were not scored, and the remaining were summed. At pre-treatment, one treatment participant did not respond to one of the scenarios, and in the Waiting List Group at the second administration, one participant did not respond to two of the scenarios. Recommendations for handling missing data on the *Coping Inventory for Stressful Situations* (CISS) were provided in the manual (Endler & Parker, 1999). The authors of the test recommend that if five or fewer items have been left blank, the mean item rating for the remaining items for a subscale should be assigned to the missing or double-circled item (a digit ranging from 1 to 5 rounded to the nearest whole number). There were no scales that had too many items missing or double-circled that required data to be discarded. On the *Coping Using Sex Inventory*, few values were missing overall and any missing values were replaced with the mean on that particular subscale.

Outliers

Histograms and Stem and Leaf plots were examined to detect outliers for each dependent measure at each administration. One outlier was identified in the Waiting List Group on the Emotion scale of the CISS. This participant scored very low on the scale at both administrations. One outlier was identified on the Social Diversion subscale of the CISS who was a low scorer in the Waiting List Group at Time 1. Another outlier was identified on the Total Score of the CUSI for the Treatment Group at post-treatment. The scores in each of these cases were altered by assigning scores within two standard deviations of the mean. Analyses were completed with and without the outliers, and since results were not significantly affected, the decision was made to retain the participants in the analyses.

Normality

In order to ensure multivariate normality of the sampling distribution, a sample size that produces 20 degrees of freedom for error should ensure normality, even with unequal n and a few dependent variables. In the current study, the sample size in both groups exceeded 20. Nevertheless, normality distributions were examined by means of normal probability plots and by examining the values of skewness and kurtosis for each variable at each time period. After treatment of outliers, the data appeared sufficiently normally distributed, with the exception of the variable assessing use of sex as a coping strategy. At both administrations for both groups, the Rape and Child Molest subscales were positively skewed due to the majority of participants endorsing the lowest possible scores. As well, the variances on both of these subscales were close to zero. Therefore,

it was decided that only the Consenting subscale would be used in the analyses, rather than the Total Score (which is composed of the problematic subscales).

Homogeneity of the Variance/Covariance Matrices

Box's M test was used to check for homogeneity of variance-covariance (Tabachnick & Fidel, 1996). Although this test is often too strict, it was not significant, Box's $M = 126.61$, $F(78, 9764) = 1.26$, $p > .05$, indicating that this assumption was met. The determinant of the pooled within-cells correlation matrix for each analysis indicated no problems with multicollinearity and singularity.

Reliability Analyses

The values for Cronbach alpha for each scale total, and the subscales where applicable, are presented in Table 4.

In the current study, interrater reliability was calculated for the *Sex Offender Situational Competency Test*. Two independent judges (graduate students) rated initial data (5 sets of measures). The ratings were examined, and although judges had little difficulty rating strategies as either effective or ineffective, they had greater difficulty agreeing upon specific ratings (e.g., score of 4 or 5 or score of 2 or 3). These difficulties were addressed and sample strategies were identified, eliciting scores in each of the categories (Appendix I). Twenty percent of the data sets were randomly chosen from both the Treatment and Waiting List Groups to determine interrater reliability. The analysis revealed kappa statistics ranging from .65 to .75. These kappas were considered low but adequate for the current analysis.

Unfortunately, no normative scores were available for the SOSCT. The minimum possible score that a participant could receive was 14, while the maximum score was 70.

Table 4

Inter-item Consistency for Measures

Questionnaire	Alpha
Paulhus Deception Scale	
Total Scale	.81
Self-deceptive enhancement	.73
Impression management	.81
Coping Inventory for Stressful Situations	
Total Scale	.87
Task-focused	.89
Emotion-focused	.84
Avoidance-focused	.88
Distraction	.82
Social diversion	.72
Coping Using Sex Inventory	
Total Scale	.72
Consenting	.78
Rape	.49
Child molest	.70

Considering that an effectiveness score for each item of 3 falls within the moderately effective range on the original author's rating of effectiveness (1 = ineffective, 3 = moderately effective, 5 = highly effective), a decision was made to place scores into categories for ease of interpretation. Total scores ranging from 56 to 70 were considered high, since strategies within this scoring bracket are considered highly effective coping strategies. Total scores ranging from 42 to 55 were considered moderate-high, since strategies within this scoring bracket are considered moderate to very effective coping strategies. Total scores ranging from 28 to 41 were considered moderate, since strategies within this range are considered to be somewhat to moderately effective coping strategies. Total scores ranging from 14 to 27 were low, since strategies within this range are considered to be ineffective coping strategies.

In the current study, the alpha reliability of the *Coping Inventory for Stressful Situations* Total scale was $\alpha = .87$. The alpha reliabilities for the scales were $\alpha = .89$ for Task; $\alpha = .84$ for Emotion; and $\alpha = .88$ for Avoidance. The subscales of the Avoidance scale, Distraction and Social Diversion, had alpha reliabilities of $\alpha = .82$ and $\alpha = .72$, respectively. These values were consistent with previous research on this scale and were considered satisfactory.

Test-retest reliability had not previously been evaluated for the *Coping Using Sex Inventory*; therefore it was examined prior to the current study. A separate group of 15 child molesters incarcerated at Millhaven Institution were recruited to complete the measure at two intervals approximately two weeks apart. The two-week test-retest correlation for the scale was $r = .70$, which was considered satisfactory. In the current study, the internal consistency of the Total scale was $\alpha = .72$. The internal consistencies

for the subscales were $\alpha = .78$ for the Consenting subscale; $\alpha = .49$ for the Rape subscale; and $\alpha = .70$ for the Child Molest subscale. These values were lower than those found in previous research, particularly the alpha for the Rape subscale. As this value was less than satisfactory, this subscale was excluded from analyses. As mentioned earlier, due to the psychometric problems with the Rape and Child Molest subscales, it was decided that the Consenting subscale would be examined separately in the analysis rather than the Total Score on the *Coping Using Sex Inventory*. As well, Cortoni, Anderson, and Looman (1999) found that child molesters are more likely to use consenting sexual activities than either child or rape-related activities. Both child molesters and rapists used consenting sexual activity as a coping strategy more than non-sexual violent offenders, suggesting they are more sexually-oriented than non-sexual offenders.

Correlations

The relationships between the various coping measures were examined through a series of correlational analyses. Although no specific hypotheses were generated, one would expect the measures to be at least moderately correlated. Previous research (Cortoni & Marshall, 2001) found a significant relationship between the use of sex as a coping strategy and both emotion-focused and avoidance-focused strategies.

Initial Administration. At the initial administration, results indicated a significant positive correlation between task-focused and avoidance-focused strategies, $r = .32$, $p < .02$. Examining the subscales of the Avoidance scale, significant positive correlations were noted between task-focused strategies and social diversion strategies, $r = .43$, $p < .00$, but not with distraction strategies, $r = .24$, $p > .05$. Of note, task-focused strategies were not significantly correlated with emotion-focused strategies. However, emotion-

focused strategies were significantly and positively related to distraction strategies, $r = .31$, $p < .05$. Although situational competency (SOSCT) was not significantly correlated with any of the other dependent measures, it was moderately correlated with both task and emotion-focused strategies.

Second Administration. At the second administration, results revealed significant positive correlations between task-focused strategies and both distraction, $r = .39$, $p < .001$ and social diversion strategies, $r = .55$, $p < .001$. Situational competency was significantly negatively correlated with emotion-focused strategies, $r = -.29$, $p < .05$. Emotion-focused strategies were significantly and positively correlated with the use of sexual coping on the Child molest subscale, $r = .26$, $p < .05$.

Tables 5a and 5b display the correlational matrices for these analyses. Dependent measures were considered appropriate for multivariate analyses of variance (moderately but not highly correlated).

Initial Measures

Participants were not randomly assigned to the groups; therefore initial scores on the measures were compared to ensure that the groups were equivalent at initial administration. Analyses of variance were conducted to determine whether there were any significant differences between groups at initial administration. There were no significant differences between the groups on any of the dependent measures.

Table 5a

Correlations between Coping Measures at Time 1

	Situational Competency	Task- focused	Emotion- focused	Avoidance- Focused	Distraction	Social Diversion	Sexual Coping	Consent	Rape	Child
1		.23	-.25	.05	-.01	.18	-.07	-.1	-.02	-.02
2			-.08	.32*	.24	.43**	.04	.01	.04	-.01
3				.21	.31*	.09	.19	.21	.12	.12
4					.9**	.78**	.14	.14	.16	-.04
5						.55**	.21	.19	.28*	-.02
6							.04	.07	-.03	-.01
7								.94**	.31*	.33*
8									.14	.23
9										-.16

Notes: *p<.05, **p<.001

Table 5b

Correlations between Coping Measures at Time 2

	Situational Competency	Task- focused	Emotion- focused	Avoidance- Focused	Distraction	Social Diversion	Sexual Coping	Consent	Rape	Child
1		.18	-.29*	-.05	-.05	.08	.18	.08	.06	.08
2			-.04	.45**	.39**	.55**	-.11	.02	-.1	-.1
3				.17	.23	.11	-.16	-.11	.05	.26*
4					.94**	.77**	.19	.19	.15	-.14
5						.56**	.14	.16	.19	-.12
6							.25	.19	.12	-.07
7								.88**	.20	.24
8									.11	.09
9										-.02

Notes: * $p < .05$, ** $p < .001$

Mean scores on dependent measures are presented in Table 6. Appendix J highlights normative values and previous research for comparison purposes.

Multivariate Analysis

A 2 X 2 doubly multivariate repeated-measures analysis was conducted to determine whether there were overall within- and between-group differences on the combination of the five dependent measures: situational competency, task-focused coping, emotion-focused coping, avoidance-focused coping, and sexual coping (consenting subscale). The between-subject independent variable was Group (Treatment versus Waiting List) and the within-subject independent variable was Time (Administrations 1 and 2).

Examining the main effect of Group, the between-subject independent variable, there was no significant effect, Wilks' Lambda = .912, $F(6, 53) < 1$. This indicates that averaging over both administrations, there were no significant differences between groups.

The second effect that was examined was Time, the within-subjects independent variable. Wilks' Lambda = .426, $F(6, 53) = 11.92$, $p < .001$, was highly significant. This finding indicated that there was a significant change in scores on the dependent measures over time. Univariate analyses were conducted on individual coping measures to explore the nature of the differences. These are reported below.

The final effect that was examined, and the one of crucial interest in this study, was the Group X Time interaction. Wilks' Lambda = .603, $F(6, 53) = 5.82$, $p < .001$, was highly significant. This was the effect of interest, and it indicated that the differences in

dependent measures across time depended on whether the child molesters received treatment. This overall interaction effect justified the subsequent examination of each measure separately, through the use of univariate analyses. A Bonferroni adjustment was made based on the number of comparisons. With five dependent measures, the critical alpha was adjusted to $p = .01$.

Table 6

Mean Scores on Coping Measures at Times 1 and 2

	Treatment (<u>n</u> = 33)		Waiting List (<u>n</u> = 27)	
	Time 1	Time 2	Time 1	Time 2
Sex Offender Situational Competency Test	28.90 (6.43)	41.58** (8.64)	32.82 (8.86)	36.17 (9.64)
Coping Inventory for Stressful Situations				
Task-focused	58.68 (7.62)	65.60** (7.31)	61.70 (10.70)	61.95 (8.39)
Emotion-focused	50.85 (8.69)	48.24 (8.97)	48.27 (10.27)	47.73 (9.75)
Avoidance-focused	46.69 (8.18)	53.60 (8.56)	49.52 (12.50)	52.12 (13.24)
Distraction	23.25 (5.47)	23.77 (5.69)	23.93 (8.31)	23.49 (7.75)
Social diversion	17.52 (2.94)	20.16** (3.46)	17.93 (4.20)	17.86 (4.14)
Coping Using Sex Inventory				
Total Score	23.09 (5.73)	23.40 (4.59)	23.12 (4.46)	21.77 (5.10)
Consenting	11.30 (4.90)	12.25 (4.46)	10.55 (3.46)	10.27 (4.05)
Child Molest	4.30 (.81)	4.1 (.40)	4.26 (.55)	4.55 (1.00)
Rape	6.18 (.64)	6.13 (.42)	6.48 (1.25)	6.05 (.20)

** $p < .001$

Coping Strategies

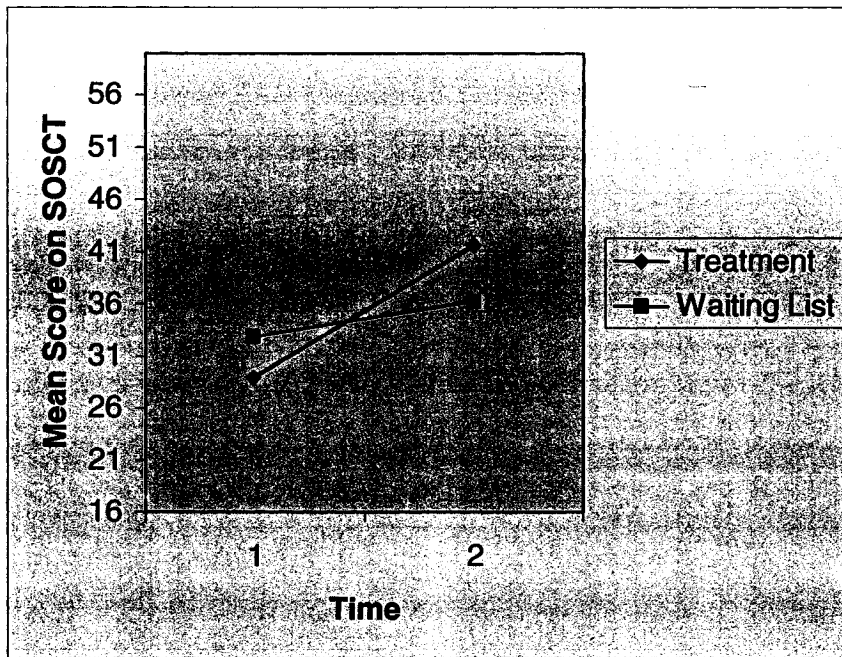
Situational Competency

Participants' ability to identify strategies to cope with specific high-risk situations was assessed using the *Sex Offender Situational Competency Test*.

Figure 1 displays the mean scores and interaction for the Treatment and Waiting List Groups at both administrations of the test. It was hypothesized (Hypothesis 1) that treated child molesters would provide more effective coping strategies to manage high-risk situations between Time 1 and Time 2, while child molesters in the Waiting List Group would demonstrate no significant differences. A univariate F-test examining the effect of Time revealed a significant effect, $F(1, 58) = 58.17, p < .001$. A univariate F-test examining the Group X Time interaction revealed a significant effect, $F(1, 58) = 19.88, p < .001$. These results indicated that there was a significant difference from Time 1 to Time 2, and that difference depended on group membership. A paired samples t-test was conducted to determine the nature of this difference. The critical alpha was adjusted based on these follow-up comparisons to $p = .005$. The t-test revealed that the treated child molesters demonstrated a significant increase in their ability to identify more effective coping strategies following treatment, $t(32) = -7.94, p < .001$, while the child molesters in the Waiting List Group did not, $t(26) = -2.60, p < .05$.

Figure 1.

Situational Competency for Offender Groups at Times 1 and 2



General Coping

The general coping strategies of participants were assessed using the *Coping Inventory for Stressful Situations*. This scale assesses the overall coping patterns and includes task-focused, emotion-focused, and avoidance-focused coping.

Figure 2 displays the mean scores and interactions on the Task scale for the Treatment and Waiting List Groups over the two administrations. It was hypothesized (Hypothesis 2) that treated child molesters would demonstrate an increase in task-focused strategies between Time 1 and Time 2, while the Waiting List Group would demonstrate no significant changes over time. A univariate analysis demonstrated that there was a significant effect of Time, $F(1,58) = 12.99, p < .001$. There was also a significant Group X Time interaction, $F(1, 58) = 13.14, p < .001$. Therefore, there was a significant change on this scale from Time 1 to Time 2, and that change was dependent on group membership. A paired samples t-test and an examination of mean scores indicated that the Treatment Group demonstrated a significant increase in Task-focused strategies, $t(32) = -4.86, p < .001$, compared to the Waiting List Group, $t(26) = .02, p > .05$.

Figure 2.

Task-focused Coping Strategies for Offender Groups at Times 1 and 2

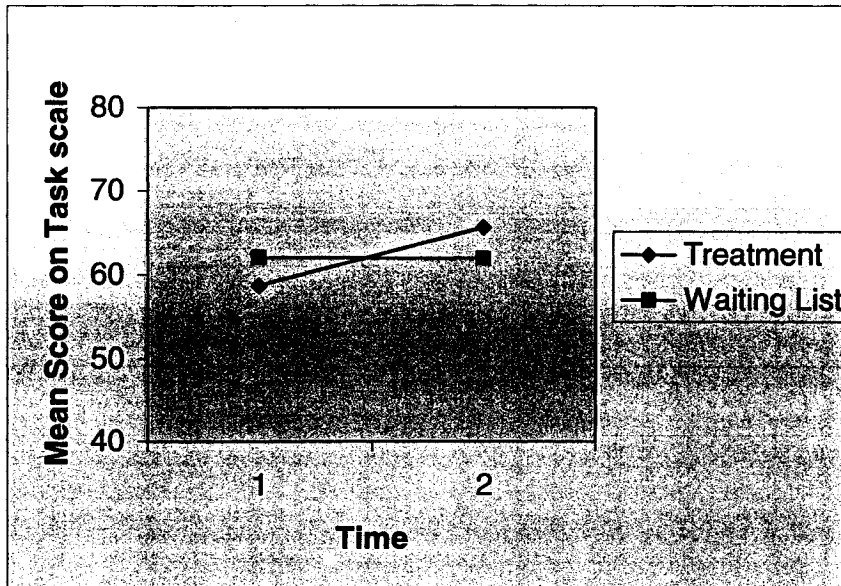
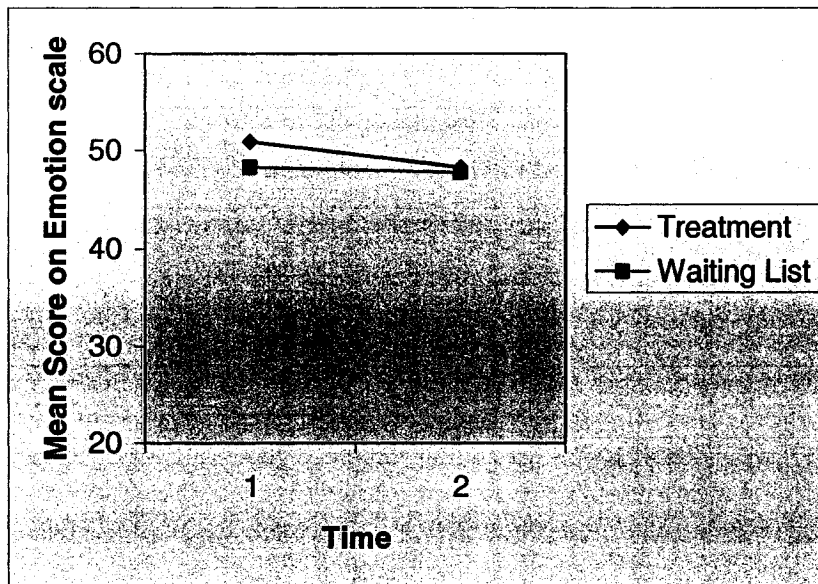


Figure 3 displays the mean scores on the Emotion-focused scale for the Treatment and Waiting List Groups over the two administrations. It was hypothesized (Hypothesis 3) that treated child molesters would demonstrate a decrease in their endorsement of emotion-focused strategies following treatment, while the Waiting List Group would demonstrate no significant change at Time 2. A univariate analysis examining the effect of Time indicated there was no significant change, $F(1, 58) = 1.82, p > .05$. Furthermore, a univariate analysis examining the Group X Time interaction revealed no significant effect, $F(1, 58) < 1$. An examination of the mean scores for these groups over the two administrations revealed that the means were similar for both groups and remained generally constant over time. Therefore, the hypothesis related to this subscale was not supported.

Figure 3.

Emotion-focused Coping Strategies for Offender Groups at Times 1 and 2



It was hypothesized (Hypothesis 4) that treated child molesters would demonstrate a decrease in their endorsement of avoidance-focused coping strategies between Time 1 and Time 2, while child molesters in the Waiting List Group would demonstrate no significant changes. Figure 4 displays the mean scores for both groups on the Avoidance-focused subscale. A univariate analysis examining the effect of Time demonstrated a significant effect, $F(1, 58) = 16.69, p < .001$. A univariate analysis examining the Group X Time interaction revealed no significant effect, $F(1, 58) = 3.45, p > .05$. Specifically, it was hypothesized that treated child molesters would demonstrate a decrease in their endorsement of Distraction strategies. The significant change over time permitted an examination of the Distraction and Social Diversion subscales of the Avoidance-focused subscale.

Figure 5 displays the mean scores for both groups on the Distraction subscale. A univariate analysis examining the effect of Time demonstrated no significant effect, $F(1, 58) < 1$. Similarly, a univariate analysis examining the Group X Time interaction revealed no significant effect, $F(1, 58) < 1$. Therefore, there were no differences between the groups on their use of Distraction coping at either administration, nor were there any changes within-group at the second administration. Thus, the hypothesis that treated child molesters would show a decrease was not supported. Figure 6 displays the mean scores on the Social Diversion subscale. A univariate analysis examining the effect of Time revealed no significant effect, $F(1, 58) = 8.44, p < .05$, and a univariate analysis examining the Group X Time interaction revealed a significant effect, $F(1, 58) = 8.87, p < .001$. A paired samples t-test revealed that the Treatment Group demonstrated a

significant change following treatment, $t(32) = -4.08$, $p < .001$, while the Waiting List Group did not, $t(26) = .12$, $p > .05$. An examination of the mean scores revealed that the Treatment Group's identification of social diversion strategies increased following treatment.

Figure 4.

Avoidance-focused Coping Strategies for Offender Groups at Times 1 and 2.

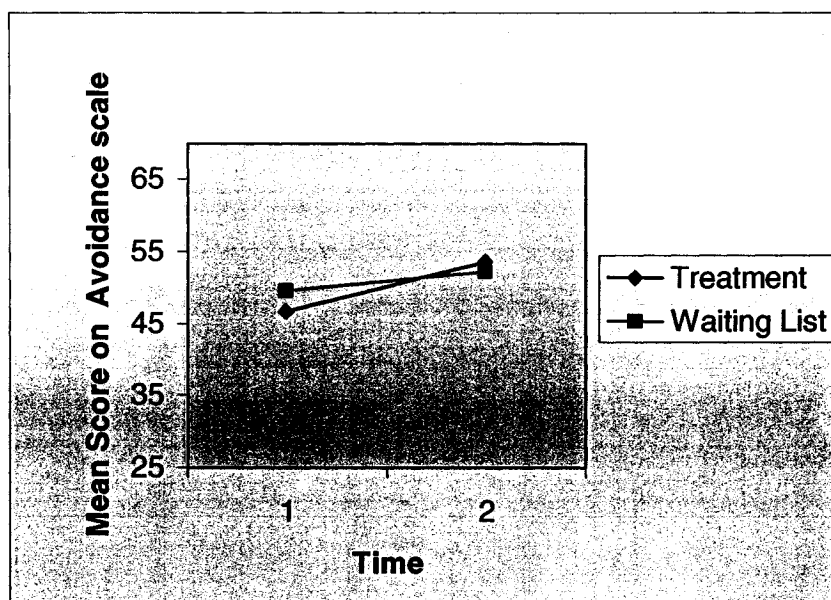


Figure 5.

Distraction Coping Strategies for Offender Groups at Times 1 and 2

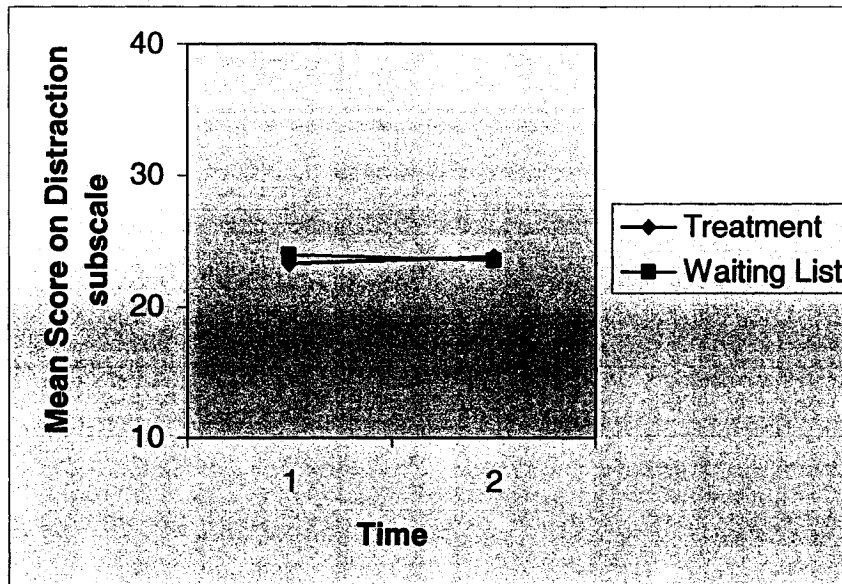
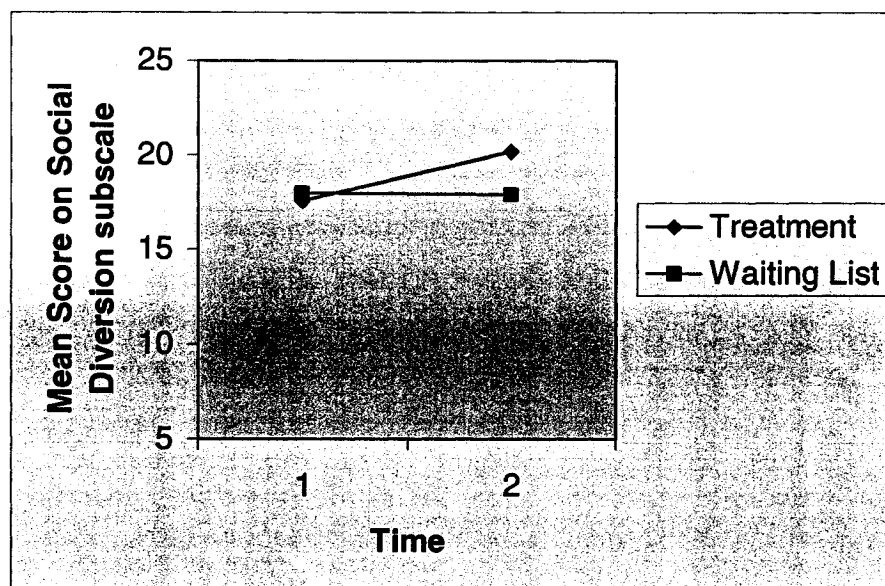


Figure 6.

Social Diversion Coping Strategies for Offender Groups at Times 1 and 2



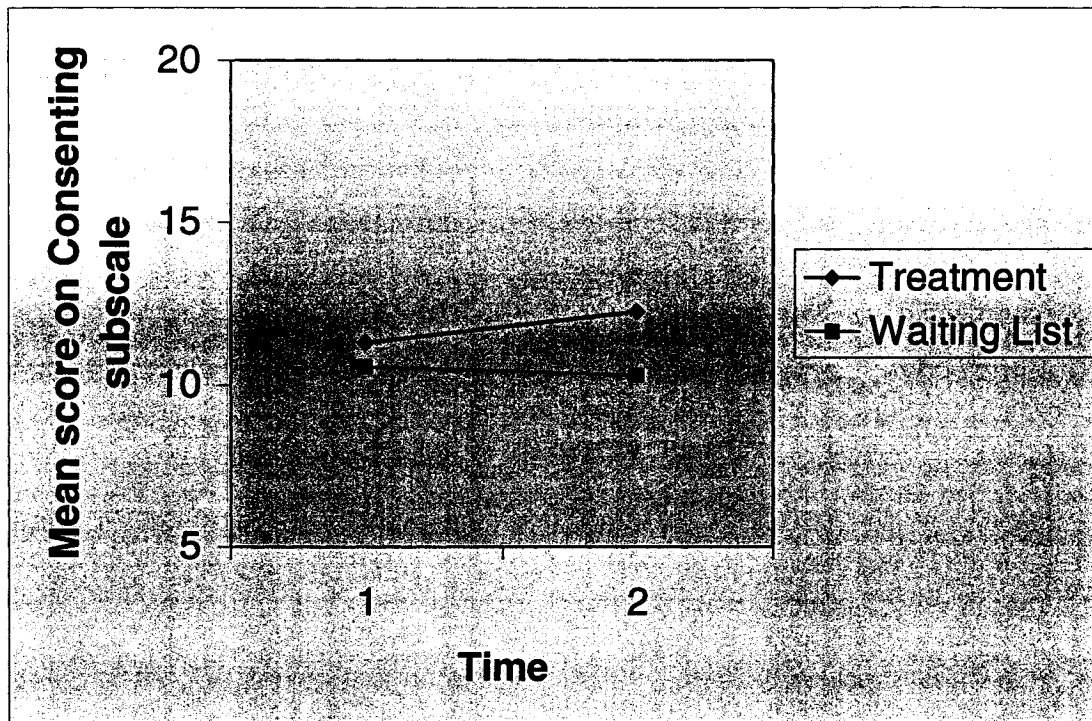
Sexual Coping

To examine the use of sexually related coping strategies, the Consenting subscale of the *Coping Using Sex Inventory* (CUSI; Cortoni & Marshall, 2001) was examined.

Figure 7 displays the mean scores for the Treatment and Waiting List groups. A univariate F-test revealed no significant effects for Time, $F(1, 58) < 1$, or for the Group X Time interaction, $F(1, 58) = 1.18, p > .05$. The hypothesis (Hypothesis 5) that treated child molesters would show a decrease in the use of sex as a coping strategy following treatment was not supported.

Figure 7.

Sexual Coping (Consenting Strategies) for the Offender Groups at Times 1 and 2.



Discussion

This study was designed to assess the effects of cognitive-behavioural treatment on changes in coping strategies for sexual offenders. Several major findings emerged from this study. Overall, compared to the Waiting List Group, treated child molesters demonstrated a significant increase in the effectiveness of the coping strategies they identified on a measure designed to examine their responses to high-risk situations. Second, treated child molesters demonstrated a significant increase in the endorsement of task-focused strategies and social diversion strategies on a general coping style measure. Third, no significant changes were found in the endorsement of emotion-focused strategies in either group on a general coping style measure. Finally, there were no significant changes in the reported use of sex as a coping strategy in either group.

Coping with High-risk Situations

Sexual offenders' ability to effectively cope with high-risk situations is viewed as essential to reducing risk to reoffend (Pithers et al., 1983). Original relapse prevention treatment programs concentrated specifically on teaching sexual offenders new, more effective coping strategies to prevent relapse. In the current study, coping with high-risk situations was measured by responses on the *Sex Offender Situational Competency Test*. This test includes commonly experienced high-risk situations, such as coping with urges to drink or use drugs, coping with emotions such as anger, and coping with opportunities to offend. Following treatment, child molesters were able to specify more effective strategies to cope with specific high-risk situations, compared to child molesters waiting to enter treatment.

Unfortunately, there is no normative data for the *Sex Offender Situational Competency Test*, making it difficult to determine exactly what the scores mean. However, an effectiveness rating scale was provided to score each response, ranging from highly effective to ineffective strategies. It is reasonable to expect treated child molesters to identify at least moderately effective strategies. From this perspective, at the initial administration, both groups scored within a range from ineffective (poor strategies) to somewhat acceptable (i.e., in some situations they were able to offer strategies that at least offered the possibility of reducing risk). Following treatment, the treatment group scored within a range that would be considered moderately effective, while the Waiting List Group remained in the somewhat acceptable range. This suggests that in the majority of the high-risk situations presented, treated sexual offenders were able to offer strategies that would allow them to effectively cope.

Current treatment programs for sexual offenders concentrate on reducing dynamic risk factors, and it is necessary for each offender to be able to effectively cope with his own dynamic risk factors. Therefore, increasing effective coping should contribute to a reduction of sexual reoffending. Considering that the goal of sexual offender treatment is to better equip the offenders to effectively address problematic issues, it is encouraging that the Treatment Group demonstrated an overall significant increase in their competency. Although not examined during the current study, certainly in some cases the offenders also practice more effective strategies (e.g., expressing themselves in an assertive manner, using self-talk). Strategies such as these serve to improve their overall mood state and ability to manage difficulties.

General Coping Style

The focus on general coping styles in this study resulted from previous research suggesting that sexual offenders have ineffective general coping styles. General coping strategies were assessed using the *Coping Inventory for Stressful Situations*. In this regard, three general styles were examined: task-focused, emotion-focused, and avoidance-focused. Within the avoidance-focused scale, there were two subscales measuring different styles of avoidance-focused coping, namely distraction and social diversion.

Task-focused coping

Task-focused coping refers to strategies used to directly solve a problem, reconceptualize it, or minimize its effects. At the initial administration, the mean scores of the Treatment and Waiting List Groups were similar. In general, research has demonstrated that incarcerated offenders report lower levels of task-focused coping when compared to noncriminal males from the community (Endler & Parker, 1990). However, the two groups in the current study demonstrated somewhat higher scores compared to the norms reported by Endler and Parker (1990). Child molesters in the current study, however, demonstrated similar scores to child molesters in previous research (Cortoni & Marshall, 2001). At the initial administration, child molesters in the Treatment Group scored at the 46th percentile compared to normal adult males, while the child molesters in the Waiting List Group scored at the 58th percentile. However, following treatment, the treated child molesters increased their endorsement of task-focused strategies to the 73rd percentile, while the child molesters in the Waiting List Group remained at the same level as they were initially.

This is an encouraging finding, particularly considering that task-focused strategies are viewed as the most adaptive and effective strategies (Zeinder & Endler, 1996). In research on the influence of coping responses to adjustment, active, problem-oriented strategies have been found to moderate the adverse influence of negative life events (Billings & Moos, 1981). In a similar vein, the proportion of task-focused coping in relation to other types of coping has been associated with reduced depression (Mitchell, Cronkite, & Moos, 1983). The fact that child molesters report greater choice of these types of strategies following treatment speaks positively of the treatment program. If child molesters are more inclined to use task-focused strategies, it follows that they will more effectively deal with stressors and problems in the future, thus contributing to a reduction of the likelihood of reoffense.

Emotion-focused coping

Emotion-focused coping was another general style measured by the CISS. Emotion-focused coping describes emotional reactions that are self-oriented, and are aimed at making one feel better about the situation without changing the problem. According to this general definition, emotion-focused coping need not necessarily be a negative strategy. However, the specific strategies comprising the emotion-focused style on the CISS were overwhelmingly problematic (e.g., “get angry”, “feel anxious about not being able to cope”, “become very upset”, “blame myself for putting things off”).

In this study, the child molesters in both the Treatment and Waiting List Groups scored higher in emotion-focused coping than did the incarcerated offenders in Endler and Parker’s (1990) study. However, this is not surprising considering that previous research (Cortoni & Marshall, 2001; Marshall, Serran, & Cortoni, 2000) demonstrated

that it is sexual offenders, rather than general offenders, who demonstrate a higher use of emotion-focused strategies. At the initial administration, child molesters in the treatment group were at the 85th percentile on the Emotion-focused subscale compared to nonincarcerated adult men. The mean score of child molesters in the Waiting List Group did not differ significantly from the treated child molesters at the initial administration, although their overall score was somewhat lower and was at the 79th percentile. At the second administration, again the Treatment and Waiting List Groups did not differ in their mean scores, and they were at the 79th and 76th percentiles, respectively.

Research has consistently demonstrated a positive link between emotion-focused strategies and various dimensions of psychopathology, such as depression and anxiety (Endler & Parker, 1999). For example, they found a relationship between emotion-focused coping, depression, and low self-esteem. For sexual offenders, this style of coping could be particularly problematic, especially when one considers the link between offending and mood-state. Negative emotional states and interpersonal conflict (which results in negative emotional states) are frequently associated with relapse and deviant sexual fantasies in sexual offenders (Pithers et al., 1983; Proulx et al., 1996). The tendency of sexual offenders to engage in self-denigration (Neidigh & Tomiko, 1991) and emotional rumination (Roger & Masters, 1997) suggests that emotion-focused strategies are widely used and are detrimental. These findings also point to a link between negative affect and emotion-focused coping strategies, such that the inability or unwillingness to control negative moods is linked to poor coping (Flett, Blankstein, & Obertynski, 1996).

In order to demonstrate a change in emotion-focused coping, it may be necessary to directly (rather than indirectly) target this approach in treatment. A preliminary study in Australia examining changes in coping following treatment (using the CISS) demonstrated a decrease in emotion-focused coping (Feelgood, Golias, Shaw, & Bright, 2000). Specific modules in this Australian program targeted coping, and the practice and refinement of effective skills was promoted in the treatment environment. Feelgood et al. noted that their treatment program focuses intensively on emotion-based issues. Similarly, Roger and Masters (1997) demonstrated a decrease in emotion-focused coping following a specific emotion-control program aimed at coping effectively with emotional distress. Alternatively, changing the type of emotion-focused strategies employed can be another alternative in treatment. Stanton and Franz (1999) suggest that emotional approach coping can be adaptive. Adaptive emotional approach coping involves strategies focused on effectively expressing emotion (e.g., appropriately expressing emotions, emotional identification). Perhaps assisting sexual offenders in effectively processing and expressing emotion may be most effective. Considering that emotion-focused coping might serve to increase negative emotions, it becomes essential to find methods that reduce the tendency to adopt ineffective strategies.

Avoidance-focused coping

Avoidance-focused coping is another general style measured by the CISS. Avoidance-focused coping describes activities and cognitive strategies aimed at avoiding or escaping the stressful situation. The Avoidance scale in this study was divided into two subscales, namely Distraction and Social Diversion. These subscales represent different categories of avoidance-focused strategies. In the current study, both groups

demonstrated similar mean scores at the initial administration on both the overall Avoidance scale and the Distraction and Social Diversion subscales, although these means were slightly higher than the offender norms demonstrated by Endler and Parker (1990). The Treatment and Waiting List Groups were at the 82nd and 86th percentiles on the overall Avoidance scale, respectively, compared to nonincarcerated adult men.

Although the use of distraction was high in both groups (84th percentile) and did not change significantly at the second administration, the use of social diversion strategies significantly increased in the treatment group (79th to 93rd percentile). Examining the individual items shed further light on this finding. Proposed strategies included “phone a friend”, “talk to someone whose advice I value”, “try to be with other people”. One component of the sexual offender treatment program involves the development of a circle of support, and group members are advised to contact their support network when they notice any “warning signs” or problems. Therefore, the fact that there was an increase on this subscale likely indicates an adaptive approach to coping, rather than an avoidance of dealing with problems. In fact, the availability of social resources is said to promote adaptive coping because they provide emotional support, tangible assistance, and informational guidance (Holahan & Moos, 1987). More specifically, support from family and friends is associated with greater reliance on information-seeking and problem-solving and less reliance on emotional discharge coping (Fondacaro & Moos, 1987). Feelgood et al. (2000) also found an increase in social diversion coping in their study and drew similar conclusions.

Research associated with avoidance coping in general demonstrates ambiguous results. Some research suggests that avoidance coping is associated with higher levels of

distress (Billings & Moos, 1984) while other research finds avoidance strategies to be effective (Brown, Vik, Patterson, Grant, & Schuckit, 1995). This implies that the outcome of using avoidance strategies might depend on the particular avoidance strategies employed. Specific avoidance strategies (e.g., watching television, listening to music, or going to sleep) might be less harmful than avoidance strategies involving overeating or substance use. Notably, the avoidance items in the current study were more benign in nature. As well, although avoidance strategies are given less encouragement in current sexual offender treatment than in original relapse prevention approaches (Mann, 1998), classic avoidance strategies (e.g., avoiding unsupervised contact with underage children, avoiding the use of alcohol) are still encouraged. Furthermore, the positive relationship found between task-focused and avoidance-focused strategies suggests that the specific avoidance-focused strategies measured in this study may be adaptive, at least to a certain degree. Providing that offenders do not completely avoid addressing problems and stressors, occasionally utilizing certain avoidance strategies will likely not prove harmful in the long run.

Sexual Coping

In the current study, the tendency to use sex as a coping strategy was measured with the *Coping Using Sex Inventory*. This measure provided an overall score, as well as scores on three subscales, Consenting, Rape and Child Molest. Although this measure has shown some success in previous research (Cortoni & Marshall, 2001), results were not significant in the current study. The subscales measuring deviant sexual activities elicited minimal responding and displayed no variance. Although this finding might be expected for the Rape subscale, as only child molesters were involved in the current

study, it was also the case for the Child Molest scale, which was not expected. Previous research (Cortoni & Marshall, 2001) found that child molesters used both child and rape-related sexual items when they attempted to cope with difficult or stressful situations. As well, they also made greater use of consensual sexual activities as a coping strategy compared to nonsexual offenders. Feelgood et al. (2000) used the CUSI in their treatment study and found significant decreases in the overall score, as well as on the Rape and Child molest subscales. Unfortunately, they do not provide mean scores on their measures, so we cannot compare their results with the present findings.

In the current study, the mean scores on this measure were much lower than those found in previous research. In fact, both groups demonstrated mean scores similar to those found in research utilizing nonsexual offenders (who have been shown to score lower on this measure than sexual offenders). As the mean initial score of the treatment group was sufficiently low that reducing the score may have proven difficult, it was not surprising that the group did not demonstrate a reduction in their use of sexual coping strategies following treatment.

It is not clear why the results in the current study differ from those of previous research, although they could represent a floor effect. The items in the scale are highly transparent, and it is possible that all participants simply chose not to endorse the items. It is also possible that participants in previous research studies were higher risk offenders and more likely to utilize sexually-based coping strategies. As well, considering that when in a negative mood state sexual offenders were more likely to engage in deviant sexual fantasy, they might be more likely to endorse sexual coping strategies when experiencing negative affect. It might be more useful to include sexually-based items in

a scale consisting of other general coping strategies, since offenders were somewhat more likely to endorse the consensual items. In line with this concept, Riches (2000) developed the Prisoner Coping Scale (PCS). This scale identified four distinct coping dimensions: problem-oriented, emotion-oriented, sexually-oriented, and active avoidance-oriented. Examples of items on the sexually-oriented subscale include “Take my mind off the problem by thinking about someone I find attractive” and “Comfort or distract myself by looking at pornography”. Perhaps measures such as these will better clarify our understanding of the role of sexual coping among sexual offenders.

Alternatively, previous research demonstrates that sexual offenders are more likely to experience deviant sexual thoughts or fantasies when faced with interpersonal conflicts and negative mood states. Perhaps a more behaviourally-oriented approach to determining when or if sexual offenders use sexual coping strategies would be more useful. An interview-based approach would assist in clarifying our understanding of the use of these strategies.

Clinical Implications

Instead of adopting a traditional relapse prevention approach focused on avoidance goals, therapists should move toward a focus on self-management and a “good lives” conception (Ward, 2000) in their treatment programs. Ward suggests that offenders lead a criminal lifestyle because it is rewarding in some ways, and in order to rehabilitate offenders it is necessary to instill the skills, knowledge, and resources to live different lives. The process involves identifying the internal and external obstacles that have been thwarting the individual’s ability to meet his needs, such as defensive strategies, coping deficits, unhealthy attitudes, and/or lack of social support. This overall

approach fits nicely within a treatment program focused on self-management. This approach also links well with Ward and Hudson's self-regulation model of sexual offending (Ward, Hudson, & Keenan, 1998). Even offenders who do not evidence problems with self-regulation per se (e.g., intact self-regulation but inappropriate goals), can still learn more adaptive ways of coping with and managing their lives so as not to reoffend. Those offenders who evidence coping skills-deficits may need to focus more specifically on learning and practicing more effective coping strategies, while those who do not would identify alternate goals to increase their life satisfaction and reduce their likelihood of recidivism.

Both the Good Lives Model and the Self-regulation Model provide avenues to manage different types of offenders with different types of coping deficits. As mentioned above, the types of goals chosen by offenders are critical. Sexual offenders who choose new, more positive life goals will be less likely to place themselves in high risk situations, but for those who do encounter high risk situations, learning to address these appropriately during self-management/relapse prevention is critical. For offenders with ineffective self-regulation, learning more practical coping strategies and learning to manage emotion more effectively are necessary treatment goals. In terms of sexual coping, one goal might be to challenge unhealthy ideas/attitudes about sexuality. Another goal would be to strive for a healthy approach to sexuality (e.g., effective communication about sexual issues, challenging sexual myths, sharing appropriate fantasies and activities with a partner). Offenders following a misregulation pathway appear most likely to use sexualized coping strategies and these offenders should learn healthier strategies to cope. Those who possess intact self-regulation but inappropriate

goals need to challenge inappropriate attitudes and choose a healthier approach to sexuality.

Conclusions

This study attempted to explore the reported use of a variety of coping strategies, both as general styles and in specific high-risk situations, and the effects of treatment on these coping strategies. Successful treatment of sexual offenders is most frequently measured through recidivism studies. In essence, if sexual offenders do not reoffend, it is assumed that treatment has been successful. Success could also be determined by changes in relevant factors, such as coping strategies. Improvement in the various domains of coping signifies an improvement in emotional well-being, and theoretically also affects the likelihood that sexual offenders will choose to reoffend. Child molesters' choice of coping strategies on some of the coping measures did change following treatment. These results are promising and suggest that treatment is influential in helping child molesters improve the effectiveness of their coping strategies, both in dealing with high-risk situations and in their general way of coping with problems. More effective coping is related to higher self-esteem and better psychological well-being (Rector & Roger, 1996), which are overall goals in sexual offender treatment. Since conflict, stress, and risk factors cannot be completely avoided, those who are capable of managing their problems more effectively and living satisfying lives should be at lower risk to sexually reoffend.

Although only one specific sexual offender treatment program was included in the current study, the components covered in this treatment program are similar to those components covered by other sexual offender programs in North America (Marshall,

Serran, & Moulden, in press). Currently, all programs at Federal Institutions in Canada are required to conform to the National Standards for Sexual Offender Treatment (Yates, Jeglic, Martin, & Goguen, 2002). This requirement is an attempt to standardize treatment for sexual offenders across institutions and programs. Interestingly, coping strategies are not specifically targeted in treatment as a separate component, but are focused on throughout the program. While there is no specific component in treatment designed to alter coping strategies, offenders are encouraged to identify new ways in which they will cope with problems in the future as part of the self-management section of treatment.

The current findings are encouraging, as they demonstrate some specific areas of improvement, particularly in dealing with high-risk situations and increasing task-focused strategies. However, due to the problems associated with emotion-focused coping (e.g., higher self-focus, lower self-esteem, stronger negative affect) and the clear finding from earlier studies that child molesters are more likely to endorse emotion-focused strategies, further research and treatment strategies must explore this area.

Limitations to the Current Study

The most important limitation that must be acknowledged is that this study was based on self-report measures and is therefore subject to various biases and problems.

Since coping strategies were identified through the use of self-report measures, it is unclear whether participants actually applied these strategies (or would apply these strategies) to difficult or stressful situations. Unfortunately, it was not possible to monitor specific behaviours, although this would be useful to determine whether they would actually apply the strategies to real situations.

In terms of the usefulness of the various measures, several issues should be noted. Ratings on one of the coping measures, the *Sex Offender Situational Competency Test*, were based on judgment and interrater reliabilities. While adequate, they also demonstrated room for improvement. This issue could be addressed by developing a more exhaustive list of sample strategies (and corresponding scores) to assist raters. As well, some of the situations in this measure do not apply to all offenders. For example, substance abuse is not a risk factor for all offenders. To address this limitation, offenders could rate their top five risk situations and respond solely to those situations. Competency scores would therefore be based on risk factors that are relevant to each offender.

Heppner, Cook, Wright, and Johnson (1995) note that items on general coping measures are often ambiguous and can easily have multiple meanings. As mentioned previously, the *Coping Using Sex Inventory* did a poor job of assessing this construct, making it difficult to draw any conclusions regarding the role of sexual coping.

Future Research

Further research should replicate and extend the current study. The current study included a variety of participants, some of who demonstrated stronger coping abilities in some areas prior to treatment (e.g., stronger endorsement of a task-focused style). It would be valuable to choose offenders who show clearly poor coping initially in order to fully test the influence of treatment. Extending the research to allow for more long-term assessments, particularly after offenders are released from prison, would contribute to our understanding of the influence of treatment and the stability of treatment-induced changes.

As well, it would be valuable to relate general coping styles and strategies to the context of problematic situations. For example, task-focused coping might not be effective if the strategy chosen is unrealistic, while certain types of emotion-focused strategies (e.g., accepting the situation and trying to survive it as best as possible) might be beneficial in certain situations. Therefore, future research endeavors targeting coping behaviour would be valuable. Related to this is the idea of minimal skill acquisition. Marshall and colleagues have developed a Therapist Rating Scale that consists of skill acquisition related to various treatment-relevant targets (e.g., general and victim specific empathy, general coping strategies, risk recognition, quality of self-management plan). Based on this scale, therapists rate clients post-treatment on each component. The goal is to help clients achieve various skills that improve their ability to live offence-free lives. Research linking skills acquisition, coping strategies, and recidivism would be valuable.

The current findings point to the importance of flexibility in treatment. Although it is relevant to focus on specific components in treatment, some offenders have specific needs that should be addressed to increase the effectiveness of treatment. Recent research (e.g., Marshall et al., 2002) is attempting to address various methods of improving the effectiveness of treatment (e.g., process issues) and the identification of idiographic and monothetic treatment targets should be a continued goal of researchers.

References

Barbaree, H.E., Marshall, W.L., & Conner, J. (1988). The social problem-solving of child molesters. Unpublished manuscript, Queen's University, Kingston, Ontario, Canada.

Beckett, R., (1998). Community treatment in the United Kingdom. In W.L. Marshall, Y.M. Fernandez, S.M. Hudson, & T. Ward (Eds.), Sourcebook of treatment programs for sexual offenders. (pp. 133-152). New York: Plenum Press.

Beckett, R., Beech, A., Fisher, D., & Fordham, A.S. (1994). Community-based treatment of sex offenders: An evaluation of seven treatment programmes. Home Office Occasional Paper. London: Home Office.

Billings, A.G., & Moos, R.H. (1981). The role of coping responses in attenuating the impact of stressful life events. Journal of Behavioural Medicine, 4, 139-157.

Billings, A.G., & Moos, R.H. (1984). Coping, strss, and social resources among individuals with unipolar depression. Journal of Personality and Social Psychology, 46, 877-891.

Bonta, J., & Hanson, R.K. (1994). Gauging the risk for violence: Measurement, impact and strategies for change. (Corrections Branch User Report 1994-09). Ottawa: Department of the Solicitor General of Canada.

Bolger, N. (1990). Coping as a personality process: A prospective study. Journal of Personality and Social Psychology, 59, 525-537.

- Brown, S.A., Vik, P.W., Patterson, T.L., Grant, I., & Schuckit, M.A. (1995). Stress, vulnerability and adult alcohol relapse. Journal of Studies of Alcohol, 56, 538-545.
- Carver, C.S., Pozo, C., Harris, S.D., Noriega, V., Scheier, M.R., Robinson, D.S., Ketcham, A.S., Moffat, F.L., Jr., & Clark, K.C. (1993). How coping mediates the effects of optimism on distress: A study of women with early stage breast cancer. Journal of Personality and Social Psychology, 65, 375-391.
- Carver, C.S., Scheier, M.F., & Weintraub, J.K. (1989). Assessing coping strategies: A theoretically based approach. Journal of Personality and Social Psychology, 56(2), 267-283.
- Chaney, E.F., O'Leary, M.R., & Marlatt, G.A. (1978). Skill training with alcoholics. Journal of Consulting and Clinical Psychology, 46, 1092-1104.
- Chaney, E.F., & Roszell, D.K. (1985). Coping in opiate addicts maintained on methadone. In S. Shiffman & T.A. Willis (Eds.), Coping and substance abuse (pp. 267-293). New York: Academic.
- Cohen, F. (1987). Measurement of coping. In S.V. Kasl & C.L. Cooper (Eds.), Stress and health: Issues in research methodology (pp. 283-305). New York: Wiley.
- Committee on Sexual Assault of Children and Youths (1984). Sexual offenses against children. Ottawa: Canadian Government Publishing Centre.
- Compas, B.E., Malcarne, V.L., & Fondacaro, K.M. (1988). Coping with stressful events in older children and younger adolescents. Journal of Consulting and Clinical Psychology, 56(3), 405-411.

Cortoni, F.A., Anderson, D.A., & Looman, J. (1999). Locus of control and coping in sexual offenders. Poster presented at the Association for the Treatment of Sexual Abusers 18th Annual Research and Treatment Conference, Orlando, Florida.

Cortoni, F.A. & Marshall, W.L. (2001). Sex as a coping strategy and its relationship to juvenile sexual history and intimacy in sexual offenders. Sexual Abuse: A Journal of Research and Treatment, 8, 27-43.

Cronkite, R.C., & Moos, R.H. (1984). The role of predisposing and moderating factors in the stress-illness relationship. Journal of Health and Social Behavior, 25, 372-393.

Cull & Wehner (1998). Australian aborigines: Cultural factors pertaining to the assessment and treatment of Australian aborigine sexual offenders. In W.L. Marshall, Y.M. Fernandez, S.M. Hudson, & T. Ward (Eds.) Sourcebook of treatment programs for sexual offenders (pp. 431-444). New York: Plenum Press.

Davis, J.R., & Glaros, A.G. (1986). Relapse prevention and smoking cessation. Addictive Behaviors, 11, 105-114.

Day, D.D., Miner, M.H., Nafpaktitis, M.K., & Murphy, J.F. (1987). Final report: Development of a situational competency test for sex offenders. (Available from David M. Day, California Department of Mental Health, 1600 Ninth Street, Sacramento, CA 95814).

Endler, N.S. & Parker, J.D. (1999). The Coping Inventory for Stressful Situations: Manual (2nd ed.). Toronto: Multi-Health Systems, Inc.

Endler, N.S. & Parker, J.D. (1992). Interactionism revisited: The continuing crisis in the personality area. European Journal of Personality, 6, 177-198.

Endler, N.S., & Parker, J.D. (1990). Multidimensional assessment of coping: A critical evaluation. Journal of Personality and Social Psychology, 58, 844-854.

Ender, N.S., & Parker, J.D. (1989). Coping with frustrations to self-realization: Stress, anxiety, crises and adjustment. In E. Krau (Ed.), Self-realization, success and adjustment (pp. 153-164). New York: Praeger.

Feelgood, S., Golias, P., Shaw, S., & Bright, D.A. (2000). Treatment changes in the dynamic risk factor of coping style in sexual offenders: A preliminary analysis. N.S.W. Department of Corrective Services Sex Offender Programmes Custody Based Intensive Treatment (CUBIT).

Flett, G.L., Blankstein, K.R., & Obertynski, M. (1996). Affect intensity, coping styles, mood regulation expectancies, and depressive symptoms. Personality and Individual Differences, 20, 221-228.

Freeman-Longo, R., Bird, S.L., Stevenson, W.F., & Fiske, J.A. (1994). 1994 Nationwide survey of treatment programs and models. Brandon, VT: Safer Society Press.

Folkman, S. & Lazarus, R.S. (1986). Stress processes and depressive symptomatology. Journal of Abnormal Psychology, 95, 107-113.

Folkman, S., & Lazarus, R.S. (1985). If it changes it must be a process: A study of emotion coping during three stages of a college examination. Journal of Personality and Social Psychology, 48, 150-170.

Folkman, S., & Lazarus, R.S. (1980). An analysis of coping in a middle-aged community sample. Journal of Health and Social Behavior, 21, 219-239.

Fondacaro, M.R., & Moos, R.H. (1987). Social support and coping: A longitudinal analysis. American Journal of Community Psychology, 15, 653-673.

Furby, L., Weinrott, M.R., & Blackshaw, L. (1989). Sex offender recidivism: A review. Psychological Bulletin, 105, 3-30.

Goldfried, M.R., & D'Zurilla, T.J. (1969). A behavior-analytic model for assessing competence. In C.D. Spielberger (Ed.), Current topics in clinical and community psychology (Vol.1; pp. 151-196). New York: Academic.

Hanson, R.K. (1997). How to know what works with sexual offenders. Sexual Abuse: A Journal of Research and Treatment, 9(2), 129-146.

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

Hanson, R.K., & Harris, A.J.R. (2000). Where should we intervene? Dynamic predictors of sexual offense recidivism. Criminal Justice and Behavior, 27(1), 6-35.

Hanson, R.K., Gordon, A., Harris, A.J.R., Marques, J.K., Murphy, W., Quinsey, V.L., & Seto, M.C. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. Sexual Abuse: A Journal of Research and Treatment, 14, 169-194.

Heppner, P.P., Cook, S.W., Wright, D.M., & Johnson, C.W. (1995). Progress in resolving problems: A problem-focused style of coping. Journal of Counseling Psychology, 42, 179-293.

Holohan, C.J., & Moos, R.H. (1987). Personal and contextual determinants of coping strategies. Journal of Personality and Social Psychology, 52, 946-955.

Hughes, G., & Zamble, E. (1993). A profile of Canadian correctional workers: How they experience and respond to job stress. International Journal of Offender Therapy and Comparative Criminology, 37, 99-113.

Hunter, N., & Kelley, C.K. (1986). Examination of the validity of the adolescent problems inventory among incarcerated juvenile delinquents. Journal of Consulting and Clinical Psychology, 54, 301-302.

Katz, D. (in press). Victims of sexual abuse. In A.S. Bellack & M. Hersen (Eds.), Comprehensive clinical psychology: Vol. 9. Applications in diverse populations (Vol. Ed., N. Singh). Oxford: Elsevier Science.

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

Laws, D.R. (1989). Relapse prevention in sex offenders. The Guilford Press.

Laws, D.R., Hudson, S.W., & Ward, T. (2000). Remaking relapse prevention with sex offenders. The Guilford Press.

Lazarus, R., & Folkman, S. (1987). Transactional theory and research on emotions and coping. European Journal of Personality, 1, 141-169.

Looman, J. (1995). Sexual fantasies of child molesters. Canadian Journal of Behavioural Science, 27(3), 321-332.

Looman, J., Abracen, J., Maillet, G., & DiFazio, R. (1998). Phallometric nonresponding in sexual offenders. Sexual Abuse: A Journal of Research and Treatment, 10, 325-336.

Loucks, A., & Zamble, E. (1994). Some comparisons of male and female serious offenders. Forum on Corrections Research, 6, 22-25.

Mann, R.E. (1998, October). Relapse prevention? Is that the bit where they told me all the things I couldn't do anymore? Paper presented at the 17th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, Vancouver, BC.

Mann, R.E. (1996, November). Measuring the effectiveness of relapse prevention intervention with sex offenders. Paper presented at the 15th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, Chicago.

Mann, R.E., & Thornton, D. (1998). The evolution of a multisite sexual offender treatment program. In W.L. Marshall, Y.M. Fernandez, S.M. Hudson, & T. Ward (Eds.), Sourcebook of treatment programs for sexual offenders (pp. 47-57) New York: Plenum Press.

Mann, R.E., Webster, S.D., Schofield, C., & Marshall, W.L. (in press). Approach versus avoidance goals in relapse prevention with sexual offenders. Sexual Abuse: A Journal of Research and Treatment.

Marlatt, G.A. (1985). Relapse prevention: Theoretical rationale and overview of the model. In G.A. Marlatt & J.R. Gordon (Eds.), Relapse prevention: Maintenance strategies in the treatment of addictive behaviors (pp. 3-70). New York: Guilford.

Marques, J.K. (1987). The sex offender treatment and evaluation project: California's new outcome study. Presented at the New York Academy of Sciences Conference on Human Sexual Aggression: Current Perspectives.

Marques, J.K., Day, Nelson, & Miner (1987). Sex offender treatment and evaluation project: Second report to the legislature in response to PC 1365. Sacramento, CA: California State Department of Mental Health.

Marques, J.K., Pithers, W.D., & Marlatt, G.A. (1984). Relapse prevention: A self-control program for sex offenders. Appendix to: Marques, J.K. An innovative treatment program for sexual offenders: Report to the legislature. Sacramento: California Department of Mental Health.

Marshall, W.L. (1992). The social value of treatment for sexual offenders. Canadian Journal of Human Sexuality, 1, 109-114.

Marshall, W.L., Anderson, D., & Fernandez, Y.M. (1999). Cognitive behavioural treatment of sexual offenders. John Wiley & Sons, Ltd.

Marshall, W.L., & Eccles, A. (1996). Cognitive-behavioral treatment of sex offenders. In V.B. Van Hasselt & M. Hersen (Eds.), Sourcebook of psychobiological treatment manuals for adult disorders (pp. 295-332). New York: Plenum Press.

Marshall, W.L., Serran, G.A., & Cortoni, F.A. (2000). Childhood attachments and sexual abuse and the effect on adult coping in child molesters. Sexual Abuse: A Journal of Research and Treatment, 12, 17-26.

Marshall, W.L., Serran, G.A., & Moulden, H. (in press). Effective intervention with sexual offenders. In H. Kenshall & G. McIvor (Eds.). Sexual offenders: Managing the risk, research highlights in social work. London: Jessica Kingsley.

Marshall, W.L., Serran, G.A., Moulden, H., Mulloy, R., Fernandez, Y.M., Mann, R.E., & Thornton, D. (2002). Therapist features in sexual offender treatment: Their

reliable identification and influence on behaviour change. Clinical Psychology and Psychotherapy, 9, 438-450.

McCormick, R.A., & Smith, M. (1995). Aggression and hostility in substance abusers: The relationship to abuse patterns, coping style, and relapse triggers. Addictive Behaviors, 20, 555-562.

McKibben, A., Proulx, J., & Lusignan, R. (1994). Relationships between conflict, affect, and deviant sexual behaviors in rapists and pedophiles. Behaviour Research and Therapy, 13, 571-575.

McRae, R.R., & Costa, P.T. Jr. (1986). Personality, coping, and coping effectiveness in an adult sample. Journal of Personality, 54, 385-405.

Miller, S.M. (1990). To see or not to see: Cognitive informational styles in the coping process. In M. Rosenbaum (Ed.), Learned resourcefulness: On coping skills, self-control, and adaptive behavior (pp. 95-126). New York: Springer.

Miller, S.M., Brody, D.S., & Summerton, J. (1988). Styles of coping with threat: Implications for health. Journal of Personality and Social Psychology, 54, 142-148.

Miner, M., Day, D., & Nafpaktitis (1988). Instruction manual: Sex Offender Competency Test. California Department of Mental Health, Sex Offender Treatment and Evaluation Project.

Mitchell, R.E., Cronkite, R.C., & Moos, R.H. (1983). Stress, coping and depression among married couples. Journal of Personality and Social Psychology, 92, 433-448.

Neidigh, L. & Tomiko, R. (1991). The coping strategies of sexual abusers. Journal of Sex Education and Therapy, 17, 103-110.

Parker, J.D., & Endler, N.S. (1996) Coping and defense: A historical overview. In M. Zeidner & N.S. Endler (Eds.). *The handbook of coping*. John Wiley & Sons, Inc.

Parker, J.D., & Endler, N.S. (1992). Coping with coping assessment: A critical review. European Journal of Personality, 6, 321-344.

Paulhus, D.L. (1998). Paulhus deception scales: Users manual. Multi-Heath Services.

Pithers, W.D. (1990). Relapse prevention with sexual aggressors: A method for maintaining therapeutic change and enhancing external supervision. In W.L. Marshall, D.R. Laws, & H.E. Barbaree (Eds.), The handbook of sexual assault: Issues, theories and treatment of the offender (pp. 363-385). New York: Plenum.

Pithers, W.D., Kashima, K.M., Cumming, G.F., Beal, L.S., & Buell, M.M. (1988). Relapse prevention of sexual aggression. In R.A. Prentky & V.L. Quinsey (Eds.), Human sexual aggression: Current perspectives (pp. 244-260). New York: New York Academy of Sciences.

Pithers, W.D., Marques, J.K., Gibat, C.C., & Marlatt, G.A. (1983). Relapse prevention with sexual aggressors: A self-control model of treatment and maintenance of change. In J. Greer & I.R. Stuart (Eds.), The sexual aggressor: Current perspectives on treatment (pp. 214-239). New York: Van Nostrand Reinhold.

Prentky, R.A., & Burgess, A. (1990). Rehabilitation of child molesters: A cost-benefit analysis. American Journal of Orthopsychiatry, 60, 80-117.

Proulx, J., McKibben, A., & Lusignan, R. (1996). Relationships between affective components and sexual behaviors in sexual aggressors. Sexual Abuse: A Journal of Research and Treatment, 8(4), 279-289.

Rector, N.A., & Roger, D. (1996). Cognitive style and well-being: A prospective examination. Personality and Individual Differences, 21, 663-674.

Riches, E. (2000). Construction and validation of the Prisoner Coping Scale (PCS). Unpublished Master's Thesis.

Roger, D. (1995). Emotion control, coping strategies, and adaptive behavior. Stress and Emotion, 15, 255-264.

Roger, D. & Masters, R. (1997). The development and evaluation of an emotion control training program for sex offenders. Legal and Criminological Psychology, 2, 51-64.

Stanton, A.L., & Franz, R. (1999). Focusing on emotion: An adaptive coping strategy? In C.R. Snyder (Ed.) Coping: The psychology of what works. New York: Oxford University Press.

Tabachnick, B.G., & Fidell, L.S. (1996). Using multivariate statistics (3rd edition). New York: Harper Collins.

Ward, T. (2002). Good lives and the rehabilitation of offenders: Promises and problems. Aggression and Violent Behaviour, 7, 513-528.

Ward, T., & Hudson, S.M. (1996). Relapse prevention: A critical analysis. Sexual Abuse: A Journal of Research and Treatment, 8, 177-200.

Ward, T. & Hudson, S.M. (1998). A model of the relapse process in sexual offenders. Journal of Interpersonal Violence, 13(6), 700-725.

Wormith, J.S., & Hanson, R.K. (1992). The treatment of sexual offenders in Canada: An update. Canadian Psychology, 33, 180-198.

Zamble, E., & Porporino, F.J. (1988). Coping, behavior, and adaptation in prison inmates. New York: Springer.

Yates, P.M., Jeglic, E., Martin, G., & Goguen, B.C. (2002). National Sex Offender Programs: Service Providers' Training and Resource Manual. Correctional Service of Canada.

Zamble, E., & Quinsey, V.L. (1997). The criminal recidivism process. New York: Cambridge University Press.

Zeinder, M., & Endler, N.S. (1996). Handbook of coping: Theory, research, applications. New York: John Wiley.

Appendix A

Description of the Treatment Program

Upon admission to the penitentiary system, all offenders are sent to the Millhaven Assessment Unit for initial assessment. The purpose of the assessment is to determine the appropriate institutional placement, treatment requirements, and static risk factors.

Bath Institution Sexual Offender Treatment Program

Type: Medium security institution

Intensity: Moderate/Low-Moderate

Director: W.L. Marshall, Ph.D., C. Psych.

Therapists: MA-level/Ph.D. therapists in clinical psychology

Theoretical orientation: Cognitive-Behavioural with Relapse Prevention

Service Delivery Mode: Group therapy

Size of groups: approximately 10 clients per group

Duration of Program: 16 weeks

Number of sessions/hours per week: Two sessions/3 hours per session/6 hours per week

Exclusions: Absolute Denial

Open and Closed groups

Confidentiality: The importance of confidentiality within the group is stressed. Group members are reminded that they are not to discuss anything that occurs in the group sessions with anyone not in the group. Therapists only discuss sessions with their supervisor and the parole officers.

Program Description/Contents:

The Sexual Services Treatment Program at Bath Institution is designed to facilitate the safe release of sexual offenders incarcerated at Bath Institution and to promote their successful reintegration into the community. Treatment is designed to reduce the level of the factors that contribute to the inmate's risk of reoffense and to assist the offender in developing a strategy to prevent reoffense. Offenders are expected to complete homework between sessions.

Components:

Introduction to treatment. During this phase of treatment, clients are oriented to treatment, with the focus on enhancing motivation. Clients are asked provided with an overview of the program and are provided with an opportunity to discuss their goals and expectations for treatment. During these initial sessions, therapists facilitate a discussion of the cognitive-behavioural model of therapy and basic information about risk, in order to introduce offenders to the principles of risk. This exercise is designed to enhance motivation for treatment. During the initial sessions, the group develops a list of group rules.

1. Addressing issues of responsibility. Initially, offenders are required to provide a comprehensive disclosure of their offences. The purpose behind the disclosure is to identify the extent to which they accept responsibility for their actions and to identify any cognitive distortions they endorse. Throughout treatment, clients are assisted in developing an understanding of the attitudinal, cognitive, and affective processes that underlie criminal sexual behaviour and violence, and to personalize this by addressing their own distortions. Cognitive distortions are challenged and changed through cognitive restructuring. The goal is to replace self-talk and attitudes which support

offending, with self-talk and attitudes that are not conducive to offending through extensive practice and rehearsal.

2. **Victim Awareness and Empathy Enhancement:** The goals for this component generally are: a) to develop empathy for victims and to have a better understanding of their trauma; b) to learn victim awareness as a tactic to control urges to offend; c) to increase sense of caring for others; d) to change the problematic attitudes and cognitive distortions that make it easier to commit an offense; e) to identify ways of making appropriate sexual content, judging consent; f) to examine issues such as age of consent, power, and control; g) to challenge sexual myths related to offending; h) to facilitate inmates' ability to deal with their own abuse (if applicable). Offenders complete victim empathy letters and/or victim diary entries specific to their own victims. Discussions regarding victim empathy are utilized to help develop an understanding of victim issues. Perspective-taking abilities are enhanced through examples and exercises.
3. **Relapse Prevention/Self-management:** The goals for this component generally include the following: a) the offender develops his offense analysis, that is, the circumstances, thoughts, feelings, behaviour that lead to the commission of the offense; b) to help him to identify his high-risk situations and warning signs; c) to help him to understand and control the decision-making processes associated with commission of the offense; d) to help him develop effective coping strategies to effectively cope with high-risk situations.

During this component of treatment, each offender completes an autobiography which is read during the group session. Through this autobiography and group

discussions, various issues related to the offending behaviour are identified. He is required to identify background and proximal factors that play a role in the decision to offend. Predisposing risk factors are factors which are pre-existing or which develop over time, and which are not necessarily immediately evident in the situation in which offending occurs. Rather, they are underlying factors that set the stage for future difficulties. These factors may include early abuse experiences, poor peer relations, impulsivity, anger or difficulty controlling anger, antisocial attitudes/behaviour, intimacy/relationship problems, deviant sexual arousal/behaviour and substance abuse.

Proximal factors include interpersonal conflict, negative mood states (e.g., anger, depression), access to victims, and deviant sexual fantasies/arousal. These risk factors are analyzed through the pathways to offending treatment activity and are targeted for intervention in the development of the self-management and release planning treatment activities. Perpetuating risk factors are factors that occur after the offence has been committed and function to reinforce and maintain sexual offending behaviour. Perpetuating risk factors may also function to justify sexual offending after its occurrence, such as cognitive distortions and attempts to hide the offence. These factors are also analyzed during the pathways to offending treatment activity and are targeted for intervention during the self-management exercise.

After offenders develop a comprehensive understanding of the factors involved in their offences, they are required to focus on relapse prevention/self-management. Effective self-management involves utilizing a variety of strategies for coping with high-risk situations. During this aspect of treatment, offenders are taught effective

coping strategies to manage high risk situations. Offenders are required to identify warning signs/risk factors that suggest they are placing themselves in a position to reoffend. They are required to identify thoughts, feelings, and behaviours that are problematic for them. After identifying these factors, each offender is required to identify several coping strategies he can use to effectively cope with these risk factors. Coping strategies are discussed during treatment and distinctions are made between effective and ineffective strategies. They are asked to identify old, ineffective strategies they have used in the past and to identify why these strategies were not effective. Following this, offenders are required to identify alternative coping strategies to enhance their repertoire of effective strategies.

Self-management and release planning

Following the identification of strategies, offenders are required to develop a positive life plan that excludes offending. During this aspect of treatment, each offender is required to identify a variety of life goals and means to achieve them. This treatment activity is designed to assist clients in developing individualized, practical strategies to prevent the recurrence of both sexual offending behavioural and lifestyle factors associated with an increased likelihood of reoffending. Clients should:

- Develop skills and strategies that will allow the client to intervene in the pathway to offending
- Learn to anticipate and identify “risk to offend” thoughts, feelings, behaviours, and circumstances

- Develop a realistic plan of action that includes effective strategies that will assist the client in successfully managing internal and external risk factors at any stage in the behavioural progression to offending.
- It is critical that clients develop strategies that are concrete and practical that can be easily implemented.
- Coping strategies: Reliance on avoidance of high-risk situations as the sole strategy must be avoided. While it is desirable that offenders refrain from placing themselves in high-risk situations, it is inevitable that they will encounter some situations, and they must be prepared to cope with that possibility.
- Although strategies should target specific high-risk situations, it is equally important that general coping strategies are learned as well. It is expected that these skills will be generalized to a variety of situations.

Self-management strategies:

- Self-monitoring: Daily monitoring of thinking, feelings, attitudes and behaviours through keeping a journal, challenging self-talk, and being aware of emotions
- Review plans: Periodic review of goals and plans to ensure clients are maintaining a positive lifestyle
- Social support: Maintaining consistent contact with social supports
- Other coping strategies: using “time-outs”, treatment for long-term issues such as childhood abuse

- Cognitive and behavioural interventions: challenging self-talk, relaxation exercise, lifestyle approaches, using effective communication, practice and rehearsal, rewarding yourself.
- Avoidance and escape strategies: plan to avoid high-risk situations (e.g., access to victims, substance abuse, negative emotions).

4. Relationships, Intimacy, and Social Functioning. The goal of this component is to improve the ability to develop an understanding of one's patterns of relationships, to initiate, maintain and cope with feelings of loneliness and rejection, and to improve self-esteem. Clients are helped to develop an understanding of the relationship between a lack of social and intimacy skills and sexual offending behaviour, and upon becoming aware of one's own deficits in social and intimate relationships and assist the client to link these factors to his offending. Beliefs, expectations, and sexual satisfaction in relationships are addressed. These include unrealistic expectations, beliefs, and myths about sex that affect healthy sexuality. For example: orgasm is the primary goal of sex, penile penetration is sufficient for orgasm, sex is dirty. Discussions surrounding consent are conducted in order to understand the process of consent and to understand how certain behaviours or situations (e.g., intoxication, criticizing, threatening, withholding approval or affection) can interfere with consent.

Initiating a Relationship. Clients are taught various skills for initiating relationships, including initiating and maintaining a conversation. Problematic behaviours include being overbearing, monopolizing the conversation, only talking about what you want or about yourself, boasting, putting other people down, telling the person all of your life problems, and coming on sexually too quickly and aggressively.

Maintaining Relationships Clients are taught healthy relationship skills, including good communication, trust, and confidence. Healthy relationships require respect, honesty, compromise, and listening skills. Clients learn that trust develops over time and that they need to take risks to learn to trust. Role plays and discussions are used to identify effective and ineffective means of communication. Negotiation is presented as an important skill, and the following strategies are discussed: discussing important issues, being specific and focusing on one issue, speak one at a time, look for compromise, do not use force or aggression. Conflict resolution is critical for maintaining relationships and the skills presented are similar to problem-solving.

5. Strong community support is emphasized. Clients are taught that strong support can provide practical help, such as finding a job or apartment, as well as emotional support. Good supports are prosocial in that they will not support sexual offending behaviour and will challenge risk to offend. Clients are required to develop community support lists including community agencies, family, friends, self-help groups, and parole officer.

Treatment Process

The treatment program is designed for adult male sexual offenders (familial and non-familial) who have sexually offended against either women or children (See Marshall & Eccles, 1996). Mixed groups are conducted to help overcome beliefs in particular offenders that their crimes were not as bad as others. The largest percentage of clients are child molesters and rapists, with fewer exhibitionists. The general approach to therapy is to be supportively challenging when an offender is minimizing, denying, or distorting. Participants' self-confidence is enhanced during treatment by 1) encouraging them to distinguish their behaviour from their global image of themselves 2) being

supportive yet firm when challenging distortions and 3) persuading them that change is a possibility.

Targets include offense-specific targets such as denial, minimization, victim empathy, distorted attitudes and beliefs, fantasies, and the development of a relapse prevention plan. Offense-related targets include relationship skills, substance abuse, anger management, social and life skills, and communication.

Entry into the Program

Offenders are thoroughly assessed in order to determine treatment needs, risk for reoffending, suitability for particular placement, etc.). All clients are given the opportunity to enter treatment, whether they are minimizing or denying certain aspects of the offence, or suffering from some other disorder. Only if the client's intellectual functioning is below an IQ of 70 is he excluded from the group program.

Appendix B

Demographic Information

Age: _____

Marital Status (Circle One):

1. Single
2. Married
3. Widowed
4. Separated
5. Divorced
6. Common-law

Education Level Completed: _____

Current Offense: _____

Length of Sentence: _____

Offense History (Please list your convictions, use the back of page if necessary):

As an Adult

As a Juvenile

1. _____
2. _____
3. _____
4. _____
5. _____

- _____
- _____
- _____
- _____
- _____

Appendix C

Paulhus Deception Scales

Appendix D

Instructions for SCT:

As part of our research to improve our treatment program, we want to find out how you react to some real life, everyday situations that you might find outside the prison. Read each situation carefully, and imagine that it is actually happening to you. Write down what you would normally say, do, and think if you were in that situation. If the situation requires doing something rather than saying something, then just describe what you would do, but remember to imagine that the situation is actually happening to you. Some situations may not seem to fit you too well. For example, they may suggest that you have a wife or stepchild. If you are not married, think of a live-in lover if that is easier to imagine. If you don't have a stepchild, you might substitute a lover's child. Do your best to reply to all of the situations.

Appendix D continued

SCT - 1

1. You are unable to raise the money for transportation, and there is nothing to do close to home. You are very bored. What do you do?
2. You come home from a trip and find your wife gone. This makes you very angry. You go out looking for your wife but can't find her. What do you do?
3. You are going through withdrawal from alcohol and drug abuse, and you feel very tense. You call your doctor but he is unavailable. What do you do?
4. Your mother has been blaming you for drinking too much and being lazy. You argue with her almost daily. What do you do?
5. You've been fired from your job, and because it was so hard to get, you know it will be hard to find a new one. Things are looking desperate. What do you do?
6. You are using a lot of drugs and alcohol and just had a fight with your wife. What do you do?
7. You are out of work with a lot of time on your hands. To escape the boredom you have gone for a drive and see a woman hitchhiking along the road. What do you do?
8. You are on your way home from a party and you're pretty high. You think about going over to the apartment of a woman you met at the party. You know she will be alone. What do you do?
9. You just had a fight with your wife. You go to a bar and get pretty high. You meet a woman there who agrees to go for a ride with you. What do you do?
10. Your girlfriend has recently moved out. She told you that you could never satisfy a woman. You are cruising around and notice a woman alone. She looks kind of like a hooker. What do you do?
11. You have a bad hang-over from using alcohol and cocaine. You find your girlfriend in bed in a sexy nightgown. You try to have sex with her, but she resists. What do you do?
12. You've been drinking and smoking pot with a girlfriend. You get her into your bedroom and ask her to take her clothes off. She refuses, but you feel she isn't refusing. What do you do?

Appendix D continued

13. You have picked up a prostitute who agreed to spend the night with you. She argues about where you are going to go and then changes her mind and tries to get out of the car. What do you do?
14. You and some friends, including a woman, are drinking and riding around in a car. Your buddy says, "let's rape this woman". What do you do?

Appendix D continued
SCT - 2

1. You are unable to raise the money for transportation, and there is nothing to do close to home. You are very bored. What do you do?
2. You come home from a trip and find your wife gone. This makes you very angry. You go out looking for your wife but can't find her. What do you do?
3. You are going through withdrawal from alcohol and drug abuse, and you feel very tense. You call your doctor, but he is unavailable. What do you do?
4. Your mother has been blaming you for drinking too much and being lazy. You argue with her almost daily. What do you do?
5. You've been fired from your job. And because it was so hard to get, you know it will be hard to find a new one. Things are looking desperate. What do you do?
6. You are using a lot of drugs and alcohol and just had a fight with your wife. What do you do?
7. You're helping a neighbour who is giving a birthday party for one of her children. She runs out of ice cream and asks you to watch the kids as she runs to the store. What do you do?
8. A young neighbour girl tells you she thinks you are sexy. What do you do?
9. You suspect your wife of having an affair. You come home to find your stepdaughter home alone. You are fairly certain that your wife is with her lover. What do you do?
10. Some kids down the block find out you are an ex-offender and order you to buy them some beer or they are going to tell people you touched them. What do you do?
11. You are living with relatives who are incestuously involved. You are around their children a lot. What do you do?
12. A young neighbour girl says you can play with her if you give her money. What do you do?
13. Your stepdaughter tells you that unless you have sex with her she will tell her mother you tried to seduce her. What do you do?
14. An acquaintance says he knows a young girl who likes to have sex with adults. He asks you to come along and promises she won't tell anyone. What do you do?

Appendix D continued
SCT - 3

1. You are unable to raise the money for transportation, and there is nothing to do close to home. You are very bored. What do you do?
2. You come home from a trip and find your wife gone. This makes you very angry. You go out looking for your wife but can't find her. What do you do?
3. You are going through withdrawal from alcohol and drug abuse, and you feel very tense. You call your doctor but he is unavailable. What do you do?
4. Your mother has been blaming you for drinking too much and being lazy. You argue with her almost daily. What do you do?
5. You've been fired from your job, and because it was so hard to get, you know it will be hard to find a new one. Things are looking desperate. What do you do?
6. You are using a lot of drugs and alcohol and just had a fight with your wife. What do you do?
7. You're helping a neighbour who is giving a birthday party for one of her children. She runs out of ice cream and asks you to watch the kids as she runs to the store. What do you do?
8. You are strolling in the park and catch two little boys masturbating each other. What do you do?
9. You work in a store and have to keep an eye out for children who come in to steal things. You see a boy grab a "Playboy" magazine and run for the door. You chase him and catch him. What do you do?
10. Some kids down the block find out you are an ex-offender and order you to buy them some beer or they are going to tell people you touched them. What do you do?
11. You are living with relatives who are incestuously involved. You are around their children a lot. What do you do?
12. You think you are a homosexual but have concealed this from others because you are afraid of their reaction. You are high from too much beer, and you are alone with your nephew who idolizes you. What do you do?
13. You're sitting in the living room with your mother and sister watching TV and smoking dope. Your nephew comes up to you and whispers in your ear that he wants you to go outside so he can give you a blow job. He insists you go right now or he will tell everyone that you've been molesting him. What do you do?

Appendix D continued

14. You find out that one of the guys who lives in your rooming house is involved with little boys. These kids hang around his place. This guy tells you that you really ought to come over. Everybody's having a lot of fun. What do you do?

Appendix E

Code Number: _____

Coping Inventory for Stressful Situations

Appendix F

Coping Using Sex Inventory

The following are ways people react to various difficult, stressful, or upsetting situations. Please circle a number from 1 to 5 for each item. Indicate how much you engage in these types of activities when you encounter a difficult, stressful, or upsetting situation.

	Not at all			Very Much	
	1	2	3	4	5
1. Fantasize about having sex with a consenting adult.					
2. Fantasize about having sex with a child.	1	2	3	4	5
3. Fantasize about forcing an adult to have sex.	1	2	3	4	5
4. Have sex with my regular partner.	1	2	3	4	5
5. Have sex with a child.	1	2	3	4	5
6. Go out and 'score' with a stranger.	1	2	3	4	5
7. Masturbate while fantasizing about a consenting adult.	1	2	3	4	5
8. Masturbate while fantasizing about raping an adult.	1	2	3	4	5
9. Masturbate while fantasizing about a child.	1	2	3	4	5
10. Masturbate while fantasizing about hurting someone.	1	2	3	4	5
11. Use pornography depicting consenting adults.	1	2	3	4	5
12. Use violent pornography.	1	2	3	4	5
13. Use pornography depicting children.	1	2	3	4	5
14. Masturbate while using pornography.	1	2	3	4	5
15. Go out and rape someone.	1	2	3	4	5
16. Force my regular partner to have sex.	1	2	3	4	5

Appendix I

Sample Coping Strategies and Scores on the *Sex Offender Situational Competency*

Measure

Examples of Strategies scoring "1": (Situation 4) "Do nothing"; (Situation 6) "I don't know because I don't have a problem with alcohol or drugs"; (Situation 7) "Stay and watch the kids"

Examples of Strategies scoring "2": (Situation 1) "Borrow a car or seek a ride from a friend"; (Situation 3) "Talk to parents/friends/loved ones"

Examples of Strategies scoring "3": (Situation 6) "Walk away/ Later talk to her about the source of the argument/stop drinking" (Situation 12) "Walk away/Tell Parole Officer"

Example of Strategies scoring "4": (Situation 11) "First I would move out of the residence and I would inform them of the inappropriateness of their behaviour and also inform the Children's Aid Society" (Situation 7) "Instead of watching the kids, inform her I will go to the store for ice cream"

Examples of Strategies scoring "5": (Situation 7) "I would explain to her that I could not be alone with the children due to my background unless supervised by an adult" (Situation 2) "Stop and Think about the way I'm feeling about the anger, then start with positive self-talk, take a time out, and analyze the importance of her time for herself and mine"

Appendix J

Norms for Dependent Measures

General coping styles measured by the <i>Coping Inventory for Stressful Situations</i>			
	Task	Emotion	Avoidance
Cortoni (1998)			
Child Molesters	58	54.05 ^a	44.27
Rapists	55.76	43.19 ^b	47.90
Violent Offenders	56.78	40.18 ^b	45.87
Marshall, Serran, & Cortoni (2000)			
Child molesters	61.20	47.63 ^a	47.17
Non-sex offenders	64.67	37.96 ^b	47.58
Nonoffenders	60.69	41.34 ^b	47.59

Sex as a coping strategy measured by the <i>Coping Using Sex Inventory</i>				
	Total Score	Consenting	Rape	Child
Cortoni (1998)				
Child molesters	31.50 ^a	15.07 ^b	7.50 ^{ab}	7.07 ^b
Rapists	28.55 ^a	13.14 ^{ab}	8.55 ^a	4.55 ^a
Offenders	22.27 ^b	10.47 ^a	6.00 ^b	4.00 ^a

Taken from Marshall, Anderson, & Fernandez (1999).

Normative Values for the *Paulhus Deception Scales*

Paulhus Deception Scales		Prison Inmates
Total Score	7.5 (3.5)	
IM	5.3 (3.6)	
SDE	2.2 (2.7)	

Taken from Paulhus (1999).

Appendix J continued.

Normative values for the *Coping Inventory for Stressful Situations*.

		Prison Inmates
Coping Inventory for Stressful Situations		
	Task	51.49 (11.01)
	Emotion	45.46 (11.16)
	Avoidance	42.42 (11.84)
	Distraction	18.05 (6.56)
	Social Diversion	15.44 (4.90)

Taken from Endler & Parker (1999).

Appendix K

Repeated Measures MANOVA Tests

Effect	Wilks λ	df	F	p
Group	.91	6, 53	.85	.535
Time	.43	6, 53	11.81	.000
Group X Time	.61	6, 53	5.72	.000

Appendix L

ANOVA Tests

Group Effect	Hypoth. SS	Error SS.	Error MS	F	p
Situational Coping	16.52	6206.08	107.00	.15	.696
Task	.91	6790.58	117.08	.01	.930
Emotion	70.46	7868.90	141.35	.57	.474
Avoidance	13.11	10789.96	185.88	.07	.792
Distraction	1.23	4401.90	75.89	.02	.899
Social Diversion	26.51	1271.28	22.10	1.21	.276
Sexual Coping	55.51	1585.44	27.34	2.03	.160

Time Effect	Hypoth. SS	Error SS.	Error MS	F	p
Situational Coping	1939.94	1934.16	33.35	58.17	.000
Task	354.21	1581.57	27.27	12.99	.001
Emotion	73.39	2337.52	40.30	1.82	.182
Avoidance	669.80	2326.97	40.12	16.69	.000
Distraction	.06	949.31	16.37	.00	.954
Social Diversion	50.42	346.39	5.97	8.44	.005
Sexual coping	3.30	559.15	3.30	.34	.561

Group X Time	Hypoth. SS	Error SS.	Error MS	F	p
Situational Coping	646.01	1932.14	33.31	19.39	.000
Task	358.42	1581.57	27.27	13.14	.001
Emotion	31.88	2337.52	40.30	.79	.377
Avoidance	138.60	2326.97	40.12	3.45	.068
Distraction	6.77	949.32	16.37	.41	.523
Social Diversion	54.45	339.84	5.86	9.29	.003
Sexual Coping	11.35	559.15	9.64	1.17	.282

Appendix M

Paired Samples T-Tests

Treatment	df	t	p
Situational Coping	32	-7.94	.000
Task Coping	32	-4.86	.000
Social Diversion	32	-4.08	.000

Waiting List	df	t	p
Situational Coping	32	-2.60	.015
Task Coping	32	.02	.987
Social Diversion	32	.12	.906