MIDSA
Clinical Manual

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OVERVIEW OF THE MANUAL

The Multidimensional Inventory of Development, Sex, and Aggression (the MIDSA) is a computerized, self-report inventory that provides a clinical report to support therapeutic interventions with juveniles and adults who sexually offend. This manual is intended to inform the user about the generation and psychometrics of the MIDSA, to give guidelines for the clinical administration of the inventory, and to provide a clinical and research context for the interpretation of the MIDSA Report. Including the present introductory section, this manual is divided into five major sections. The second section, Why Use the MIDSA, describes what the MIDSA is, how it might be used, and the features that maximize its clinical utility. The third section, History and Construction of the MIDSA, presents the technical information about the development and the psychometrics of the inventory. Although this section is important for a fuller understanding of the inventory, and it provides essential data on the MIDSA's reliability and validity, it is not required for the administration or clinical interpretation of the MIDSA report.

Those interested in the clinical issues relevant to the administration of the instrument to clients should go first to the fourth section, Clinical Issues in the Administration of the MIDSA, which discusses both the competencies required of session managers (those who administer the MIDSA to clients) and important characteristics of the ideal testing environment.

The clinician who interprets the MIDSA Report should go to the fifth section, the MIDSA Report, which is the most important section for interpreting the MIDSA and placing the respondent's individual responses in the larger context of the research and clinical literature on sexual coercion. This section is subdivided into two parts. The first orients the clinician to the overall goal of the report (identify treatment targets) and to the various report formats in the MIDSA that communicate the respondent's unique history, behavior, cognitions, and attitudes to the interpreting clinician.

The second part of the MIDSA Report section describes the format of the scales and the general principles for interpreting these scales. It then provides the details of how to interpret the individual scales. The scales are divided into 14 overarching domains. Within each domain the empirical and clinical contexts for interpreting the scales are presented. Within each of the 14 domains we first review the general theoretical and empirical background relevant to understanding the scales in that domain and to placing each scale in the general empirical and clinical literature. Although sometimes there is sufficient research that the empirical background for each scale can be reviewed, for several domains the extant research only supports a review of the entire domain. After the background is discussed, the content of each scale is described and an item exemplifying the scale is presented. This is followed by a brief description of the process involved in the generation of the MIDSA scales in each domain. These generation sections are only necessary for those wishing a more extensive background, and are not essential for interpretation. Finally, we make some practical suggestions about the interpretation of each scale.

WHY USE THE MIDSA

The Role of the MIDSA in the Treatment of Sexual Aggression

Why use psychological assessment at all? Meyer et al. (2001) examined data from more than 125 statistical reviews (meta-analyses) on test validity and 800 samples. Their analysis led to 4 general conclusions about the utility of psychological assessment in clinical settings: (a) psychological test validity is strong and compelling, (b) psychological test validity is comparable to medical test validity, (c) distinct assessment methods provide unique sources of information, and (d) clinicians who rely exclusively on interviews are likely to have incomplete understanding. They further identified primary purposes of assessment as: (a) describing current functioning of clients, (b) confirming, refuting, or modifying the impressions formed by clinicians through their less structured interactions with clients, (c) identifying therapeutic needs, (d) aiding in differential diagnosis, (e) monitoring treatment over time to evaluate the success of interventions or to identify new issues that may arise as older concerns are resolved, (f) managing risk, including minimization of potential legal liabilities and identification of untoward treatment reactions, and (g) providing skilled, empathic assessment feedback as a therapeutic intervention in itself. The effectiveness of assessment feedback as a therapeutic intervention has recently been examined in a meta-analysis of 17 studies by Poston and Hanson (2010). They found consistent positive effects of sharing assessment feedback with clients. The strongest effect was on therapy process variables, such as self-understanding, working alliance, and counselor influence (*Cohen's d* = 1.12 (95%CI [0.68, 1.55]), but effects on therapy outcome (*d* = .37, [0.26, 0.48]) and combined process/outcome (*d* = .55, [0.19, 0.90]) were also positive. These effect sizes are comparable to those found in substance abuse/dependent treatment (0.45; Dutra et al., 2008) and close to those found in psychotherapy in general (0.80; Wampold, 2001). The results are particularly impressive, because therapeutic assessment models involve as few as three sessions (cf. Finn, 1999).

The MIDSA is a psychological assessment tool that was designed specifically to identify important target domains for therapeutic intervention with individuals who have been sexually coercive. It is intended to serve as a risk management instrument. Research on interventions with individuals who sexually aggress has indicated treatments that focus on risk factors for recidivism are the most successful (Hanson, Bourgon, Helmus, & Hodgson, 2009). Therefore identifying treatment targets is essential for adequate treatment. The MIDSA is not a risk actuarial and is not designed to be used for adjudication purposes.

Using research reviews and meta-analyses of the correctional treatment research, Andrews and Bonta (1994, 1998, 2003, 2007) identified three principles that maximized effective treatment for correctional samples, and Hanson et al. (2009) have shown that these same principles apply to the treatment of sex offenders. These principles have also been shown to apply to juveniles (Andrews & Bonta, 2003; Hawkins et al., 1998; Lipsey, 1995, Lipsey & Wilson, 1998). These three principles are the *risk* principle, the *need* principle, and the *responsivity* principle. The *risk* principle asserts that treatment services should be directed at higher risk offenders and not at the lowest risk offenders. The *need* principle urges clinicians to target factors that are closely related to recidivism. The *responsivity* principle proposes the use of

treatment methods that are appropriate to the abilities, learning style, and personality characteristics of the clients treated.

In keeping with these principles throughout this manual we will provide information about the apparent risk potential of the various domains that are assessed. We will review the importance of each domain to the etiology and continuance of sexually coercive behavior. Although we plan to conduct the requisite follow-up research to determine the predictive potency of the various domains measured in the MIDSA, it is important to recognize that this research has not yet been completed. The MIDSA is not intended to assess risk for dispositional decisions about the perseverance of sexually aggressive behavior. Rather, it is intended to identify treatment targets in domains known to have some relation to risk, so that intervention efficacy can be maximized. It is important to note that although for adults the actuarials developed for the prediction of recidivism do show "marginal" to "modest" (Sjöstedt & Grann, 2002) predictive accuracy (Barbaree, Seto, Langton, & Peacock, 2001, Knight & Thornton, 2007), for juveniles even the most recent predictive tools have still not been adequately validated. The authors of the JSOAP-II (Prentky & Righthand, 2003a), the ERASOR (Worling & Curwen, 2001), and the JSORRAT – II (Epperson, Ralston, Fowers, Dewitt, & Gore, 2006) emphasize the limitations of their instruments and caution the user not to misuse their scores. Thus, considerable research remains to be done to hone predictive tools, and premature pessimism for even severely troubled youth is not warranted.

Although the MIDSA is comprehensive, users can choose how they want to use the MIDSA. For each respondent, the administrators can choose whether to give the whole assessment or just part of it. Common choices are to administer only the Basic Inventory, which focuses on the scales and perpetration-related questions, or to administer only the Developmental History, which assesses respondents' caregiver and abuse history. The scales can be given repeatedly to measure therapy change (see discussion of the MIDSA parts in Section 4, Clinical Issues in the Administration of the MIDSA, starting on page 19.

The Coverage of the MIDSA for Assessing Sexual Aggression

The MIDSA was developed to provide clinicians with a comprehensive assessment and to acquire information not typically found in case reports. It is systematic, consistent, and exhaustive in the questions it asks. Of the 18 essential assessment domains identified by the Association for the Treatment of Sexual Aggression (ATSA), the MIDSA has some coverage on all but two. It covers in detail:

1. Criminal and other antisocial behavior and values,
2. Developmental history and family background,
3. Deviant sexual interests and arousal,
4. Education and employment histories,
5. Peer and romantic relationship history,
6. Relevant personality traits such as, but not limited to suspiciousness, hostility, risk-taking, impulsivity, and psychopathy,

7. Sexual history, including sexual fantasies, urges, and behavior, early sexual experiences; number and duration of sexual relationships; gender identity and sexual orientation; masturbation and intercourse frequency; sexual functioning; and unusual sexual interests or behavior that are not sexually deviant (as defined in this document) or illegal, such as cross-gender dressing,
8. Substance use,
9. Use of sexually arousing materials (e.g., magazines, computer pornography, books, videos, Internet sites, telephone sex services).

It moderately covers:

10. History of aggression or violence,
11. History of sexually abusive behavior, including details about victims, tactics used in the commission of the offense, and the circumstances in which the sexual abuse occurred,
12. Level of cognitive functioning and other responsivity factors,
13. Level of self-disclosure and accountability,
14. Official and unreported history of sexual and nonsexual crimes,

It touches on:

15. Insight into offense precursors and risk,
16. Medical and mental health history,

MIDSA does *not* cover:

17. Availability of appropriate community supports,
18. Access to potential victims.

The Self-Report Nature of the MIDSA

Although the MIDSA is a contingency based computerized inventory with a heavy emphasis on the reporting of specific life experiences, it also assesses subjective emotional states, fantasies, attitudes, behavioral proclivities, and cognitions. As a self-report instrument, it is vulnerable to the problems inherent in this form of assessment including faulty memories, defensive minimization, duplicity, poor reading and comprehension abilities, and lapses in attention and poor test engagement (Cohen & Swerdlik, 2005).

Despite its problems self-report remains an important assessment mode for gathering data that would be difficult or impossible to gather from other methods of assessment. In general, self-report measures agree moderately well with ratings of knowledgeable observers, and the more observable the trait (e.g., extraversion as opposed to neuroticism) the higher the correlations (Kendrick & Funder, 1988). Also, the non-shared variance between self-report and observation should not automatically be attributed to error, because a significant portion might represent incremental validity contributed by the self-report (Meehl, 1959). Consistent with this notion, it has been argued that self-reports may be most useful at assessing enduring affective dispositions (Grove & Tellegen, 1991). There is also evidence that in some instances, as when youth report

their early abuse experiences (Eckenrode, Izzo, & Smith, 2007), self-report may provide superior evidence for predicting outcomes when compared to both caseworker and parental reports. In predicting criminal justice outcomes, when the self-report inventories have been developed for antisocial or offender populations, these measures have yielded equivalent predictive accuracy to risk-appraisal procedures (Walters, 2006b). Moreover, self-report measures have been found to account for criminal justice outcome variance that is not accounted for by the risk-appraisal procedures (Walters, 2006b).

It is important to emphasize that the MIDSA represents only one source and one mode of information and other collateral sources and modes of information should be sought (see the ATSA Standards and Guidelines). If discrepancies between self-report responses and known information in the respondent's clinical file or information from other informants emerge, this creates an opportunity to confront the respondent with the discrepancy and attempt to resolve conflicting reports. Ultimately, the clinician's intervention must be based on assessment that is multimodal and multisource.

Features to Promote Truthful and Accurate Answers.

MIDSA is given to clients via computer for three reasons. First, individuals responding to computers rather than to interviewers tend to give more honest answers (Gribble, Miller, Rogers, & Turner, 1999). Second, computer administration is systematic, consistent, and exhaustive in ways that humans can never hope to match. Third, although the assessment is extensive, respondents are only asked questions appropriate for them (e.g., only respondents who identify themselves as interested in children are asked the child molester questions).

Computer administration allows a number of specific features to enhance accuracy:

- A reading test is embedded in the instructions. It is designed to test a fourth grade reading level. Respondents who fail the reading test may do so because they have difficulty reading or because they are not paying attention. They may be allowed to retake the reading test, have the questions read to them, or not take the assessment.
- The assessment includes a "speeding test." If respondents' response times are faster than the empirically determined time to read items, the assessment stops. Respondents are given two warnings. On the third time the assessment stops, the person giving the assessment (session manager) is alerted, and is given the option of deciding whether to continue, suspend (continue at a later time), or terminate the assessment.
- Respondents can change answers within a section (approximately 20 questions) if they realize they answered incorrectly.
- Respondents are asked to verify answers to crucial questions.
- There is a glossary function. When respondents are unsure what a term means, they can click on the word and see a definition or explanation of the word.
- Similar questions are grouped on one screen to reduce cognitive load.
- Respondents must answer the current question before proceeding to the next.

- Respondents cannot close or move the assessment window so they must remain on the task.
- Respondent fatigue is assessed by the person giving the assessment. The MIDSA may be suspended at any time and continued in a later session. In addition, at several critical junctures, the MIDSA gives an estimate of how long it will take to complete the assessment. Although the estimates are very rough, because there is tremendous variability in the time respondents take, they provide a guideline by which the session manager can judge when to suspend.
- Questions are asked in several different ways to increase the probability that respondents will be asked the appropriate questions. For example, respondents will be given the child molester modus operandi questions if they admitted they ever had sexual contact with a child, if they were ever charged or convicted of a sexual offense involving contact with a male or female under 16 years old, or if they admitted to even kissing or fondling someone 13 or younger when they were 16 or older. Respondents often deny such contact when asked in one way, but admit it when asked in another context.

It is reasonable to argue that the availability of such a wide range of reliability enhancing techniques actually constitutes a major advantage of self-report over other assessment methods. Such response-style and reliability checks are lacking in other modes of assessment.

Features to Assess Truthfulness of Respondents

The MIDSA contains two types of features to detect lying. First, as indicated in the section below on duplicity scales, we have created several content scales aimed at assessing lying, defensive responding, and poor test engagement.

Second, prior to the administration of the MIDSA to a respondent, the person giving the assessment is asked to answer specific questions about the respondent. The respondent is asked similar questions, and in the MIDSA Report the session manager's responses are compared with the respondent's answers to the same questions to alert the report reader to the possibility of discrepancies in perspective and understanding, or to willful denial on the part of the respondent.

HISTORY AND CONSTRUCTION OF THE MIDSA

The MIDSA represents a radically new vessel for the old wine of its distant predecessor, the Multidimensional Assessment of Sex and Aggression (the MASA). The administrative structure in which the test is embedded, the organization and programming of all components of the questionnaire itself, the object-oriented recording of life course, the acquisition of lists of significant people in the respondents' lives, and both the report and the report generator are all completely new. Nonetheless, the MIDSA builds on the empirical and theoretical foundation that the MASA established and incorporates the research that has been done on that instrument and in the field of sexual aggression over the last two decades. An understanding of the history of the MASA clarifies the validity of the empirical foundation on which the MISDA is built.

Overall Test-Construction Strategy and Theoretical Perspective

The overall strategy for creating the MASA and the MIDSA was an iterative process of item creation, testing, revision, and re-testing that parallels the combined deductive and inductive program described by Knight for typology generation and validation (Knight, 1988, 1992; Knight & Prentky, 1990). Following the perspective first explicated by Cronbach and Meehl (1955) and later developed by Jackson (1970; 1971), Millon (1994), and Tellegen and Waller (in press), the logic of the test creation process followed the edict that the interplay of theoretical postulation and empirical corroboration or disconfirmation should be woven into the fabric of test creation and validation. Thus, the first stage of item generation involved the explicit postulation of theoretical constructs that served to guide the creation of prototypical items for each scale. The homogeneity of these scales and their interrater reliabilities were then tested. Also, using a variety of strategies, including exploratory factor analyses aimed at uncovering unanticipated covariations among items, we explored both the homogeneity of the postulated constructs and their interrelations (Knight, Prentky, & Cerce, 1994; Knight & Cerce, 1999). This internal, structural process was used to strengthen the homogeneity of the scales and weed out weak items. Structural equation modeling of etiological models (Daversa & Knight, 2007; Knight & Sims-Knight, 2003, 2004) explored the interrelation among the scales and integrated them into the extant models of personality and of the etiology of criminality and sexual aggression. External validation has included cross-sample confirmatory replication (Knight & Sims-Knight, 2003) and comparisons to community controls (this manual).

Samples and Procedures for the Validation and Standardization Analyses

Participants

Three samples of participants were assessed to create the comparative distributions for the MIDSA--one juvenile sample (juveniles in residential treatment programs for youths who sexually offend) and two adult samples (adult sexual offenders and a community control sample of males never adjudicated for any crimes). We will describe each sample in turn. All of the participants voluntarily agreed to participate to be administered the Multidimensional Assessment of Sex and Aggression (the MASA; Knight & Cerce, 1999), which was administered under conditions of

complete confidentiality with the backing of a Certificate of Confidentiality from the National Institute of Health to reduce the potential of duplicitous responding. All participants were paid for taking the MASA.

Juvenile Sample

The 307 juveniles who sexually offended were sampled from different inpatient treatment facilities in the states of Maine, Massachusetts, Minnesota, and Virginia. All juveniles had been adjudicated for at least one serious sexual crime against a victim of any age. A serious sexual crime was defined as an assault that was sexually motivated and involved physical contact with the victim. The 307 juveniles were selected from a larger sample of 329 youths assessed at these facilities. Twenty-two juveniles were omitted either because of multiple instances of being caught for responding faster than the minimum time required for item reading or for Improbability scores (see below) of 2 or 3, indicating less than complete cooperation with the testing procedure.

Including their present offense, these juveniles were arrested an average of 3.4 times, and the average age of first arrest was 9.6 years. Approximately 30% had spent at least a year, and 25% spent at least two years in juvenile treatment programs. The mean age of the sample was 15.2 years (*SD* = .24, range = 11 - 22). Only 6% were over the age of 18, having committed at least one offense prior to their 18th birthday, but still being in treatment at the juvenile facility. Thus, the sample was considered to be within the developmental boundaries of adolescence and under the legal and responsible age of adulthood. The sample was ethnically diverse (Caucasian= 59%, African-American= 17%, Hispanic= 7%, Asian= 4%, Native American = 4%, other = 9%). The average period of commitment was one to two years. At least once during their lifetime 21% of the sample had received some form of mental health treatment, and 41% had received treatment for sexual aggressive behavior more than once.

Adult Sexual Offender Sample

All of the adult sexual offenders (n = 528) were assessed in forensic institutions located in Massachusetts and Minnesota. The mean age of the sample at the time of testing was 39.0 years (*SD* = 10.4, range = 20 - 68), and the average years of education was 11.0 (*SD* = 3.0). Fifty percent had never been married. The sample was somewhat ethnically diverse (Caucasian= 71%, African-American= 17%, Hispanic= 4%, Asian= .4%, Native American = 4%). Their average number of arrests, including the one for the incarceration at the time of testing was 7.9 (*SD* = 15.1). Their average amount of lifetime incarceration was 4.2 years (*SD* = 1.8), and their average age at first incarceration was 20.2 years (*SD* = 10.3).

Adult Community Sample

The community sample (n = 168) consisted of adult males, none of whom had ever been arrested for a sexual crime. The 168 community controls were all sampled from a male club in Philadelphia, Pennsylvania. Their mean age was 35.2 (SD = 12.7). Their average years of education was 12.2 (SD = 1.9), and 65% had been married at least once. A large portion of the local chapter of the club volunteered because their payment for participation ($18.00 each) was donated to the organization. In age and years of education these community controls were comparable to, and did not differ significantly from the adult offender sample. The distribution of races in this sample was, however, limited--97.6% Caucasian. This was considerably different from both juvenile and adult samples, which had significantly more African Americans, Hispanics, Asians, and Native Americans. The salary levels of the community sample indicated a preponderance of lower-middle class and middle class participants.

Procedures

All samples were administered the computerized form of either Version 3, 4, 5, or 6 of the MASA (Knight et al., 1994; Knight & Cerce, 1999). For the offenders the selection of the participants involved a simple two-step process. Potential volunteers were identified and approached by on-site personnel, and parental or legal guardian permission was obtained for any participant below the age of 18 before the testing team entered the facility. All interested participants were convened in groups of 7 to 12 offenders and informed in more detail about the nature of the study and about the Writ of Confidentiality that the research team had been awarded from the National Institute of Mental Health. They were also informed that they would be paid for their participation ($18). The research team also made a strong plea for honesty and the potential future benefits of adequate assessment of offenders.

The human participant procedures were reviewed and approved by the Institutional Review Board at Brandeis University. In addition, at each separate institution in which participants were tested, Institutional Review Boards approved both the procedures and informed consent forms, which were modified for the special needs of each institution without losing the core requirements of prior reviews.

After informed consent statements had been explained and signed both by the offender and a member of the research team, the participant was seated at a computer, which provided a tutorial on how to answer the MASA, a check that the participant understood the directions, and a brief fourth grade level reading test. The MASA Versions 3, 4, 5, & 6 have been written for a 4th grade reading level. For those offenders who had difficulty reading and/or comprehending the questions, a member of the research team read the inventory to them in a private room.

All community controls were tested using the paper and pencil version of the MASA (Version 3) in large groups.

Versions of the MASA

The initial impetus for the first version of the MASA was circumspect, aiming specifically at gathering data on sexual and aggressive behaviors, cognitions, and fantasies that were necessary for making classification judgments for the Massachusetts Treatment Center rapist typology (MTC:R3). Such information was not consistently recorded in the archival sources at the MTC that we were accessing for our early typological research. At this juncture our research program was also expanding to other institutions and populations. When we started studying research participants from other institutions outside of MTC, we discovered that the record sources were considerably inferior to those we had been accustomed. Typically, reports on juvenile history and juvenile criminal history were missing. We were also beginning to test non-criminal community and college samples, for whom records sources were non-existent. Although the initial scope of the MASA was limited at first to adult rapists and to supplementing archival records, it gradually grew to encompass the assessment of child molesters, the testing of juvenile sexual offenders, and the exploration of sexual aggression among community samples.

Our strategy for generating and testing the items for the first version of the MASA, which has previously been described in detail (Knight et al., 1994), illustrates the test construction procedures applied throughout the history of the MASA. In brief, it involved the specification of the critical domains that research had shown important in the assessment of the aspects of sexual aggression that we wished to measure. Initially, we focused on the domains necessary for classifying rapists in MTC:R3. For each domain of interest we created an extensive item pool sampling from as many sources as we could locate. Using a modified version of the content validity specification procedure proposed by Lawshe (1975), we had clinicians with extensive experience making classification judgments on MTC:R3 rate the appropriateness of every item for each domain of interest. We combined their ratings and selected the items rated most suitable for each domain. Selected items were sometimes rewritten to maximize their relevance to the domains. We then assessed the degree to which the chosen items covered each domain, and we created supplemental items for aspects of the domain that were not adequately represented. The resulting item sets were fashioned into a questionnaire, administered to appropriate samples, and analyzed for reliability and correspondence to archival sources (Knight et al., 1994).

This first version of the MASA, which focused more exclusively on adult rapists, assessed social competence, juvenile and adult antisocial behavior, anger and anger management, expressive aggression, sadism, sexual deviance and paraphilias, sexual preoccupation and compulsivity, offense planning, hostility toward women, and pornography use. These are the domains that are most critical for classification in MTC:R3. In subsequent versions scales appropriate for child molestation were developed. During its 17-year history the MASA was revised five times and administered to a variety of samples, including adult sexual offenders both in treatment programs and prison settings, juvenile sexual offenders both in residential settings and outpatient clinics, female sexual offenders, generic criminals, community non-criminals, and college student males and females. Only 113 of the 403 items in the first version of the MASA have made it without modification into the MIDSA, which because of its contingency-based questioning now has a total item count that exceeds 4000 items.

The changes to the MASA over its history have included the following – (a) the

transformation of the instrument into a contingency-based questionnaire that can only be administered by a computer; (b) the addition of a full developmental history assessing caregiver stability and change, and the childhood and adolescent experience of sexual abuse, physical abuse, neglect, caregiver antipathy and rejection, and the observation of vicarious violence; (c) the creation of a life history assessment that includes--social and school history; antisocial, drug, and alcohol use; and sexual behavior including pornography use and exposure; (d) the introduction of duplicity and compliance measures including a sex lie scale, a measure of improbability responding, two social desirability responding measures, and a speeding detection subroutine that identifies and attempts to interrupt the failure to read items; (e) the simplification of the language to a fourth grade reading level, the introduction of an online glossary for confusing terms, and the creation of alternative age-appropriate questions so that the MASA was suitable for juveniles; (f) an evaluation of components of Hare's Psychopathy Checklist (Hare, 1980; Hare et al., 1990) that are relevant to sexual offending (Knight & Guay, 2006); and (g) the incorporation of multiple subroutines only appropriate for and only administered to child molesters, including routines on sexual preferences and fixations, the amount of contact with children, and an assessment of the modus operandi engaged for child sexual offending.

Reliability and Validity of the MASA

For the original sample we calculated the internal consistencies and test-retest reliabilities for a set of rational scales that had been designed to measure the critical domains for classification in MTC:R3. The high coefficient alphas for all these scales (94% greater than .70) and high test-retest reliabilities (only two scales--Vandalism in Adulthood and Impulsivity in the Offense yielding reliabilities < .70) indicated that reasonable reliability had been achieved (Knight et al., 1994).

For these rational scales we also reported concurrent validity coefficients, derived by correlating each scale with a parallel, independent assessment of the same domain, which was created by rating the information provided in the participants' archival records. These analyses indicated that only the domains of sexualization, sexual aggression, and sexual offense planning failed to show adequate concurrent validity coefficients. A comparison between offenders' answers to the MASA scales for these domains and the information garnered from their archival files indicated that far more sexual preoccupation, deviance, compulsiveness, inadequacy, and sadistic fantasies and behaviors were reported on the MASA than were evident in the archival files, suggesting that the MASA provided greater validity and coverage of the relevant information than the criminal and clinical files.

In addressing the question of whether Revision 3 of the MASA was an appropriate assessment tool for juveniles, we (Knight & Cerce, 1999) examined the test-retest reliabilities of the factor scales on both the adult and juvenile sex offenders. In this study we compared responses to the paper-and-pencil version of the MASA with responses to the first computerized version. These estimates would, therefore, yield somewhat lower test-retest reliability estimates because of the different testing formats for the two administrations. Table 1 presents for both juvenile and adult sexual offender samples the average test-retest reliabilities for the ten factor domains that were tested in this version of the MASA. For these domains the scales closely approximate the scales in the current MIDSA and are good estimates of the MIDSA reliabilities.

The test-retest reliabilities were based on the 41 factor scales that the ten domains comprised. As can be seen in Table 1, the correlations are sufficiently high that they can be considered reasonable assessments of test-retest reliability. For the juveniles 93% of the test-retest reliabilities were greater than .60, and approximately 90% exceeded .70. The test-retest reliabilities of the juveniles, although slightly lower than those of the adults, were high and support the reliability of these factor scales for the juveniles. It is noteworthy that the factors with low test-retest reliabilities for the juveniles were exclusively in those domains that could be considered less appropriate for a juvenile sample—social competence and adult antisocial behavior, which are not reported in the current version of the MIDSA.

Internal consistencies were calculated on all three standardization samples (community controls, adult sexual offenders, and juvenile sexual offenders) for all MIDSA scales presented in the MIDSA Report. These are presented in Table 2. Only two scales had internal consistencies that fell below .60, and both of these were found in the community sample. Understandably, because of the low prevalence of the use of child pornography among the community sample, the internal consistency of this scale was low (α = .58). The majority items on the Positive Image scale, which is the other scale with low internal consistency, were added in Version 4 of the MASA, and consequently we were only able to use the four of the nine items on this scale that had been administered to the community controls in the current standardization. The community sample had been administered Version 3 of the MASA. Consequently, the Cronbach alphas for this scale are low for all three samples, with the lowest (α = .39) found in the community sample. This will be rectified in the next version of the MIDSA. All other scales had reasonable or high internal consistencies across all samples. Neither sexual offender sample had any Cronbach alphas less than .60, and 95% and 87% of the alphas were ≥ .70 for the adult and juvenile samples, respectively. For the community controls 84% of the alphas were ≥ .70. The majority of the alphas for the sexual offender samples exceeded .80 (79% for the adults and 63% for the juveniles). Thus, there is substantial evidence for the high internal consistencies of the scales across all three samples.

In addition to the concurrent validation of the MASA demonstrated by their high correlation with archivally rated scales that were constructed to measure the same constructs (Knight et al., 1994; Knight & Cerce, 1999), the validity of the MIDSA scales has been attested to by the consistency of the pattern of correlations among scales that has been repeatedly found in multiple disparate samples (college students, community males, generic nonsexual criminals, adult sexual offenders in treatment programs, adult sexual offenders who are civilly committed as sexually dangerous, and residential juvenile sexual offenders--e.g., see Knight & Cerce, 1999). Moreover, the same etiological model for sexually aggressive behavior against peers or adult females that was generated using MASA scales on adult sexual offenders (Johnson & Knight, 1998) has been replicated using confirmatory structural equation modeling on college students and generic criminals (Knight & Sims-Knight, 1999), on a community male sample (Knight & Sims-Knight, 2003), and on juvenile sexual offenders (Knight & Sims-Knight, 2004). Finally, recent studies comparing outpatient and residential samples of juveniles who sexually offend have replicated the same differences between these groups in juveniles in Pennsylvania (Zakireh, Ronis, & Knight, 2008) and in Minnesota and Massachusetts (Schatzel & Fletcher, 2004). Such consistency of results across samples differing in age, social status, criminal status, and geographic location corroborates the validity of the scales that form the basis of these comparisons.

Transition to the MIDSA

The MASA was a research instrument, so cumbersome and complicated to administer that even when it was shared with other researchers for research purposes, they gave up on mastering it and begged for a more user-friendly reversion. It had been programmed in Authorware, a courseware authoring system that had several significant limitations, and test administrators had to have substantial computer expertise. Moreover, the MASA provided no mechanism for transforming an individual's responses into a format that either could be used for research or was readily interpretable for clinician purposes.

To provide a clinically useful assessment, the entire MASA had to be reconceptualized, reorganized, and programmed from scratch in a new language, JAVA. As described in the user documentation, the entire testing process was embedded in a newly developed administrative structure that allows systematic approval of testers (called session managers) and choice of the MIDSA sections that the administrator wants each respondent to take. The program keeps a detailed record of all testing done at a particular site, and it allows the administrator to request a report over the Internet. In contrast with the MASA, the questions of the MIDSA have been organized into four separate modules for timely administration and more specific area content choice. The most serious programming problems of the MASA were solved (e.g., the respondent's inability to go back to previously answered questions, the inability to interrupt the administration of the MASA in the middle of a section and restart at a later time from the same spot).

A report generation program was created. We surveyed clinicians who treat sexual offenders with a questionnaire that asked about their preferences for report content areas and modes of presentation (e.g., narrative, tables, lists, scales), and we presented several alternatives for how scale information could be presented. The clinicians reported some clear preferences in how they wanted scale information presented, but when it came to content and mode, the majority simply wanted everything. We decided to be overinclusive and included multiple feedback modes in the report. We hope that users will give us feedback about the report and help us to fashion it into the most useful tool possible.

In addition to providing specific developmental and historical information about the respondent in a format that can be readily incorporated into a life history report, the MIDSA also presents the results of 53 scales (i.e., 53 for adults and 50 for juveniles) that assess various constructs that have been found important in the etiology and continuance of sexually aggressive behavior. With the exception of a couple of rational scales (which will be noted in the scale descriptions), all of the scales were the results of factor analyses of critical domains. The item selection for the MIDSA scales was constrained so that the same items loaded to the same degree and direction on the same scales for adult and juvenile sexual offenders and for the community sample. This allowed us to standardize all scale scores using the means and standard deviations of the community sample, and thus like the Minnesota Multiphasic Personality Inventory (the MMPI), to present T scores (mean = 50, standard deviation = 10) with a community reference.

CLINICAL ISSUES IN THE ADMINISTRATION OF THE MIDSA

Choosing What Parts of MIDSA to Give

MIDSA administrators choose whether to give each respondent the entire MIDSA or only parts of it. This choice is made at the time they decide to give the MIDSA to an individual. The following parts may be chosen--

The Basic Inventory (Sexual Preoccupation in the juvenile version) includes:

- Lifetime Sex (a section that asks respondents if they have had any sexual contact with young girls, grade school girls, . . . old men);
- Their experiences with pornography as children, teens, and, for adult respondents, in adulthood;
- Antisocial history as juvenile and, for adult respondents, as adults: comparable questions are asked first about their behaviors, whether caught or not, and second about their criminal offenses;
- Attitudes, which includes 4 lie scales and 33 content scales described in the MIDSA Report section of this manual;
- For offenders or for those who admit to sexually coercive behavior, questions about their offense planning, which results in four scales;
- For those who admitted sexual contact with someone younger, questions about the kind of sexual contact, their sexual thoughts about children, and questions about their modus operandi.

The Developmental History includes:

- The Timeline, which asks respondents questions about their caregivers from birth to 18 years (or current age, for juveniles);
- Family information about the marital status of parents, their siblings (biological, step, foster, and unrelated children in the home);
- Caregiver scales—respondents are asked to identify the one or two male and the one or two female caregivers who had the most influence, positive or negative, on them and were then asked a series of questions that are combined into acceptance-neglect and emotional abuse scales;
- Physical abuse—respondents are first asked to identify all adults, both within and outside the home, who physically punished them, and then they are asked a series of questions about the duration (age when it started and age when it ended), frequency, and severity of the abuse by each adult so identified;
- Sexual abuse—respondents are first asked to identify all people with whom they have had sexual contact, are then asked to identify the direction of force (whether they were the victims, perpetrators, or willing participants), and are then asked about the duration, frequency, and severity of the abuse (and the age of the other person if not an adult) for each person so identified. If respondents have had sexual contact with more than three

unrelated age peers, they are asked to answer the frequency and severity of the abuse in the aggregate.

Social and Antisocial Behavior includes:

- School history, including behavior problems that are part of the Juvenile Fighting and Assaultive scale;
- Questions that result in the three scales related to attention deficit hyperactivity disorder (ADHD);
- Friendship history as juvenile, and for adult respondents, as adults—these questions tap social isolation, peer social reference group, and friendship intimacy;
- Romantic history, defined as any relationship that lasts more than three months and with whom respondents felt close—the results of this section give a picture of the respondents' marriage history, heterosexual and homosexual romances, and yield intimacy scales for significant relationships;
- Questions about his relationships with his biological and step offspring;
- An inventory about his work and military history (for adults);
- Juvenile and Adult alcohol and drug use, which results in a narrative of the extent of use and problems resulting therefrom, plus the Juvenile and Adult Alcohol and Drug Abuse scales;
- Juvenile and Adult antisocial behaviors (whether caught or not) and criminal offenses, which result in the Juvenile Delinquency scale and the Adult Conduct Disorder and Fighting and Assaultive Behavior scales.

MIDSA also can accommodate those clinicians who wish to assess therapeutic change. We provide a choice for Attitudes Only, which provides scales on the 4 lie scales and 33 attitude scales.

Issues in Administering the MIDSA

No matter how well validated a test may be, its usefulness will be greatly diminished if important phases of the assessment process are not properly executed. Consequently, there are important obligations that must be observed prior to, during, and after MIDSA administration. It is critical that a prepared and suitably trained person administer the MIDSA properly. Specific issues in testing children or adolescents must be addressed and mastered (Sattler, 1988; 2001).

The session manager must be familiar with the technical aspects of administration and with the computer used to administer the test, with the various procedures to follow in initiating the testing and monitoring the test throughout the session, and with the content of the inventory, so as to be able to respond adequately to any questions that a respondent may ask. It is important that the session manager be intimately familiar with the materials and directions before administration. This requires adequate rehearsal and anticipation of unusual circumstances that might arise, and consideration of the appropriate response. Although every effort has been made to make the administration of the MIDSA uncomplicated, the test administration process must be mastered to assure easy and correct administration, so that the session manager can focus on the needs of the individual respondent. For instance, bright respondents will likely have no

difficulty responding to the inventory questions, but persons with average or below average intelligence may require help to assure that they are responding properly.

The session manager must also ensure that the room in which the test is conducted is suitable and conducive to testing. An effort should be made to identify a testing environment that minimizes distracting conditions (such as excessive noise, interruptions, extremes of temperature, inadequate ventilation, glaring sunlight, etc). Although it is possible to test more than one respondent at a time, it is critical that each respondent in such a testing session be situated so that his answers to the MIDSA questions are completely confidential. It is not recommended that a single session manager test more than three respondents at the same time, and single person administration is the ideal.

Rapport between the session manager and the respondent is critically important. As in general clinical practice, rapport is defined as the establishment of a working relationship between the session manager and the respondent. Just as the working relationship is central to improvement in clinical interventions (Norcross, 2002), this relationship of trust and cooperation is essential to encouraging the respondent to feel comfortable about revealing unfavorable information about himself or delving into issues that may be painful. This is especially important when assessing adolescents who have been sexually abused, because they have been found to be especially prone to deny or minimize offending behavior (Lambie & McCarthy, 2004). It is important to communicate the nature of the test to the respondent, indicating that the information gathered will be useful in his therapy, and will help those who treat him to know more about him. He should be encouraged to be as honest and open as possible. If there are questions that he does not understand, he should seek clarification, and if he is uncertain about the answer to a particular question, he should simply give the best answer he can. He should be told that there are no right or wrong answers; the inventory is simply attempting to learn about his experiences and thoughts.

Finally, the session manager should be sensitive to any potential disabilities in the respondent that might interfere with adequate responding. The MIDSA will pick up serious difficulties in reading ability or comprehension that make it difficult for the respondent to continue, but the session manager should be careful to observe any cognitive, sensory, or motor impairments that might affect performance or distort responses.

MIDSA REPORT

In this section of the manual we describe the MIDSA Report and discuss the clinical aspects of interpreting the MIDSA. This section provides relevant details and guidelines for how to read and interpret the general report and essential information about the 53 scales including their theoretical and empirical background, content, generation, and practical suggestions about how to use and interpret them.

Outline of the Content Sections of the MIDSA Report

Below is an outline of the content areas covered by the MIDSA Report, presented in the order in which they appear in the report—

INTRODUCTION TO MIDSA

VALIDITY OF RESPONDENT'S ANSWERS
- Discrepancies Analysis
- Lie Scales

GENERAL INFORMATION

FAMILY HISTORY
- Adult Caregivers
- Scales for Respondent's Relationship with His Important Caregivers
- Relationship between Caregiver Pairs
- Physical Punishment and Abuse

SEXUAL EXPERIENCES IN CHILDHOOD AND ADOLESCENCE

SOCIAL HISTORY
- School History
- Social Relationships
- Intimacy Scales
- Occupational History

ANTISOCIAL HISTORY
- Attention Deficit and Hyperactivity and Oppositional Behavior
- School Problems
- Juvenile Alcohol and Drug History
- Admitted Delinquent and Criminal Behaviors
- Criminal History
- Juvenile Antisocial Scales

ADULT ANTISOCIAL HISTORY
- Adult Alcohol and Drug History
- Adult Criminal Activities
- Adult Criminal History
- Adult Antisocial Scales

INTRODUCTION TO SEXUALIZATION SECTIONS

SEXUAL HISTORY AND PREFERENCES
- General Sexual Behavior
- Age Preferences in Sexual Contact with Females
- Age Preferences in Sexual Contact with Males
- Sexual Thoughts About Females
- Sexual Thoughts About Males
- Socializing with Potential Victims
- Modus Operandi of Child Molestation

PORNOGRAPHY
- Exposure to and Use of Pornography
- Pornography Use Scales

SEXUAL FANTASY, ATTITUDES, AND BEHAVIOR SCALES
- Sexual Lie Scale
- Child Molestation Scales
- Sexualization Scales
- Masculine Adequacy and Sexual Inadequacy Scales
- Paraphilia Scales
- Sexual Sadism Scales
- Expressive Aggression Scales
- Psychopathy and Hypermasculinity Scales
- Pervasive Anger Scales
- Offense Planning Scales

SCALE LEGEND

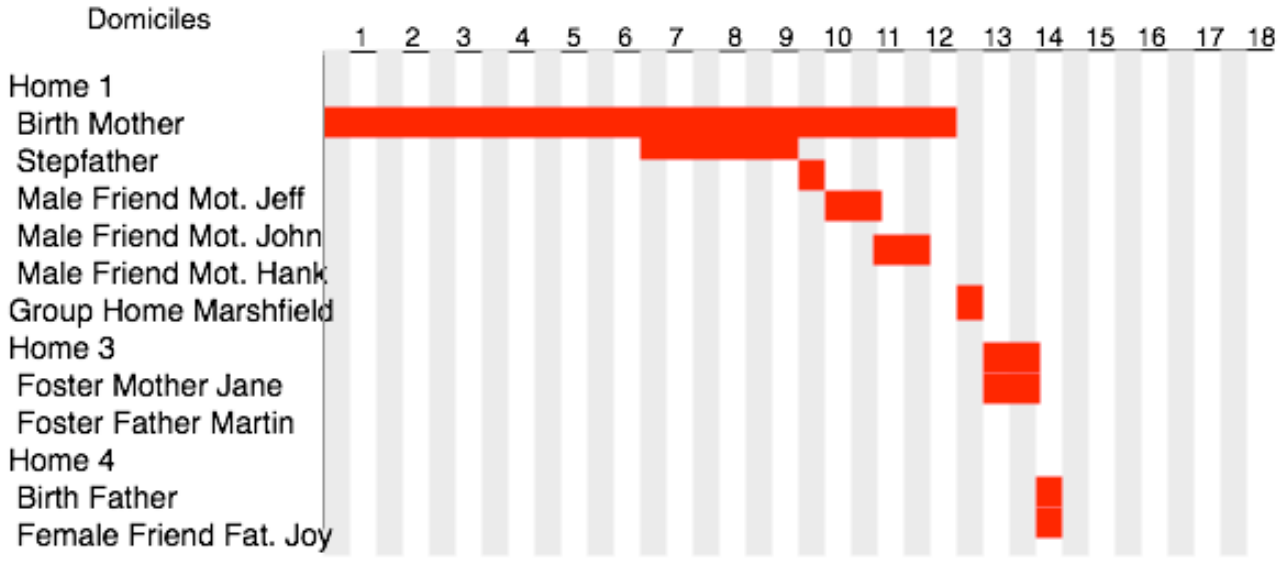
Formats of Information Provided in the MIDSA Report

The MIDSA Report comprises five formats— lifecourse chart, narrative, tables, lists, and scales. We administered a paper-and-pencil survey to 21 members of ATSA at their 2001 annual conference, presenting them with the potential feedback formats and asking which they would prefer. Almost all wanted all five formats. Consequently, we decided to include all five in the first report, and to let the users decide on which ones they found most useful to them. In the MIDSA Report each of the content sections presented in the outline above uses various combinations of the feedback formats to communicate and summarize the respondent's answers. For instance, whereas the Developmental History section makes use of all five format types, the Sexual Fantasy, Attitudes, and Behavior Scales sections present feedback only in the scale format. The interpretations of the life-course chart, the narrative, the tables, and the lists are fairly straightforward. The interpretation of the scales, however, requires more contextual information. Consequently, scale interpretation has been allocated its own extensive section, which is presented after the brief descriptions of each format in the following sections.

Lifecourse Chart

This form of feedback is unique to the developmental section. It is a representation of the object-oriented lifecourse section of the MIDSA, in which the respondent is asked to report the homes and institutions where he resided during his first 18 years, and the primary caregivers responsible for his development. The lifecourse chart, an example of which is depicted on the next page, represents this course of the respondent's life until 18.

Life-Course Chart Example:



The 14-year old male respondent depicted in this chart lived with his birth mother until he was 12 years old. His birth father was absent from his home during these years, and indeed the youth did not know him. Between the ages of 6 and 9 years old his mother remarried, and his stepfather lived in his home. After the stepfather left, his mother had a series of live-in male friends (Jeff, John, and Hank). At age 12 the respondent was sent to a group psychiatric home because of sexual behavior that he apparently initiated with his younger siblings. From here he was sent to a foster home,
where he stayed for a little over a year before moving in with his biological father and his live-in girlfriend for 6 months. From here he was referred to a residency program for juveniles who had sexually offended. Each change of residence is noted as a new "Home" by this respondent, but respondents have the option to define "Home" as a change of circumstances within the same residence. He was administered the MIDSA at the residential program at age 14.

The Narrative

This form of feedback embeds the responses of the respondent in narrative text, creating a format that the clinician can copy directly into a report. An example of this type of feedback follows. The information that is embedded from the respondent's answers to the MIDSA is indicated in italics in this example. In the regular report the italics would not appear.

Narrative Example: **DEVELOPMENTAL HISTORY**

The respondent reported that his biological parents *were married*. His parents were married *6 to 9 years*. They were *separated for a while, but never divorced*. He was *10 years old* at the time.

The respondent's *biological mother died when he was 12 years old*.

The respondent has *two older brothers and one younger brother(s).* He *has one older and two younger sister(s)*. *Two* of his siblings has (have) been arrested. *One* of his siblings has (have) been admitted to a psychiatric facility

Tables

The tables provide data about the specific kinds and frequencies of behavior that a particular respondent manifests on individual items. Such data add greater precision to the means, standard deviations, and percentiles that are presented in the scales. The scales give information about the respondent's position relative to other offenders and community controls on global domains of behavior. They do not, however, provide data about the specific kinds and frequencies of behavior that a particular respondent manifests. The detailed information presented in the tables is helpful for targeting in therapy the unique problems of an individual client. The table feedback format provides this specific information for each client. Below is an example of a table describing the frequency with which a respondent reported using specific kinds of pornography as a teenager. As can be seen by perusing the table, he admitted that he used pornographic magazines once or twice a week and X-rated videos once or twice a month. He had no experience accessing pornography on the internet or going to live sex shows. Not only do the tables provide substantial, detailed information about behaviors that the respondent has admitted, but they also allow the clinician to compare his knowledge of the client's behavior to that which the respondent admitted in the MIDSA, thereby helping to identify areas about which the respondent might be defensive, or might not be admitting the full extent of his involvement.

Table Example: Use of Pornographic Materials

The kinds of pornographic material he has accessed as a teenager are:

	Never	*Once or a few times*	*A few times a year*	*Once or twice a month*	*Once or twice a week*	*Almost every day*
Magazines					✓	
X-rated sex movies or videos				✓		
Internet sites	✓					
Live sex shows	✓					

Lists

In a number of instances the respondent is only asked about the presence or absence of particular behaviors, rather than being asked to specify the frequency of the behavior. Our experience administering the MASA indicated that respondents oftentimes had difficulty remembering the frequencies of behaviors in these instances, and simply the presence of the behavior seemed to be what could be established reliably. In the example below the respondent was asked about his the nature of his sexual contacts with a specific age range of boys—

List Example: **Types of Sexual Behavior with Boys 14-17 Years Old**

The respondent reported the following sexual contact:

Touching and fondling
Fellatio of victim
Fellatio of respondent

The list simply reports the kinds of sexual behavior that the respondent indicated occurred in these sexual encounters.

Scales

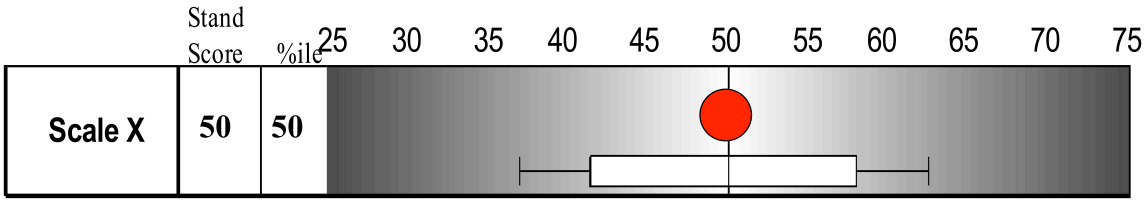
For the first version of the MIDSA we have developed 59 scales (54 for the juvenile version). In each scale the score of the respondent is presented within the context of both juveniles or adults who have sexually offended and community controls. The scale format is the most complex of the feedback formats, and consequently we devote the entire following section to the scales. This section explains the interpretation of the format of the scales and provides information on the background, description, generation, and clinical implications of each scale. A list of the actual items in each scale is provided in the Appendix at the end of the document. It is essential for the clinician who is interpreting the scales to review the background section, which provides the empirical data supporting the scale, the description section, which details the content of each scale, and the practical considerations section, which suggests evidence-based applied correlates of each scale. The generation section, which reports the statistical procedures that were used in the creation of each scale, is not essential for interpretation, and is given for those who wish a fuller understanding of the psychometrics of each scale.

In the report when respondents score very high on an attitude scale (greater than 1.5 standard deviations above the mean) their scores on all individual items are presented immediately following their scale scores. This provides clinicians with a full understanding of what constituted the scale scores.

MIDSA Scales

Description of the Scale Format

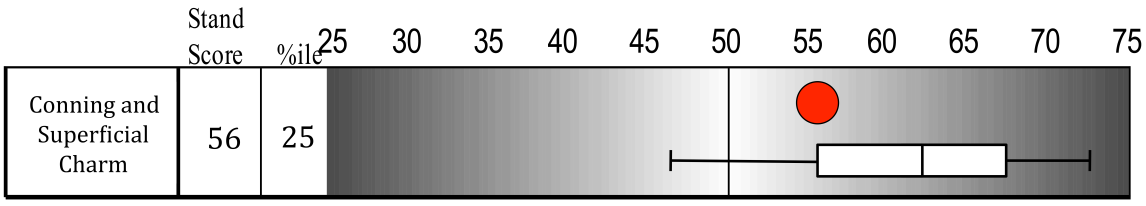
Fifty-three scales were created for the MIDSA using factor analysis and rational scale construction. T scores (Mean = 50, SD = 10) were calculated for each scale using the mean and the standard deviation of the community sample. As can be seen in the figure below, the T score distribution of the community controls constitutes the gray and white background of each scale. T scores equal to or greater than 65 indicate that approximately 8% of the community sample scored at or above that score. If a respondent scores at or above a 65 T score on a scale, the construct measured by that scale should definitely be a target for intervention. Scores greater than a 57 T score indicate that the respondent scored in the top 25% of the control sample. Domains on which a respondent scores above 57 should be further evaluated as potential treatment targets.



Superimposed on the T score distribution background is a whisker plot generated from the percentile scores of the juvenile or adult sexual offender samples. Juvenile and adult respondents are compared to their age appropriate compatriots. In the figure above the whisker plot represents and offender distribution that would be equivalent to the community control. The vertical line within the rectangle of the whisker plot is the median of the offender group. Fifty percent of the offender comparison group had scores below this point. In the example the median of the offender group falls at the mean of the community sample. The left end of the whisker plot rectangle marks the 25th percentile, and the right end of the rectangle indicates the 75th percentile. The vertical line at the end of the "whisker" line projecting from the left end of the rectangle is the 10th percentile, and the vertical line at the end of the right whisker marks the 90th percentile.

The whisker plot provides a second group against which to compare the respondent's score. Certainly, a score that is in the top quarter of the offender comparative group warrants therapeutic attention. Indeed, one might want to further evaluate as potential treatment targets constructs with scores above the median of the offender control. The whisker plots also yield important information about how the responses of the offenders in the standardized sample compared to the community controls. The whisker plots indicate both the level and the shape of the scores of the offenders and suggest the potential importance of a particular scale for discriminating sexually coercive individuals. As can be seen in the figure below, which

represents the score of an adult sex offender on the Conning and Superficial Charm scale, the median



of adult sex offender standardization sample is at a T Score of 62.3 for the community controls. The respondent's T score on the above scale, which locates his score in relation to the community sample, is presented in the leftmost box of the figure (56). His percentile score (25^{th}), which indicates the percent of the appropriate offender group that scores below him, is presented in the second box on the left. The large circle in the graph then indicates where these two scores locate the respondent relative to both the community T Score distribution and the offender whisker plot.

The following sections describe the scales in each of the major content domains. The order of the domains follows the same order in which the scales are presented in the report. The sections within each content domain have similar general formats. First, the general theoretical and empirical background either of the content domain or, where appropriate, of each scale in the domain is briefly presented. Second, the content of the MIDSA scales is described and an item exemplifying each scale is presented. Third, the process involved in the generation of the MIDSA scales in each domain is briefly summarized. Fourth, practical information about the interpretation of the scales is provided. The items on each scale are given in the Appendix.

Lie Scales

Background of the Lie Scales

It has long been known that criminals can easily discriminate socially acceptable responses, and when duplicitous responses are advantageous, they are likely to respond in ways that minimize their involvement in illegal behavior, (Gendreau, Irvine, & Knight, 1973). This problem of duplicity or defensiveness of responding is exacerbated in sexual offenders (Abel, Barlow, Blanchard, & Guild, 1977; Hucker, Langevin, & Bain, 1988; Marshall & Hall, 1995; McGrath, Cann, & Konopasky, 1998), who are questioned not only about illegal behavior, but also about sexually deviant behavior. Simply talking about sexual behavior can engender considerable anxiety and discomfort, and illegal deviant sexual behavior is among the least acceptable of even criminal behaviors in our society. Consequently, the problem of duplicity or defensiveness constitutes a significant obstacle to using self-report to assess sexual offenders. Some may deny their guilt during adjudication and even maintain their innocence after conviction. Some may minimize or deny sexually deviant fantasies or behavior or preferences on psychological inventories, thereby withholding information important in establishing treatment goals and assessing risk.

Previous research on duplicitous responding on the MASA compared responding under a confidential, essentially anonymous condition to a non-confidential condition in which the respondent's results were subsequently placed in his clinical/criminal records (Knight, 1999b). The sample comprised 100 adult sexual offenders incarcerated at the Massachusetts Treatment Center and awaiting consideration for civil commitment. Offenders were tested twice, once under conditions of complete confidentiality and a second time when they were informed that their answers would be placed in their clinical files, which would be available for their civil commitment procedures. The results of this study supported the validity of the Positive Image scale (described below) and indicated that duplicity was domain specific. That is, only sexual behavior and fantasies, and items reflecting impulsivity and negative masculinity were affected by the testing manipulation. Items in other domains, including antisocial behavior, nonsexual aggression, and anger, were not affected by a defensive orientation in responding and were the same in both administration conditions. Response latencies were also found to be related to defensive responding, but the pattern of this relation was more complex than that found by Holden (1995).

For the first version of the MIDSA we have implemented only the more traditional content approach to duplicity detection, and we have left assessment of response latencies to later revisions. The content approach uses the information presented in the item to assess the respondent's tendency to use specific response styles. The four lie scales designed to assess different aspects of defensive responding in the MIDSA are described below. When administering the MIDSA every effort should be made to engage the respondent's cooperation and to convince him that his responses will be used to improve his treatment. Such a response set will hopefully minimize tendencies to be defensive. If the respondent's answers to one of the lie scales indicate that he is defensive, his defensiveness may be domain specific and other aspects of the report may still be valid.

Description of the MIDSA Lie Scales

The MIDSA includes four lie scales. All respondents answer the questions for the Positive Image scale. Only respondents who take the Attitudes and Behavior Change portion of the MIDSA will generate scores on the other three scales as well.

The respondent's scores on the Positive Image scale and Negative Emotion Denial scale appear on the contiguous charts. The number score for the Improbability scale is reported with these two scales. The Sex Denial scale is presented with the Sexualization scales. It is generally considered that scores above 65 indicate questionable validity of responses to scales that are in a related domain. Note that these are standardized against community adults. The Improbability scale is a summative 4-point scale (range 0 – 3). A score of 2 or 3 indicates problematic responding.

Positive Image scale. The Positive Image scale consists of 9 items that respondents would answer if they wished to appear in a positive light to others. The scale captures the respondent's tendencies to attempt to manage the impressions of others toward a more positive view of him, and the item content suggests conscious manipulation that is not apparently believed by the respondent. High scores indicate a greater desire to appear positive. The internal consistency for juveniles was .65 and for adults .69. An example of an item on the scale is –

I am always polite, even to people who are rude.

Negative Emotion Denial scale. The Negative Emotion Denial scale consists of 9 items that assess respondents' tendency to deny negative characteristics, primarily emotional or reluctance to admit that emotions affect their behavior. The scale contains items that are overly positive beliefs that the individual could hold about himself. High scores indicate a greater denial of negative emotions. The internal consistency for juveniles was .70 and for adults .73. An example of an item on the scale is –

I sometimes get upset, if I don't get my own way. (reverse scored item)

Improbability scale. The Improbability scale consists of 3 items that describe behaviors that are unlikely to be endorsed. The scale is calculated as a sum of these three, where 0 is probable and 1 is improbable. Because the respondent has passed the reading test at the beginning of the MIDSA administration, if a respondent answers 2 or more items in the improbable direction (score ≥ 2), one should question whether the respondent is continuing to actively engage the test. Alternatively, one should check his Attention-Deficit Hyperactivity Disorder (ADHD) scales to determine whether he has difficulties maintaining his attention. An example of an item on the Improbability scale is –

I have looked at a television set. (reverse coded, don't know or false answers = improbable)

Sexual Denial scale. This scale contains six items that describe sexual thoughts and behaviors. High scores on this lie scale indicate that the respondent is denying engaging in sexual behaviors and having sexual thoughts. T Scores greater than 65 on this lie scale indicate defensiveness about sexual behavior, and suggest that responses on the sexualization scales should be interpreted with caution. The internal consistency for juveniles was .79 and for adults .74. An example of an item on the scale is –

When I have sexual thoughts, I get sexually excited.

Generation of the Lie Scales

Two of the MIDSA scales, the Positive Image Scale and Negative Emotion Denial scales, were fashioned after the work of Del Paulhus (1984, 1986, 1991; Paulhus & Levitt, 1987; Paulhus & Reid, 1991) and represent subcomponents of the construct social desirability (Crowne & Marlowe, 1964). These two scales were derived from a principal components analysis. The factors generated were equivalent across juvenile and adult sexual offender samples and the community controls. The nine items on each of the two scales produced equivalent loadings across the three samples.

The generation of the Improbability scale followed a procedure similar to that suggested by Millon (Millon, Davis, & Millon, 1997). We generated a number of items whose endorsement described an improbable event (e.g., “I have not taken a shower or bath in the last year”). Three items were selected so that combined endorsement scores of 2 or 3 identified less than 5% of the juvenile sample.

The Sexual Denial Scale is a rationally created summative scale, generated using homogeneous keying (Nunnally, 1978). A large number of items were generated that described sexual behaviors that were typically endorsed by a large number of males under conditions of anonymous administration (e.g. “I masturbate” [frequency response]). Items were chosen from this pool on the basis of attaining the highest internal consistency for juvenile and adult sexual offenders and community controls.

Practical Considerations for the Lie Scales

High scores (T Scores $\geq$ 65) indicate different kinds of defensiveness in responding to MIDSA items. High scores on the Positive Image scale and/or the Negative Emotion Denial scale would suggest that the respondent is either trying to paint or believes an overly positive picture of himself and might be defensive or duplicitous in admitting unfavorable characteristics in other domains. Scores of 2 or 3 on the Improbability scale would suggest that the test taker did not take the test seriously, decided to respond randomly, and/or was not reading the items carefully. Because the respondent had passed the reading and instruction test at the beginning of the MIDSA administration, it is not likely that reading difficulties or failure to understand instructions would account for such scores. High scores on the Sex Denial scale would indicate that the respondent either has extremely low sex drive and interest, or is not willing to acknowledge anything about his sexual behavior and fantasies.

Scales for Respondent's Relationship with His Important Caregivers

Background of the Caregiver Relationship Scales

Affective parent-child relationships marked by low levels of warmth and affection, and high levels of hostility and coercive exchanges have long been recognized as correlates of antisocial behavior in general (Henggeler, 1989; Patterson, 1982; Dishion & Patterson, 2006). Such parental child rearing behaviors have been found in the families of adolescent sexual offenders (Bagley & Shewchuk-Dann, 1991; Lambie, Seymour, Lee, & Adams, 2002), though the levels may not differ from those found in generic delinquents (Bischof, Stith, & Whitney, 1995; ; Bischof, Stith, & Wilson, 1992; Blaske, Borduin, Henggeler, & Mann, 1989). Antipathy, another name for our Emotional Abuse construct, has also become a significant variable in assessing mood and anxiety disorders in clinical populations (Bifulco, Moran, Baines, Bunn, & Stanford, 2002; Chambless, 2004; McCarty, Lau, Valeri, & Weisz, 2004; Smith, Lam, Bifulco, & Checkley, 2002) and has been found to be associated with poor outcome in many childhood medical and psychiatric disorders (Wamboldt & Wamboldt, 2000).

In the developmental studies that have used MIDSA items and scales, the Hostile-Control or antipathy scale has always been found to covary with the severity of childhood physical abuse, and has consistently yielded the highest correlations with the affective and interpersonal traits associated with psychopathy (Daversa & Knight, 2007; Knight & Sims-Knight, 2003; 2004). These results corroborate the work of Marshall and Cooke (1999) who found that parental hostility, dislike, and neglect or disinterest toward the child increased the risk of a psychopathic outcome in criminal samples.

These MIDSA results support the hypothesis that the hostile and physically abusive features of parent-child relationships contribute to the development of a callous, conning, and grandiose interpersonal style, which is both important in the later development of a psychopathic personality disorder and increases the potential for sexually coercive behavior. Both the callous unemotional and impulsive antisocial components of psychopathy have been found critical in both the etiology of sexually coercive behavior against women and in the typological differentiation of rapists (Knight & Guay, 2006). Psychopathic personality and behavior have also been found to constitute one mediating path between these abuse components and sexual aggression against children (Daversa & Knight, 2007).

Description of Caregiver Relationship Scales

The MIDSA includes two factor-analytic scales describing the relationship between the respondent and the caregivers he has identified as most important in his life (1-2 women and 1-2 men). The scales are standardized against community adults. Respondents who knew their caregivers during both their childhood and teenage years were asked these questions twice, once for each time period. Because the community controls were only asked these questions for their entire childhood, rather than for child and adolescent periods separately, the T scores for the factors are calculated for the entire period until the respondents 18th birthday.

Acceptance-Neglect. This scale has 8 items that describe ways in which the caregiver expressed love and acceptance to the respondent. Examples are the frequency the caregiver

hugged or kissed the respondent and the frequency the caregiver took care of the respondent's needs. Higher scores mean greater acceptance. The internal consistencies for juveniles were .90, .94, .92, and .93 respectively for biological mother, biological father, other female caregiver, and other male caregiver. The internal consistencies for adults were .93, .95, .94, and .96, respectively for biological mother, biological father, other female caregiver, and other male caregiver. An example of an item on the scale is –

How often did your mother hug or kiss you as a child?

Emotional Abuse. This scale has 11 items, most of which describe the frequency that the caregiver engaged in verbal abuse. The internal consistencies for juveniles were .90, .91, .93, and .93 respectively for biological mother, biological father, other female caregiver, and other male caregiver. The internal consistencies for adults were .94, .94, .95, and .96, respectively for biological mother, biological father, other female caregiver, and other male caregiver. An example of an item on the scale is –

How often did your mother say things to scare or frighten you?

Generation of the Caregiver Relationship Scales

The caregiver relationship scales were generated by exploratory factor analyses first calculated on the adult sexual offender sample and subsequently replicated on the juvenile and community samples. Across all three samples the exact same two factors emerged for female and male caregivers and either primary or secondary caregivers. The sole exception was the secondary caregivers of the community. So few secondary caregivers were identified for the community controls that factor analysis was impossible. Consequently, the mean and the standard deviation of the primary caregivers of the community males were used in the calculation of the T scores for both the primary and secondary caregivers.

Practical Considerations for the Caregiver Relationship Scales

An accurate and detailed history is critical for making dispositional decisions about juveniles, and determining both the caregiver resources that can be marshaled in affecting and maintaining an effective treatment strategy. A full knowledge of the early experiences of the adolescent both provides insights into the causes of current behaviors and suggests ameliorative intervention strategies.

In subsequent versions of the MIDSA additional developmental scales will be added. For the present these childrearing scales can be integrated with the tables, lists, and narrative of developmental section to provide a detailed picture of the respondent’s family history. The advantage of these scales is that they provide some norm against which to compare the respondent’s early caregiver experiences.

Intimacy Scales

Background of the Intimacy Scales

Marshall and Barbaree (1990) suggested that developmental adversity interferes with the development of intimacy and empathy (see Kendall-Tackett, Williams & Finkelhor, 2001, for a review of the effects of sexual abuse and Reyome, 2010, for a review of the effects of emotional abuse). Marshall (2010) also argued that intimacy deficits are characteristic of sex offenders (see also Hudson & Ward, 2000). Juveniles who have committed sexual offenses have fewer appropriate peer relationships (Bagley & Shewchuk-Dann, 1991; Milloy, 1994) and are more likely to be characterized as isolated and/or low in social competence (Awad & Saunders, 1991; Hunter, Figueredo, Malamuth, & Becker, 2003). There is also some evidence that inadequate social relationships contribute to recidivism for both adults and adolescents (Hanson & Bussière, 1998; Långström & Grann, 2000). Consistent with these data, various measures of achieved relationships appear on several actuarials (e.g., Static-99, Risk Matrix 2000, J-SOAP-II; A-SOAP-II; SVR-20). The STABLE-2007, which attempts to assess dynamic factors related to recidivism, included a scale for Intimacy Deficits, two components of which are the capacity for relationship stability and general social rejection/loneliness (Hanson & Harris, 2007). Hanson, Harris, Scott, and Helmus (2007) found that the stable dynamic characteristics that were included in the STABLE-2007 significantly enhanced the prediction of recidivism above the Static-99. Intimacy deficits were a significant contributor to this improved predictive potency. The item of General Social Rejection/Loneliness was the most potent predictor, significantly predicting sexual, violent, and general recidivism.

Description of the Intimacy Scales

Friendship Intimacy. This scale consists of nine questions. Respondents who scored high on this scale report that their relationship with important friends included behavioral and emotional support. They were asked these questions about friendships before their eighteenth birthday and adult friendships. An example of an item on the scale is –

I can be sure my friend will help me whenever I ask.

Respondents who reported having no friends were not given the intimacy scale.

Romantic Intimacy with Females. If a respondent said that he had at least one relationship that lasted more than three months and in which he felt close to the girl or woman, he was asked questions to determine how intimate he was with the girl or woman who meant the most to him. He was also asked questions about adult relationships with women he married, lived with, or had a non-cohabitating relationship with. A scale is displayed for the relationship in which he reported the highest intimacy.

The intimacy scale consists of eight items. Respondents who scored high on this scale report that their relationship was emotionally and behaviorally supportive. An example of an item on the scale is –

I can trust my friend to keep my secrets and not betray me.

Generation of the Intimacy Scales

The intimacy scales were developed and tested in two larger studies with university students (343 and 312 participants, respectively). After reducing the original number of items based on exploratory factor analysis, the 22- and 17-item scales were analyzed using item response theory. The resulting scales comprised 8- and 9-item scales (see Appendix). Cronbach's alpha for romantic intimacy were .81 and .79 for the two studies; for friendship intimacy alpha was .78 in both studies. Both intimacy scales correlate with perspective taking, emotional intelligence, and empathy, but do not correlate with antisocial behaviors such as alcohol/drug abuse, delinquency, and assault (Sims-Knight, in preparation). Dussault (2007) found that romantic intimacy was negatively correlated with machievellianism, as measured by the Mach IV scale, and positively correlated with rate of selection of an honest romantic partner. Thus, there is both convergent and divergent validity.

Practical Considerations for the Intimacy Scales

The predictive potency of intimacy-related measures described above would argue that enhancing social supports and increasing intimacy with such supports should be a focus of intervention. Consistent with such data, Shursen, Brock, and Jennings (2008) have suggested that adding an emphasis on relationships to traditional cognitive behavioral treatment of sex offenders might be effective in reducing recidivism. The good lives model's (Ward, 2002; Ward & Stewart, 2003a, 2003b; Marshall, Marshall, Serran, & Fernandez, 2006) emphasis on enhancing the client's ability to satisfy basic human needs of intimacy and relatedness is also consistent with the Andrews and Bonta needs principle.

Intimacy may also serve as a protective factor. Bollmer, Milich, Harris, and Maras (2005) found that externalizing juveniles who had a high quality friend were less likely to bully than externalizers who did not. Although we do not know of any comparable studies with sex offenders, it may be that intimacy serves as a moderating protective factor for sexual aggressors as well.

Attention-Deficit/Hyperactivity Disorder and Oppositional Behavior Scales

Background of the ADHD and ODD Scales

The two attention-deficit/hyperactivity disorder (ADHD) scales and the Oppositional Defiant Disorder (ODD) scale in the MIDSA (described below) are fashioned after the symptoms listed in DSM-IV-TR for these diagnoses and attempt to assess these disorders. ADHD is a disorder that is characterized by difficulties with attention, hyperactivity, and impulsivity. It occurs in an estimated 3% to 5% of schoolage children (Barkley, 2006). The MIDSA assessment of ADHD comprises two separate factors. The Attention factor assesses disorganized and distractible behavior, and the Inhibition Difficulties assesses difficulties inhibiting verbal and motoric behaviors. The Oppositional Behavior factor measures childhood anger and refusal to obey rules.

The three most common psychological diagnoses given to juvenile offenders are ADHD, ODD, and Conduct Disorder (CD) (Hoge & Andrews, 1996). Many children referred to clinics with ADHD also meet diagnostic criteria for ODD or CD (American Psychiatric Association, 2000). The frequency with which children and adolescents with ADHD are also diagnosed with ODD and CD ranges from 9% to 65% (Barkley, DuPaul, & McMurray, 1990; Brown & Borden, 1986, Zagar, Arbit, Hughes, Busell, & Busch, 1989). The apparent relation between ADHD and CD is that ADHD symptoms make conduct disordered behavior worse (e.g., Abikoff & Klein, 1992; Forehand, Wierson, Frame, Kempton, & Armistead, 1991; Loeber, Farrington, Stouthamer-Loeber, & Moffitt, 2001; Magnusson & Bergman, 1988; Vitelli, 1998; Walker, Lahey, Hynd, & Frame, 1987; Waschbush, 2002; Whittinger, Langley, Fowler, Thomas, & Thaper, 2007). Children with ADHD who have been followed are more likely to have criminal involvement as adolescents (Mannuzza, Klein, Konig, & Giampino, 1989; Moffitt & Silva, 1988; Satterfield, Swanson, Schell, & Lee, 1994). Similarly, adolescents with ADHD are at increased risk for criminal involvement (e.g. Barkley, Fischer, Edelbrock, & Smallish, 1990; Moffitt 1990) and for antisocial impulsivity (Biederman, Faraone et al., 2006; Biederman, Monuteaux et al., 2006). They are also at risk to use higher levels of alcohol, tobacco, and illicit drugs (Molina & Pelham, 2003).

ADHD has been found to be prevalent among males with paraphilic disorders (Grant, 2005; Kafka & Hennen, 2002, Kafka & Prentky, 1998). It is frequently found in pedophiles (Raymond, Coleman, Ohlerkng, Christenson, & Miner, 1999) and in other types of sexual offenders (Ahlmeyer, Kleinsasser, Stoner, & Retzlaff, 2003; Dunsieth et al., 2004; Fago, 2003; Robertson, Knight, & Conboy, 1999). It is especially common in adolescent sexual offenders. Robertson et al. (1999) found that 57% of residential juvenile sexual offenders either had been treated with medication for ADHD or reached the cutoff for ADHD on a self-report scale. Fago (1999) reported that 77% of children and adolescents evaluated for sexually aggressive behavior met the diagnostic criteria for ADHD, and Galli et al. (1999) reported a similar prevalence rate (71%) in an adolescent sample of sexual offenders. Such high rates of ADHD and ADD are quite striking, especially when compared to the estimate in the general population that 3% - 5% of school aged children have this disorder (American Psychiatric Association, 1994; Anderson, Williams, McGee, & Silva, 1987; Barkley, 2006). Among juvenile sexual offenders conduct

disorder is a frequent comorbid diagnosis of ADHD (Kavoussi, Kaplan, & Becker, 1988). As in many other domains of psychopathology, comorbidity is becoming the rule rather than the exception (Faraone, 2000), and it is essential that clinicians treating sexual offenders become aware of and address possible comorbid conditions.

Several brain areas including the prefrontal cortical structures, the anterior cingulate, the amygdala, and the corpus callosum (Hutchinson, Mathias, & Banich, 2008; Plessen et al., 2006; Rhodes, Coghill, & Matthews, 2005; Seidman, Valera, & Makris, 2005; Shaw et al., 2006) have been implicated in anatomical, brain imaging, and neuropsychological studies as potentially contributing to ADHD behaviors. Although there have been several studies that have found gene X environment (diathesis-stress) interactions that predict the development of ADHD (Lasky-Su et al., 2007; Laucht et al., 2007; Retz et al., 2008; Waldman, 2007), not all studies have been consistent (Thapar, Langley, Owen, & O'Donovan, 2007). The candidate genes that appear most promising as contributors to ADHD symptoms are the dopamine transporter gene (*DAT1*) and dopamine D4 receptor gene (*DRD4*) (Gizer et al., 2008; Lasky-Su et al., 2008). In addition, Caspi et al. (2008) found in three distinct samples that the COMT dopaminergic gene polymorphism differentiated between ADHD boys who also exhibited antisocial behaviors from ADHD boys who did not.

Although ADHD is commonly thought to be a childhood disorder, it is also relatively common in adults, occurring in 2 – 6% of the population (Biederman, Faraone, et al., 2006; Kessler et al., 2006). An average of 50% of children with ADHD (range: 33%–84%) have been found to continue the disorder into adulthood (Lara et al., 2009). Robertson et al. (1999) found that 22% of adult sexual offenders either had been treated with medication for ADHD or reached the cutoff for ADHD on a self-report scale. Kafka and Hennen (2002) reported data that suggest that ADHD in adults may covary with paraphilic sexual offending and the inattentive subtype may be associated with paraphilia related disorders. These results suggest that adults, as well as juveniles who sexually offend, should be assessed for ADHD symptoms.

Description of the ADHD and Oppositional Behavior Scale

In the MIDSA respondents were asked a series of questions about their childhood behaviors and impulses that are frequently found in attention deficit/hyperactive disordered (ADHD) and oppositional defiant disordered (ODD) children.

Attention Deficit. This scale consists of nine items. Respondents who scored high on this scale report being careless, distractible, and disorganized before the age of 12 years. The internal consistency for juveniles was .89 and for adults .93. An example of an item on the scale is –

I was easily distracted.

Inhibition Difficulties. This scale consists of five items. Respondents who scored high on this scale indicate that they found it difficult to inhibit verbal and motoric behaviors as children. The internal consistency for juveniles was .84 and for adults .85. An example of an item on the scale is –

I blurted out answers before questions had been completed.

Oppositional Behavior. This scale consists of eight items. Respondents who scored high on this scale report that they tended to be hateful, angry, and argumentative, and that they often refused to obey rules when they were children. The internal consistency for juveniles was .92 and for adults .92. An example of an item on the scale is –

I argued with adults.

Generation of the ADHD and Oppositional Behavior Scale

The items were generated from the DSM-IV-TR symptoms for each disorder. Respondents are asked to report about their behavior before their 12th birthday. Exploratory factor analysis yielded three factor scales for both the juvenile and adult samples. When four items were dropped, the remaining items loaded on the same three factors with extremely similar loadings for both samples. The internal consistencies for the summative scales that were generated from the items loading on each factor all exceeded .80. Because data from the community sample were unavailable, the respondent's scores are only reported as percentiles using as appropriate either the juvenile or adult validation sample to generate the percentiles.

Practical Considerations for the ADHD and ODD Scales

Of the neurodevelopmental disorders, ADHD is not only the one most implicated in juveniles who sexually offend, but it is also the disorder with the greatest preponderance of research attention in general (Fago, 2003). Although it has been found prevalent in adult sexual offenders, where 22% were found to have a history of ADHD (Robertson et al., 1999), it is far more prevalent in children and adolescents who sexually offend (Fago, 1999, 2003; Robertson et al., 1999). Fago (2003) speculated that because a significant portion of his ADHD adolescent sexual offenders had not been sexually abused or exposed to sexual violence or disruptive family environments, it may be that simply the presence of the executive function deficits of ADHD and exposure to sexual stimulation might be sufficient in some adolescents to lead to sexual misconduct. This would suggest that a treatment plan for youth with ADHD should take into account their developmental history, the involvement of sexual deviant behavior, and their sexual history including the exposure to and use of pornographic materials. The lower prevalence of ADHD in adult sexual offender samples may suggest that a significant portion of ADHD youths' sexual offending may simply be impulsive sexual acts that may subsequently be replaced with normative sexuality (Ryan, 1999).

The ADHD and ODD scales are currently only standardized against offender samples. It is recommended that respondents who score in the top 50% of offender samples be further evaluated for treatment. A treatment plan for sexually offending youths with ADHD, in addition to directly addressing their executive function deficits, should also assess, and where appropriate treat, their social skills deficits and their difficulties processing social information (Millich & Dodge, 1984; Moffitt, 1990). Fago (2003) cautions that youths with ADHD may not be appropriate for psychoeducational group treatment. Indeed, some question the appropriateness of groups in general for delinquent youths (Dishion, McCord, & Poulin, 1999; Levant, Tolan, & Dodgen, 2002). Parental and family involvement in treatment is recommended for children with ADHD (Barkley, 1997, 1998; Fago, 2003), which nicely coincides with the recommendation of

multisystemic treatment (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). Fago (2003) recommends especially rigorous supervision on access to pornographic materials. Education on the nature of neurodevelopmental disorders and the impact of such disorders on the adolescent's behavior for caregivers is important. Barkley (1997) has developed a structured parent-training program that teaches the principles of behavior management for defiant, externalizing behaviors. It is also suggested that the clinician serve as an advocate in school to ensure that the adolescent has access to all of the special services that may be available in the school. It is important to recognize the potential for academic failure and the negative affect that this will have on the progress of therapy and the ultimate adaptation of the youth.

The research literature provides strong support for behavior parent training, behavioral classroom management, and intensive peer-focused behavioral interventions as effective interventions for children with ADHD (Fabiano et al., 2009; Pelham & Fabiano, 2008). Although effective treatment descriptions have been provided (Pelham, Meichenbaum, & Fabiano, 2005), there are some concerns about how well and to what extent these established treatments are being delivered in practice (Weiss, Yeung, Rea, Poitras, & Goldstein, 2009). Recent research has found that for children with ADHD combining behavior modification therapy with medication appears to be the most effective way to treat the disorder. Although both stimulant medication and behavior modification each yielded significant treatment effects, combining the two interventions has produced the greatest improvement (Pelham, Burrows-MacLean, et al., 2005). Importantly, combining behavioral treatment with medication allowed medication dosages to be reduced by as much as 67%, while still maintaining the same therapeutic efficacy (Pelham, Burrows-MacLean, et al., 2005). Because of the damaging side effects of stimulant medications (Pelham, 2008a), these results have serious implications for treatment recommendations. Pelham (Pelham, 2008b; Pelham & Fabiano, 2008) has questioned the commonly held belief that medication is an essential first line of intervention, supplemented by behavior interventions. Because many ADHD children can be treated effectively without medication, evidenced-based psychosocial interventions should be attempted first to reduce the negative side effects of medication.

Pharmacological intervention may be indicated, especially to aid adolescents with ADHD to overcome more serious cognitive *deficits*. Until the adolescent's control over thinking and acting is improved, and they have the ability to pause, reflect, and control, attempts to change cognitions and develop victim empathy may be compromised (Fago, 2003). The role of pharmacological agents should not be overlooked. Between 70% and 90% of children with ADHD have a positive response to stimulant medication (e.g. Dexedrine, Adderall, Methylphenidate, Magnesium Pemoline--Faraone, Biederman, Spencer, & Aleardi, 2006; Faraone, Spencer, Aleardi, Pagano, & Biederman, 2004; Goldman, Genel, Bezman, & Slanetz, 1998). Many studies have found that stimulant medication decreases aggressive or antisocial behavior in hyperactive children (Goldman et al., 1998; Hinshaw, Heller, & McHale, 1992; Murphy, Pelham, & Lang, 1992). Recently, tricyclic antidepressants, serotonin reuptake inhibitors, and mood stabilizers have also been found effective (Brown & Sammons, 2002), and the clinician should familiarize herself with these intervention possibilities. Hinshaw (2006) in a recent review of intervention techniques concludes that innovative treatments for ADHD, both pharmacologic and psychosocial, are strongly needed. He argues that treatment should combine

"cognitive strategies with direct contingency management, behavioral rehearsal, and promotion of generalization and maintenance" (p. 96).

For the present, psychostimulants remain the first line treatment of ADHD in adults (e.g., Antai-Otong, 2008; Adler, Spencer, McGough, Jiang, & Muniz, 2009; Rösler, Fischer, Ammer, Ose, Retz, 2009). Some evidence indicates that cognitive behavioral therapy might be an effective intervention with adults (Bramham et al., 2009). The well-established efficacy of behavioral interventions in youth suggests that similar programs, adapted to be appropriate for adults, can be developed.

Juvenile Antisocial Scales

The presence of an antisocial orientation can be operationalized using either personality/trait characteristics or behavioral criteria. The juvenile antisocial scales focus on the latter operationalization. The MIDSA asks a number of questions about acting out behaviors during childhood and adolescence. It uses contingency-based questioning in which the respondent is asked about his criminal activity in general domains, and if he admits any behavior in a domain, follow-up questions explore the particular crimes or antisocial behaviors in which he engaged. In this way he can be asked about a large array of antisocial behavior efficiently with a minimum number of focused questions. In creating scales that capture the variance of such a wide array of behaviors, we first had to generate rational scales for each individual crime, drug, and aggressive behavior cluster. These rational scales were then factor analyzed for juveniles and adult sexual offenders and for the community controls. For all three samples the same three factors emerged with high internal consistencies.

Juvenile Alcohol and Drug Abuse Scale

Background of the Juvenile Alcohol and Drug Abuse Scale

Whether its role is facilitative or causative, whether it serves as an excuse or as a precipitant, there is no doubt that alcohol use and abuse play a significant, multifaceted role in sexually coercive behavior in both college and criminal samples (Abbey, 1991; Abbey & Harnish, 1995; Abbey, McAuslan, Zawacki, Clinton, & Buck, 2001; Abbey, Ross, McDuffie, & McAuslan, 1996; Berkowitz, 1992; Carr & VanDeusen, 2004; Frintner & Rubinson, 1993; Koss & Gaines, 1993; Muehlenhard & Linton, 1987; Norris & Cubbins, 1992; Prentky & Knight, 1991; Richardson & Hammock, 1991). In almost 50% of sexual assaults the perpetrator has been found to have imbibed alcohol, and at the time of a sexual assault approximately one-half of victims have been found to be using alcohol (Abbey, Zawacki, Buck, Clinton, & McAuslan, 2004). As one might predict, there is a high correlation between perpetrator and victim drinking (Ullman, Karabatsos, & Koss, 1999a, 1999b). Alcohol's impairment of inhibitory controls, its exacerbation of communication misinterpretations, its disruption of higher order cognitive processing (e.g., decision making abilities), and its interaction with existing personality characteristics (e.g., trait aggression) have all been invoked as reasons for alcohol's relation to sexually aggressive behavior (Abbey et al., 2004; Mohler-Kuo, Dowdall, Koss, & Wechsler, 2004). Some evidence also supports the hypothesis that more extreme levels of drinking prior to consensual sex might also be indicative of greater persistence in sexually coercive behavior (Abbey & McAuslan, 2004).

Alcohol abuse not only increases the frequency of sexual coercion, but also it impacts the outcome of the assault. Perpetrator alcohol use has been found to increase violence for both rapists and child molesters (Hamdi & Knight, in press). Abbey, Clinton-Sherrod, McAuslan, Zawacki and Buck (2003) found that the amount of alcohol consumed during an assault correlated both with the perpetrator aggressiveness and the severity of the outcome (whether coitus was achieved). Higher perpetrator alcohol consumption was positively related to higher violence, but the relation to severity was curvilinear--increasing at lower levels of alcohol

consumption, reaching a plateau at moderate levels, and decreasing at high levels. Abbey et al. (2003) also found a positive correlation between the amount of alcohol consumed by the victim and outcome severity, suggesting that more intoxicated victims faced a greater risk of completed rape. For the victims of sexual assault, alcohol use may inhibit their ability to fully appreciate sexually aggressive signals from men and to respond in an effective fashion (Abbey et al., 2001; Norris, Nurius, & Dimeff, 1996). Testa, Vanzile-Tamsen, and Livingston (2004) corroborated these consumption correlations, but also found that perpetrator intoxication was only correlated with victim injury when the victim was sober.

The significant negative effect of substance abuse on coping skills and its disinhibitory effects in high-risk situations suggest the potential for a significant etiological and predictive role for such abuse. For juveniles Johnson and Knight (2000) found that alcohol abuse from age 13 to 18 had both a direct effect on the frequency of sexual offending against peers and older victims and an indirect effect through negative masculinity and misogynistic fantasies, suggesting a facilitative etiological role for substance abuse. Alcohol and drug abuse significantly loaded on the antisocial latent trait in Knight and Sims-Knight's (2003, 2004) structural equation etiology model for sexually coercive behavior against peers and women for both juveniles and adults. The recidivism prediction data are less consistent. Hanson and Bussière (1998) failed to find any relation to adult sex offender recidivism. In contrast, Auslander (1998) found that a history of alcohol abuse was negatively associated with violent recidivism for juveniles. Although Santman (1998) found a history of substance abuse predicted non-sexual recidivism, Miner (2002) found no support for such a relation. Despite its checkered record as a risk predictor, the potential role of alcohol in etiology and its interface with multiple aspects of the sexual offense indicate that it should constitute a focus of treatment in those with a problem.

Description of the Juvenile Alcohol and Drug Abuse Scale

This factor scale includes 6 subscales measuring the variety and frequency of drug and alcohol use as a juvenile. For both childhood and adolescent time frames questions address both the type of drug used (e.g., alcohol, marijuana, uppers, LSD, cocaine, heroin) and the frequency of use. The rational scales assess frequency, variety, and the seriousness of drug and alcohol use. Respondents who score high on this scale report frequent abuse with a variety of substances. The internal consistency of this scale for juveniles was .86 and for adults .87. An example of an item in the alcohol and drug abuse domain is –

Have you ever taken any illegal drug or used a drug to get high?

Generation of the Juvenile Alcohol and Drug Abuse Scale

Rational scales were generated to assess the frequency of alcohol use and abuse, drug use with higher weights given to more serious drugs, and the variety of drugs with which the youth experimented. Separate scales were generated for childhood and adolescence yielding the following six rational scales-- Alcohol Use (child), Alcohol Use (juvenile), Weighted Drug Use (child), Weighted Drug Use (juvenile), Variety of Drug Use (child), and Variety of Drug Use (juvenile).

As indicated above, the factor analyses for both the adult and juvenile offenders and for the community controls yielded a consistent cross-sample factor on which all of these rational scales had high factor loadings.

Practical Considerations of the Juvenile Alcohol and Drug Abuse Scale

As can be seen in the report graph of Juvenile Alcohol and Drug Abuse, the median of juvenile sexual offenders was at a T Score of 49. The whisker plot indicates that the distribution of the juveniles is positively skewed and the mean of the juveniles on this scale is actually significantly higher than the controls, indicating that among juveniles there is a small contingent of high scorers. Despite the spotted history of substance as a predictor of both non-sexual and sexual recidivism, high scores still indicate an important target for therapeutic intervention. Indeed, the mixed results in the predictive potency of this problem area might partially be a function of its susceptibility to effective treatment.

Juvenile Delinquency

Background of the Juvenile Delinquency Scale

A number of studies have found that juveniles who have committed sexual offenses as a group can be characterized as high in impulsivity and antisocial behavior (Ageton, 1983; Awad & Saunders, 1991; Awad, Saunders & Levene, 1984; Becker, Cunningham-Rouleau, & Kaplan, 1986; Fehrenbach, Smith, Monastersky, & Deisher, 1986; Knight & Prentky, 1993; Prentky & Knight, 1993; Shoor, Speed, & Bartelt, 1966; Spaccarelli, Bowden, Coatsworth, & Kim, 1997; Van Ness, 1984). Indeed, if these juvenile offenders recidivate, their reoffense crimes are more often nonsexual than sexual (Caldwell, 2002; Righthand & Welch, 2001; Worling & Curwen, 2000; Zimring, 2004). Such data have led some to hypothesize that juvenile sexual offenders are simply a subset of delinquents (Ageton, 1983). More likely, however, is the hypothesis that like adult offenders juvenile sexual offenders are heterogeneous (Knight & Prentky, 1993), and a subset of these offenders are delinquency-prone, criminal generalists, who are more likely to offend against age appropriate or older victims (Hunter, Figueredo, Malamuth, & Becker 2004; Knight & Prentky, 1993; Santman, 1998; Seto & Lalumière, 2005; Worling, 2001).

The hypothesis of the taxonomic complexity of juvenile sexual offenders is consistent with the mixed role that antisocial and non-sexual criminal behavior has played in predicting sexual recidivism. Although a history of antisocial behavior and an impulsive, antisocial lifestyle are robust predictors of general recidivism both among generic delinquents (Hawkins et al., 1998) and juvenile sex offenders (Auslander, 1998; Långström, 2002; Långström & Grann, 2000; Miner, 2002; Rasmussen, 1999; Worling & Curwen, 2000), their role in specifically predicting subsequent sexual crimes has been inconsistent. Whereas several studies have found a relation between a history of nonsexual offenses and sexual recidivism (Allan, Allan, Marshall, & Kraszlan, 2003; Caldwell, 2007; McCann & Lussier, 2008; Nisbet, Wilson, & Smallbone, 2004), and others have found a relation between sexual recidivism and a history of impulsivity, psychopathy, antisocial personality characteristics, and truancy (Caldwell, Ziemke, & Vitacco, 2008; Gretton, McBride, Hare, O'Shaughnessy, & Kumka, 2001; Schram, Milloy, & Rowe, 1991; Worling, 2001), a number of studies (Kahn & Chambers, 1991; Lab, Shields, & Schondel, 1993; Långström, 2002; Rasmussen, 1999; Sipe, Jensen, & Everett, 1998; Worling & Curwen,

2000) have failed to find a relation between nonsexual offending and sexual recidivism. Nonetheless, some evidence suggests that it may play a role in predicting persistence of sexually coercive behavior into adulthood (Park & Bard, 2006; Zimring, Jennings, Piquero, & Hays, 2009; Zimring . Piquero, & Jennings, 2007). Consistent with these results, Worling and Långström (2006) have listed antisocial interpersonal orientation and impulsivity as only *possible* risk factors for sexual recidivism.

Such inconsistency could be explained by differences in the sample compositions of the various studies. Antisocial behavior may have predictive potency for sexual offending among the rapist contingent (more likely generalists— Hagan, King, & Patros, 1994; Harris, Knight, Smallbone, & Dennison, 2011) and lack it among the specialist child molester contingent. This distinction has been hypothesized to be a viable typological discriminator among juveniles who sexually offend (Hunter et al., 2003; Knight & Prentky, 1993). A difference in the predictive potency of antisociality between youth who offend against prepubescent children and those who target pubescent and post pubescent females would parallel that found among adults (Knight & Thornton, 2007), where antisocial behavior predicts sexual recidivism for rapists, but not for child molesters. Nonetheless, in a couple of adult actuarials (the Adult Sex Offender Assessment Protocol-II [A-SOAP-II; Prentky & Righthand, 2003b]), and the Minnesota Sex Offender Screening Tool, Revised [MnSOST-R; Epperson et al., 1998]) juvenile antisocial behavior is included as an item to predict sexual recidivism for generic adult sexual offenders and not just for rapists.

There are several noteworthy findings on the MIDSA Juvenile Delinquency scale. The first is evident in the graph of the MIDSA scale in the report. The medians of both the juvenile and the adult sexual offenders fall close to the mean level of the community controls; the median for the juveniles falls at a T Score of 50 and the adults at 48. Also evident in the whisker plots on these graphs is the fact that the distributions of both sexual offender groups are positively skewed, indicating that there are large contingents of offenders in both groups who have manifested very high delinquency scores. Because of these subgroups of juvenile and adult offenders with high delinquency, the means of both offender groups are still significantly higher than that of the community controls, despite the medians falling at the mean T Score. It is noteworthy as well that the juvenile offenders' delinquency scores were higher than those of the adult sexual offenders (Knight, 2004).

Description of the Juvenile Delinquency Scale

This scale comprises 10 subscales that tap criminal behavior before age 18 in a variety of domains, including stealing, breaking and entering and trespassing, damaging property, disorderly conduct, traffic offenses, drug related crimes, crimes involving use of a weapon, truancy and running away, and assaultive crimes. A high score on this scale indicates either a high frequency of criminal activity in a single domain or criminal behavior in wide variety of criminal domains. The internal consistency of this scale for juveniles was .90 and for adults .91. An example of an item in the disorderly conduct domain is –

Before my 18th birthday I was charged with or convicted of:

> *Disorderly Conduct or Disturbing the Peace:* verbally or physically annoying others so that they called the police.

Generation of the Juvenile Delinquency Scale

Rational scales were generated to assess the frequency cohesive crime clusters charged during adolescence. The following ten rational scales were created and all yielded good internal consistencies--

Stealing
Trespassing and B&E
Damaging property
Traffic offenses
Conduct disorder
Alcohol related crimes
Drug crimes
Weapon crimes
Truancy/Running away
Assaultive crime

As indicated above, the factor analyses for both the adult and juvenile offenders and for the community controls yielded a consistent cross-sample factor on which all of these scales had high factor loadings.

Practical Considerations for the Juvenile Delinquency Scale

The well established predictive potency of high antisocial behavior in juveniles for continued antisocial behavior supports the notion that antisocial personality characteristics constitute clear criminogenic needs that should be addressed in therapy. Not all treatments for antisocial behavior have proven effective (Frick, 2001; Kazdin, 2002). Indeed, some treatments of the most chronic patterns of juvenile antisocial behavior like conduct disorder may actually increase the level of antisocial behavior. Most notable are those treatments that involve antisocial peer group interactions (Dishion et al., 1999; Levant et al., 2002). Frick (2001) argues that the treatment for antisocial behavior must take into account the developmental trajectories that lead to antisocial acting out and conduct disorder. In addition to important individual predispositions that contribute to antisocial behavior, the youth's psychosocial context (family, peer, and neighborhood) must be addressed. Frick (2001) reviews three effective cognitive/behavioral treatment approaches—contingency management programs, parent management training, and cognitive-behavioral skills training and describes the strengths and limitations of each and the personality and contextual issues best addressed by each approach. He also describes a developmental pathway model that has important implications for developing new more effective interventions.

High antisocial behavior may predict sexual recidivism better in adolescents with peer rather than child victim preferences. Consequently, it may be considered a more specific risk factor for sexual recidivism in youths with sexual preferences for peers, but this inference from the adult follow-up data (Knight & Thornton, 2007) must be replicated on juveniles. Some recidivism data (Gretton et al., 2001) suggest that the combination of antisocial behavior and sexual deviance might more accurately portend sexual recidivism than antisocial behavior alone,

as it does in the adult sexual offender literature (Harris, Rice, Quinsey, Lalumière, Boer, & Lang, 2003; Rice & Harris, 1997). "Antisocial Orientation" on the ERASOR is the item that most closely parallels this scale. On the J-SOAP-II the Scale II item, "Juvenile Antisocial Behavior (Age 10-17)," would most closely correspond to this scale, and "Ever Charged or Arrested Before the Age of 16," "Multiple Types of Offenses," and "History of Conduct Disorder before Age 10" would be related as well. As previously indicated, juvenile antisocial behavior is also included as an item in two adult sexual recidivism actuarial scales (A-SOAP-II, the MnSOST-R).

Juvenile Behavioral and Aggressive Problems

Background of the Juvenile Behavioral and Aggressive Problems Scale

The role of violence and aggression in non-sexual domains has not been studied extensively in juvenile sexual offenders. The isolation of such behavior emerged from the specific cohesion of this type of behavior in the factor analyses of both groups of offenders and the community controls in studies of the MASA data. The importance of this factor is illustrated in the report graph for this variable. The median of the juvenile sexual offenders falls at a T Score of 65, indicating the 50% of the juvenile sexual offenders have Fighting and Assaultive scores that exceed approximately 92% of the community controls. For both adults and juvenile sexual offenders the Fighting and Assaultive scores were significantly higher than those of the community sample, and the scores for juvenile sexual offenders were significantly greater than those of adult offenders. Of the three juvenile antisocial factor scales this was the factor that most clearly differentiated sexual offenders from controls.

Description of the Juvenile Fighting and Assaultive Behavior Scale

This factor scale includes 5 scales measuring instances of fighting, bullying, aggressive, and impulsive behavior. High scorers have a high incidence of fighting and impulsivity. The internal consistency of this scale for juveniles was .81 and for adults .84. An example of an item measuring fighting is—

Before my 18th birthday I:
was involved in physical fights.

Generation of the Juvenile Fighting and Assaultive Behavior Scale

Three rational scales were generated to assess the frequency of aggressive behavior and impulsivity. The aggressive scale spanned childhood and adolescence, and the impulsivity focused on acting out in grammar school and in middle school or high school. All three scales had high internal consistencies. They included --

Assaults and Fighting
Impulsivity in Grammar School
Impulsivity in Grades 7 – 12

As indicated above, the factor analyses for both the adult and juvenile offenders and for the community controls yielded a consistent cross-sample factor on which all three of these scales loaded highly.

Practical Considerations

Scores on this scale correlate significantly with scores on all the pervasive anger scales for both offender and community control samples, indicating a link between the high physical aggression and impulsivity captured in this scale and difficulties with anger management. Consequently, respondents with high scores on this scale should be considered as candidates for anger management therapy.

The ERASOR item that is most closely related to this MIDSA scale would be "Interpersonal aggression." Neither the J-SOAP-II nor the JSORRAT-II have items that focus on non-sexual violence or assaultive behavior. High scores on Juvenile Fighting and Assaultive Behavior, especially when linked to high scores on the Constantly Angry and/or Physical Fighting scales, indicate that anger management training should included in the recommendations for treatment. This scale has significant correlations with its adult counterpart, the Adult Fighting and Assaultive Behavior Scale, and additional information on this domain is discussed in the section on the adult scale.

Adult Antisocial Scales

The consideration of generic adult criminal and antisocial behavior in sexual offenders is important for multiple reasons. First, among individuals who have sexually offended antisocial behavior has consistently been found to be a predictor of recidivism both for generic criminal and sexual recidivism (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005, 2009; Knight & Thornton, 2007). Consequently, various operationalizations of criminal and antisocial behavior have been included both in commonly used actuarials for predicting sexual recidivism (e.g., the Static-99 [Hanson & Thornton, 2000], the Static-2002 [Hanson & Thornton, 2003], the Sexual Offender Risk Assessment Guide [SORAG; Quinsey, Harris, Rice, & Cormier, 1998], and the Risk Matrix 2000 [Thornton et al., 2003]), and in structured clinical guidelines for predicting sexual reoffense risk (e.g., the Sexual Violence Risk-20 [SVR-20; Boer, Hart, Kropp, & Webster, 1997] and the A-SOAP-II [Prentky & Righthand, 2003b]). Second, in contrast with a commonly held perspective that maintains that sexual offenders commit predominantly sexual offenses throughout their criminal careers (e.g., Simon, 1997a, 1997b), an alternative viewpoint, commonly held in traditional criminology, characterizes those who commit sexual offenses as versatile criminals who engage in different types of crime over their lifetime (e.g., Gottfredson & Hirschi, 1990). Recent data from the MTC follow-up study have supported the notion that specialization in sexual crimes seems predominantly limited to child molesters, and the majority of rapists can be characterized as criminal generalists (Harris, Mazerolle, & Knight, 2009; Harris, Smallbone, Dennison, & Knight, 2009). Such data are consistent with the role that antisocial behavior plays both in etiological models of sexual aggression against women (Knight & Sims-Knight, 2003, 2004) and its predominant role in the only empirically validated typology for rapists (Knight, 2009; Knight & Guay, 2006). The relative role of generalization and specialization among rapists and child molesters is also consistent with the greater potency of the antisocial behavior facet of the PCL-R in predicting sexual recidivism in rapists as compared to child molesters (Kim, Guay, & Knight, 2007). Thus, it is essential to assess adult antisocial behavior of sexual offenders so that the criminogenic needs that it represents can be addressed in treatment.

The MIDSA asks a number of questions about criminal behaviors during adulthood. It uses contingency-based questioning in which the respondent is asked about his criminal activity in general domains, and if he admits any behavior in a domain, follow-up questions explore the particular crimes or antisocial behaviors in which he has engaged. In this way he can be asked about a large array of antisocial behavior efficiently with a minimum number of focused questions. In creating scales that capture the variance of such a wide array of behaviors, we first had to generate rational scales for each individual crime, drug, and aggressive behavior cluster. These rational scales were then factor analyzed for adult sexual offenders and for the community controls. For both samples the same three factors emerged with high internal consistencies. These three factors paralleled the three antisocial factors that emerged for the juvenile antisocial domain.

Adult Alcohol and Drug Abuse Scale

Background of the Adult Alcohol and Drug Abuse Scale

The background evidence for the role of alcohol in sexually coercive behavior was reviewed in the background section for the Juvenile Alcohol and Drug scale. It is noteworthy that adult drug and alcohol abuse is included as a risk item on two actuarials--the MnSOST-II and the SORAG and one structured clinical guideline risk instrument, the SVR-20. These actuarial scales do not differentiate between rapists and child molesters. In the standardization sample for the MIDSA the rapists reported significantly higher adult drug and alcohol abuse than the child molesters.

Description of the Adult Alcohol and Drug Abuse Scale

This factor scale includes 4 subscales measuring the variety and frequency of drug and alcohol use as an adult. For adulthood the questions address both the type of drug used (e.g., alcohol, marijuana, uppers, LSD, cocaine, heroin) and the frequency of use. The rational scales assess frequency, variety, and the seriousness of drug and alcohol use. Respondents who score high on this scale report frequent abuse with a variety of substances. The internal consistency of this scale for adult offenders was .90 and for the adult community sample was .76. An example of an item in the alcohol and drug abuse domain is –

How often have you had an alcoholic drink since your 18th birthday?

Generation of the Adult Alcohol and Drug Abuse Scale

Four rational scales were generated to assess the components of substance abuse --

Frequency and aggressive consequences of alcohol abuse
Variety of different drugs used
Weighted scale of drug severity
Frequency of illicit drug use

As indicated above, in factor analyses of all of the rational scales created for substance abuse and criminal and antisocial behavior, a consistent cross-sample factor emerged on which all four rational scales for substance abuse had high factor loadings for both the adult offenders and for the community controls.

Practical Considerations of the Adult Alcohol and Drug Abuse Scale

As can be seen in the graph for Adult Alcohol and Drug Abuse in the MIDSA Report, adult sexual offenders scored significantly higher on this scale than community controls. The median of the adult sexual offenders was at a T Score of 56.3. The whisker plot indicates that the distribution of the adult sexual offenders is positively skewed with over a third of adult sexual offenders exceeding the 65 T Score of the community sample. Despite the mixed history of substance abuse as a predictor of both non-sexual and sexual recidivism, high scores still indicate

an important target for therapeutic intervention. Indeed, the mixed results in the predictive potency of this problem area might partially be a function of its susceptibility to effective treatment.

Adult Conduct Disorder

Background of the Adult Conduct Disorder Scale

This factor scale includes four subscales measuring a variety of non-violent adult antisocial behaviors, including disturbing the peace, vandalism, trespassing, vagrancy, stealing, etc. Although prior non-violent crime was not found to be a significant predictor of recidivism in the Hanson and Bussière (1998) meta-analysis, nonetheless several sexual recidivism risk instruments contain items for non-violent, non-sexual crimes like those assessed in the MIDSA Adult Conduct Disorder scale. These actuarial items either tap this domain directly (e.g., SORAG, Risk-Matrix 2000, SVR-20) or indirectly (e.g., A-SOAP-II, Static-2002). As indicated above, sexual offenders include a substantial number of criminal generalists. Consistent with the greater generalist status of rapists as compared to child molesters, rapists in the MIDSA standardization sample had significantly more of these non-violent criminal behaviors in their histories than child molesters. Moreover, in an NIJ follow-up sample they were more likely than child molesters to recidivate with non-violent, non-victim involved crimes (Knight & Thornton, 2007). Certainly, the criminogenic needs that these crimes represent should be assessed and treated (Andrews & Bonta, 2007), because of their importance in predicting non-sexual recidivism.

Description of the Adult Conduct Disorder Scale

This scale comprises 4 scales that tap non-victim involved criminal behavior beginning at age 18 in a variety of domains including disturbing the peace, vandalism, trespassing, vagrancy, stealing, etc. A high score on this scale indicates either a high frequency of criminal activity in a single domain or criminal behavior in wide variety of criminal domains. The internal consistency of this scale was .70 for adult sexual offenders and .81 for the community sample. An example of an item in the disorderly conduct domain is –

After my 18th birthday I was charged with or convicted of:

> *Disorderly Conduct or Disturbing the Peace:* verbally or physically annoying others so that they called the police.

Generation of the Adult Conduct Disorder Scale

Rational scales were generated to assess the frequency cohesive crime clusters charged during adulthood. The following four rational scales were created and all yielded good internal consistencies--

Trespassing and B&E
Conduct disorder
Contributing to the delinquency of a minor
Property crimes

As indicated above, the factor analyses for both the adult sexual offenders and for the community controls yielded a consistent cross-sample factor on which all of these scales had high factor loadings.

Practical Considerations for the Adult Conduct Disorder Scale

High antisocial behavior and criminal versatility appears to predict sexual recidivism better in rapists than in child molesters (Kim et al., 2007; Knight & Thornton, 2007). Consequently, it may be considered a more specific risk factor for sexual recidivism in rapists and most likely in criminal generalists (Knight & Thornton, 2007). Some recidivism data suggest that the combination of antisocial behavior and sexual deviance might more accurately portend sexual recidivism than antisocial behavior alone (Harris et al., 2003; Rice & Harris, 1997). As indicated in the background section above, non-violent crimes are represented in some actuarials and reflect criminogenic needs that should be addressed in treatment.

Adult Fighting and Assaultive Behavior

Background of the Adult Fighting and Assaultive Behavior Scale

The role of violence and aggression in non-sexual domains has not been studied extensively among sexual offenders. The high correlation between the violence in sexual crimes and generic non-sexual violence (Sitnikov, Goldberg, Daversa, & Knight, 2007) suggests that it is important to address generic aggressive tendencies in the treatment of sexual offenders. Although the median of the adult sexual offenders in the standardization sample only falls at a T-Score of 54, the adult sexual offenders are significantly higher on this scale than the community sample. The adult sexual offender sample whisker plot distribution is highly positively skewed (see the graph of the Adult Fighting and Assaultive Behavior Scale). This distribution indicates that there are a substantial number of adult sexual offenders with high non-sexual assaultive behavior. Indeed, approximately 25% of the adult sexual offenders in the stantardization sample had scores on this scale that exceeded a community sample T Score of 65. The high assaultive offenders are predominantly rapists. In the standardization sample rapists reported substantially more fighting and assaultive behavior than child molesters. Approximately 50% of the rapists had scores on this factor that exceeded a 65 T Score.

In their meta-analysis Hanson and Bussière (1998) found that prior violent offenses had borderline significance for predicting sexual recidivism. Several adult actuarial tools include

non-sexual violent offenses as an item in their scales (e.g., MnSOST-II, Risk Matrix 2000, SORAG, Static-99, Static-2002, SVR-20).

Description of the Adult Fighting and Assaultive Behavior Scale

This factor scale includes 5 scales that measure carrying weapons, weapon charges/convictions, assaultive crime charges/convictions, robbery charges/convictions, and fighting and assaultive behavior. High scorers have a high incidence of fighting, violent crimes, and weapon possession. The internal consistency of this scale was .71 for adult sexual offenders and .65 for the community sample. An example of an item measuring fighting is—

After my 18th birthday:
I was involved in physical fights.

Generation of the Adult Fighting and Assaultive Behavior Scale

Five rational scales were generated to assess the frequency of aggressive behavior and conviction for assaultive crimes. All five scales had high internal consistencies. They included --

Carrying weapons
Weapon charges/convictions
Assaultive crime charges/convictions
Robbery charges/convictions
Fight and assaultive behavior

As indicated above, the factor analyses for both the adult sexual offenders and for the community controls yielded a consistent cross-sample factor on which all five of these scales loaded highly.

Practical Considerations of the Adult Fighting and Assaultive Behavior Scale

Scores on this scale correlate significantly with scores on the Constantly Angry and/or Physical Fighting pervasive anger scales for both offender and community control samples, indicating a link between the high physical aggression and impulsivity captured in this scale and difficulties with anger management. Consequently, respondents with high scores on this scale should be considered as candidates for anger management therapy.

As indicated above, several adult actuarial instruments have single items for non-sexual violent offenses (e.g., MnSOST-II, Risk Matrix 2000, SORAG, Static-2002, SVR-20). The Static-99 has two items for non-sexual convictions, one for any accompanying the index sexual crime and one for prior violent convictions. Consequently, high scores on this scale should be incorporated into estimations of risk. Given the significant correlations of this factor with both the Constantly Angry and Impulsivity MIDSA scales, one would hypothesize that this scale captures important behavioral manifestations of the Impulsive Acts and Negative Emotionality/Hostility items of the STABLE 2007 General Self-regulation stable dynamic domain (Hanson & Harris, 2007; Hanson et al., 2007). Negative emotions yielded significant

ROC curves for predicting violent recidivism, and Impulsivity predicted sexual, violent, and general recidivism (Hanson et al., 2007).

Pornography Use Scales

Background of the Pornography Scales

There is considerable consensus that the exposure of youth to pornographic materials is pervasive and frequent (Kingston, Malamuth, Fedoroff, & Marshall, 2009). Today the vast majority (92%) of young males are exposed to pornographic materials by the time they are 11 years old (Bryant, & Brown, 1989). They are also constantly bombarded by sexual images on television (American Academy of Pediatrics, 2001). There is substantial disagreement about the effects of this exposure and its role in increasing sexually coercive behavior. Whereas some researchers have concluded that pornography has reliable effects on males' sexually aggressive behavior (e.g., Felson, 1996; Linz & Malamuth, 1993; Malamuth, 1989, 1993; Russell, 1988, 1998), others have reported no relation or only weak and unstable ones (e.g., Fisher & Grenier, 1994). In a meta-analysis of 46 studies Oddone-Paolucci, Genius, and Violato (2000) determined that exposure to pornographic materials was correlated with a variety of negative outcomes, including increased sexual perpetration and endorsement of rape myths, with moderate effect sizes (average weighted d's from .40 to .65). These results were corroborated in a more recent meta-analysis (Hald, Malamuth, & Yuen, 2010). Reviews of the literature (e.g. Malamuth, Addison, & Koss, 2000; Seto, Maric, & Barbaree, 2001) seem to agree with the following conclusion of the Surgeon General's Workshop, "Pornography does have effects; it is just not yet known how widespread or powerful they really are" (p. 19, Mulvey & Haugaard, 1986).

Recent work by Malamuth and his colleagues (see Malamuth & Huppin, 2005, for a review) has attempted to integrate laboratory experimental and field correlative research strategies and to provide a useful and convincing model of the likely effects of pornography on sexually aggressive attitudes and behavior. Studies have suggested that males who are high on particular risk factors such as a high frequency of sexual and hostile fantasies (Malamuth & McIlwraith, 1988), a high attraction to impersonal sex, and aggressive/dominance motivation (Bogaert, 2001) are significantly more likely to acknowledge both greater exposure to and preference for various kinds of pornography. These data are consistent with the correlative results found for the MIDSA scales. Knight and Schatzel (2005) found that across samples of community controls, and adult and juvenile sexual offenders higher scores on both the Conventional Heterosexual Pornography and the Violent Pornography scales were consistently related to the sexualization scales measuring Hypersexuality and Sexual Preoccupation and to paraphilic behavior and fantasies. In addition, across the three samples high scores on these pornography scales consistently correlated with facets of psychopathy and with higher anger and aggression.

Not only are males with a higher proclivity to sexually coercive behavior more likely to be drawn to excessive pornography use, they are also more likely to be influenced by their exposure to such materials. After viewing a rape portrayal in which a woman showed signs of sexual arousal, males with a high self-reported proclivity to sexual aggression against women were more likely to rate women as deriving pleasure from such assaults. In contrast, males low in the likelihood of raping showed no such effect (Malamuth & Check, 1981). A more recent study (Wilson, Holm, Bishop, & Borowiak, 2002) has yielded similar findings. The putative effect of

pornography on sexual coercion has also been supported by field studies that have found that pornography predicts sexually coercive behavior, even after critical risk factors have been partialled out (Carr & VanDeusen, 2004; Malamuth et al., 2000). Indeed, among males who are high on hostility toward women and preference for impersonal sex, which are major risk factors for sexually coercive behavior, those who used pornography frequently were more likely to have engaged in sexual aggression than those high on these risk factors who did not use pornography (Vega & Malamuth, 2007). Thus, it appears that males high on factors that would put them at high risk to be sexually coercive are more drawn to pornography than males without such characteristics; and these high-risk males might have their sexually coercive proclivities disinhibited by their exposure to and use of such materials (Kingston et al., 2009).

The pattern of the reported frequency of use of pornographic materials among juvenile and adult sexual offenders, as indicated by the whisker plots for both groups in their respective scale plots, is quite consistent for Conventional Heterosexual Pornography, Child Pornography, and Homosexual Pornography. In all of these scales the medians of the juvenile and adult sexual offenders falls approximately at the mean of the community controls. In all three scales both groups have, however, a disproportionate number of individuals with scores at the higher end of the scales. For the Early Exposure scale adult sexual offenders follow this same pattern, but for the juveniles their median was significantly above the mean of the controls, indicating, consistent with prior research (Ford & Linney, 1995; Wieckowski, Hartsoe, Mayer, & Shortz, 1998) that early exposure is especially prevalent in juveniles. For Violent Pornography the juveniles have the pattern of a median comparable to the community controls and overrepresentation at the high end of the scale, whereas adults are consistently *lower* on this scale than controls.

Description of the Pornography Scales

The MIDSA includes five factor scales that describe the respondent's experiences, use of, and attitudes toward pornography. One scale, Early Exposure to Pornography, is differentiated temporally from the other four, focusing only on childhood exposure. Three scales are differentiated by person depicted in the pornographic material—children, men, and women—and one scale focuses on the amount of violence in the material—Violent Pornography. In the reporting of the scales, the respondent's score on these five scales is standardized against the community adults. If the respondent denied any exposure to a particular kind of pornography, he was not given additional questions in the domain. Consequently, the scale for that pornography scale would be missing.

Early Exposure to Pornography. This scale consists of 5 items. Respondents who scored high on this scale were exposed to sexual materials during childhood. The kinds of materials included X-rated movies, nude women, and sex acts between adults. The internal consistency for juveniles was .89 and for adults .90. An example of an item on the scale is –

> My parents, brothers, sisters, or other relatives showed me sex materials (like nude pictures or videos) or made them available (bought them for me, etc.) when I was a **child** (through age 12).

Conventional Heterosexual Pornography. The juvenile scale consists of 4 items and the adult scale consists of 10 items. Both juvenile and adult respondents who score high on this

scale reported using conventional heterosexual pornography as teenagers (13-18 years of age), and the adults continued such use into adulthood. The kinds of materials they reported using included X-rated movies and nude women, and they reported masturbating to such materials. The adult items also asked about going to strip/live sex shows. All respondents were asked to report about this use of pornography when they were not confined in a home, jail, or prison. The internal consistency for juveniles was .84 and for adults .92. An example of an item on both the juvenile and the adult scales is—

> As a **teenager** (between your 13th and 18th birthdays) how often did you look at or read sexual materials (pictures of nudes, people making love, etc.)?

Homosexual Pornography. This scale consists of 2 items for the juveniles and 3 items for adults. The items in the juvenile scale ask about the use of pornography involving nude men during their childhood and teenage years. The additional item for the adults asks about the use of such materials in adulthood. The internal consistency for the juvenile scale was .72 and for the adult scale was .83. An example of an item on both the juvenile and the adult scales is—

> The kind of sex materials I looked at as a **child** (before my 13th birthday) included:
>
> Nude men

Child Pornography. This scale consists of 4 items for juveniles and 6 items for adults. Respondents who score high on this scale reported using pornography depicting nude children or sex acts involving children. For juveniles it occurred during their childhood and teenage years. For adults this use occurred during their childhood, teenage years, and adulthood. The internal consistency for the juvenile scale was .94 and for the adult scale was .92. An example of an item on both the juvenile and the adult scales is—

> The kind of sex materials I looked at as a **child** (before my 13th birthday) included:
>
> Nude children

Violent Pornography. This scale consists of 4 items for juveniles and 6 items for adults. Respondents who score high on this scale reported using pornography depicting bondage or physical harm during sex. The internal consistency for the juvenile scale was .79 and for the adult scale was .89. An example of an item on both the juvenile and the adult scales is—

> The kind of sex materials I looked at as a **teenager** (from my 13th birthday to my 18th birthday) included:
>
> Sex acts where people were not really physically harmed, but the scenes included such acts as tying, handcuffing, spanking, or similar acts.

Generation of the Pornography Scales

The five pornography scales were generated by exploratory principal components analyses with iterations. The factor analyses of the pornography items (Knight & Schatzel, 2005) yielded an impressively consistent set of factors across the sexually coercive juveniles and adults and the community controls. Both sexually coercive samples were found to share the same

factor structure, even though the juveniles were not administered the items about adult pornography use. The Conventional Heterosexual Pornography, Violent Pornography, Early Exposure to Pornography, and Homosexual Pornography factors of the community sample also mapped nicely onto the comparable factors of the sex offender samples. For these four factors the sole difference for the community sample was that they seldom endorsed the childhood items for the Violent Pornography and Homosexual Pornography factors, and consequently they had low loadings on these two factors. For the Child Pornography factor the community sample endorsed items indicating the adult use of child pornography so infrequently that these items could not be factored. The community controls only admitted to the use of child pornography when they were adolescents.

Practical Considerations for the Pornography Scales

Pornography use is a heterogeneous construct and distinct, theoretically consistent factors have been identified that show excellent consistency across samples of adult and juvenile sex offenders and reasonable generalization to a community sample. The Homosexual, Child, and Early Exposure factor scales represent new contributions to the literature. Consequently, only the Conventional Heterosexual and the Violent Pornography scales can be related to extant research literature. Although the consequences of pornography use require further investigation, some practical suggestions can nonetheless be garnered from the extant research for the Conventional Heterosexual and the Violent Pornography scales.

1. *Constellation of related traits.* Pornography use (both conventional non-violent heterosexual and violent pornography use) has consistently been found related to sexualization scales measuring hypersexuality and sexual preoccupation and to paraphilic behavior and fantasies. It also manifests a consistent pattern of relations to facets of psychopathy, to anger and aggression, and to hostile attitudes toward women and hypermasculinity (Kingston et al., 2009). Among sexually reactive children and adolescents pornography use has been found to correlate significantly with both aggressive and sexually coercive behavior (Alexy, Burgess, & Prentky, 2009). The constellation of these risk factors has been important both in correlative models of sexually coercive behavior against age appropriate peers or women (Knight & Sims-Knight, 2003, 2004) and against children (Daversa & Knight, 2007). If a client has high scores on Conventional Heterosexual and/or Violent Pornography, his scores on sexualization, psychopathy, anger/aggression, and negative masculinity should be examined. If he scores high on most or all of these, this constellation is present and its components should be targets of intervention.

2. *Specific sensitivity to pornographic material.* As indicated in the background section above, the current integration of the data from experimental laboratory and correlative field research converge to support the hypothesis that individuals with specific, identifiable dispositions, as compared to those without these proclivities, tend to be more drawn to extensive pornography use. Moreover, these high-risk individuals appear to be more negatively affected by their use of these pornographic materials. Because individuals charged or convicted of sexual coercion by definition would likely fall in this

high-risk group, therapeutic encouragement for the discontinuance of the use of such materials would seem judicious for such individuals.

3. *Risk assessment.* Because of the widespread exposure of juvenile and adult males to sexual materials, the simple occasional use of sexual materials should not be considered a risk factor. The J-SOAP (Prentky & Righthand, 2003a), however, lists "chronic and compulsive use of pornography" as one of its indicators for the item high sexual drive and preoccupation, which loads on their Sexual Drive/Preoccupation Scale. Although Worling (2005) does not cite the use of pornography as a specific concern in the ERASOR, his item, "obsessive sexual interests/Preoccupation with sexual thoughts" could certainly be interpreted to include compulsive pornography use. In a retrospective path-analytic study of 70 Australian youth, deviant sexual experiences (prior sexual victimization, exposure to sexually coercive models, and exposure to pornographic or sexually violent materials) predicted sexual recidivism through the mediation of deviant sexual fantasies (Kenny, Keogh, & Seidler, 2001). Kingston, Fedoroff, Firestone, Curry, & Bradford, (2008) have found that in adult sex offenders the frequency of reported pornography use, regardless of content, contributed to the prediction of violent recidivism (including sexual recidivism), even after other risk factors had been controlled. Certainly, there is some consensus that excessive pornography use should be considered as a component of the larger domain of sexual preoccupation/drive, and should be included as one indicator of in assessing this risk domain.

Sexualization Scales

Background of the Sexualization Scales

Sexualization is a heterogeneous domain comprising multiple facets. Deviation can occur in the frequency or intensity of fantasies or behaviors, in the age preference of the partner or victim (e.g., pedophilia), or in the arousal target or preferential arousal behavior (e.g., the paraphilias). The three scales in this section focus on the frequency and intensity aspects of sexualization.

The notion that some aspect of sexual drive or sexual appetitive behavior is a critical component of sexual aggression (Ellis, 1993; Malamuth, 1998) and may be an underlying component of other "volitional impairments" of sexual behavior (Kafka, 1997, 2003; Kafka & Hennen, 2003) has found considerable empirical support. A number of investigations have found that sexually coercive males have consensual sex at an earlier age and have more consensual sex partners than do noncoercive males (Abbey, McAuslan, & Ross, 1998, Abbey et al., 2001; Kanin, 1985; Koss & Dinero, 1988; Malamuth, Sockloskie, Koss, & Tanaka, 1991; Malamuth, Linz, Heavey, Barnes, & Acker, 1995; Senn, Desmarais, Verberg, & Wood, 2000). Sexual drive and preoccupation have been found to discriminate sexually coercive from noncoercive males in both community and criminal samples (Knight, Ronis, Prentky, & Kafka, 2011). Regardless of criminal status sexually coercive males in this study reported higher levels of sexual drive, greater frequency of sexual behavior, and more sexual deviance on the MASA than noncoercive males. Residential juvenile sexual offenders have also been found higher on these scales than non-sexual delinquents (Zakireh et al., 2008). Moreover, sexual drive, preoccupation, and compulsivity have also been found to correlate highly with each other and in turn with pornography use, expressive aggression toward women, sadism, pervasive anger, and offense planning for adult and juvenile sexual offenders (Knight, 1999a; Knight & Cerce, 1999). In both etiological models of sexual aggression directed at women (Knight & Sims-Knight, 2003, 2004) and at children (Daversa & Knight, 2007) sexually appetitive fantasies and behaviors have played a mediating role, predicting the frequency of coercive behavior against peers, adult women, and children for both juveniles and adults. Lussier, Leclerc, Cale, & Proulx (2007) corroborated the importance of sexualization in developmental path models of both rapists and child molesters. In the former sexualization and externalization yielded the best-fit model and in the latter the addition of an internalization latent trait improved the model.

Not only has high sexualization covaried with sexually coercive behavior and played a role in the etiology of sexual aggression, but also it has been found to differentiate among rapist types. Freund proposed a circumscribed role for sexual deviance in a subset of rapists. In his courtship disorder theory of the paraphilias he hypothesized that a subset of rapists, whom he termed preferential rapists (Freund, Seeley, Marshall, & Glinfort, 1972), were characterized by sexually deviant fantasies and behaviors that were distortions of normal courtship behavior (Freund, 1988, 1990; Freund, Scher, & Hucker, 1983, 1984; Freund, Scher, Racansky, Campbell, & Heasman, 1986). For the preferential, paraphiliac rapist, rape, as opposed to consensual intercourse, was an erotic preference and not merely a surrogate. The high incidence and co-occurrence of paraphilias found among sexual offenders (Abel, Becker, Cunningham-Rathner,

Mittelman, & Rouleau, 1988; Abel & Osborn, 1992; Freund, 1988, 1990) provided support for Freund's theory.

Consistent with Freund's speculations, various taxonomic models of rapists have hypothesized that the strength and influence of sexual motivation and arousal vary as a function of rapist type (Knight, Rosenberg, & Schneider, 1985). These models hypothesized that sexual deviation and aggression interacted in complex ways to characterize various types of rapists (Knight et al., 1985). The rapist taxonomic system that has received the greatest amount of empirical scrutiny, the Massachusetts Treatment Center, Version 3 (MTC:R3) typology for rapists (Barbaree, Seto, Serin, Amos, & Preston, 1994; Knight, 1999a; Knight & Prentky, 1990; Knight, Warren, Reboussin, & Soley, 1998), posits a differential role for sexualization across types. Although the recent version of this typological model has proposed that a circumplex, dimensional restructuring of the MTC model best accounts for the data (Knight, 2010; Knight & Guay, 2006), nonetheless sexualization (as defined by sexual preoccupation, sexual compulsivity, and hypersexuality) continues to play a critical role in the model.

Appetitive sexual behaviors and fantasies appear to be at least as important in juvenile samples as in adult samples. In juveniles sexualized behavior has shown some cross-temporal stability (Friedrich et al., 2005). In a comparison of juvenile and adult sexual offenders on the MASA, juvenile offenders, juvenile offenders in residential treatment facilities were found equivalent to the adult offenders in their reported Sexual Drive and Preoccupation factors, but were significantly lower only on Sexual Compulsivity (Knight, 2004). As can be seen in the whisker plots in the MIDSA report, both juvenile and adult sexual offenders have significantly higher scale scores on all three scales than the community controls.

Despite the apparent importance of this aspect of sexualization in discriminating sexually coercive males from controls and in contributing to etiological and taxonomic models, little direct evidence of its usefulness as a risk factor exists. Most of the studies of juvenile sexual recidivism have examined other facets of sexualization such as sexual interest in children (Worling & Curwen, 2001) or paraphilias (Miner, 2002), or have defined deviance so globally that it is not clear what aspect of sexualization is being measured (Schram et al., 1991). Some define sexual deviance by behaviors that could at best be considered only inferentially related to sexualization as measured in the MIDSA. For instance, Långström (2002) defined deviant sexual interests by previous sex offending behavior, two or more sexual offenses, multiple victims, stranger victims, and offending in a public area--all clearly at best tangentially related to sexualization. In general, whereas several studies support a strong association between deviant sexual arousal or fantasies and sex offense recidivism among juvenile or child offenders (Kahn & Chambers, 1991; Kenny et al., 2001; Långström, 2002; Prentky, 2006; Schram et al., 1991; Weinrott, 1996; Worling & Curwen, 2000), other studies (Gretton et al., 2001; Kenny et al., 2001; Miner, 2002) have not supported a relation, though Gretton et al. (2001) did find that deviant plethesmographic arousal did predict sexual recidivism in combination with psychopathy. Although the inconsistency in findings could be attributed to the developing and fluctuating pattern of adolescents' sexual arousal and interests (Hunter, Goodwin, & Becker. 1994), it could also suggest that better and more specific measures of sexualization such as the scales of the MIDSA need to be explored for juveniles.

Likewise, for adults there is some suggestive evidence that some aspect of sexual behavior may be important in predicting the risk for sexual recidivism among sexual offenders (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005). Indeed, consistent with the conclusions of Hanson and Morton-Bourgon (2009), Walters, Knight, and Thornton (2011) found evidence that actuarials fashioned explicitly to predict sexual recidivism improved the prediction of sexual recidivism over a scale that predicts general criminal recidivism. Moreover, it appeared that the aspects of the scales that assess sexual behavior contributed to the increased predictive potency. Yet the measurement of sexual motivation in the most popular actuarial scales has remained global and undifferentiated. Many scales, such as the Rapid Risk Assessment for Sex Offender Recidivism (Hanson, 1997), the Risk Matrix, 2000 (Hanson & Thornton, 2000), the Static 99 (Hanson & Thornton, 1999), and the Static 2000 (Hanson & Thornton, 1999, 2000) assess sexualization only by the number of sexual offenses. The Minnesota Sex Offender Screening Tool (Epperson et al., 1998) adds consideration of various components of sexual offending behavior (e.g., multiple acts on a single victim, the use or threat of force, committed in a public place). Few actuarials have a separate item for sexual motivation. The Sexual Violence Risk-20 (Boer et al., 1997) only has one item for "sexual deviance" and the Sex Offender Risk Assessment Guide (Quinsey et al., 1998) adds deviant phallometric results. Clearly, the importance of sexual motivation in discriminating sexual from nonsexual offenders would warrant more detailed exploration of the role of such motivation in predicting recidivism in adults.

Based on factor analyses of MASA data and on the theoretical speculations of Kafka (2003), the MIDSA has three separate sexualization scales, Sexual Compulsivity, Sexual Preoccupation, and Hypersexuality. Kalichman and colleagues (Kalichman et al., 1994; Kalichman & Rompa, 2001) developed a sexual compulsivity scale that overlaps substantially in content with both the MIDSA Sexual Compulsivity and Sexual Preoccuption scales. Their scale, like the MIDSA scales, has shown both high internal consistency (Dodge et al., 2008; Kalichman et al., 1994; Parsons & Bimbi, 2007) and test-retest reliability (Kalichman & Rompa, 1995). It has also shown both concurrent validity, correlating with various indices of sexual behavior (Kalichman et al., 1994), and discriminant validity, differentiating those who seek help for hypersexuality (Reid, Carpenter, Spackman, Willes, 2008).

Description of the Sexualization Scales

The MIDSA includes two factor scales and one rational scale that describe the intensity and intrusiveness of sexual fantasies and the frequency of sexual activity.

Sexual Compulsivity. This factor scale consists of nine items. Respondents who scored high on this scale reported being slave to their sexual urges/being unable to control their sexual urges. The internal consistency for the juvenile scale was .85 and for the adult scale was .91. An example of an item is—

I have to fight sexual urges.

Sexual Preoccupation. This factor scale consists of seven items. Respondents who score high on this scale report that they think, daydream, and dream about sex frequently. The internal consistency for both the juvenile and the adult scales was .90. An example of an item is—

There have been times when I thought about sex all of the time.

Hypersexuality. This rational scale consists of five items that measure sexual drive. Respondents who score high on this scale report frequent sexual activity and/or the need to have sex frequently. The internal consistency for the juvenile scale was .69 and for the adult scale was .81. An example of an item is—

I need to masturbate or have sex every day so that I feel less tense.

Generation of the Sexualization Scales

Two of the sexualization scales, Sexual Compulsivity and Sexual Preoccupation, emerged as factors comprising the exact same items for all three samples—the juvenile and adult sexual offenders and the community controls. The third scale, Hypersexuality, which assesses excessive sexual drive or sexually appetitive behavior, was generated rationally to measure a construct proposed by Kafka (1997, 2003). As can be seen in Table 2, both the Sexual Compulsivity and Sexual Preoccupation scales had high internal consistencies for all three samples. The Hypersexuality scale yielded high internal consistency for the adult sexual offenders, but moderate consistency for both the community controls and the juvenile sexual offenders.

Practical Considerations for the Sexualization Scales

Even though the predictive potency of these three scales and the frequency and intensity of sexual fantasies and behavior have not been unequivocally established as specific risk factors, their clear role in etiology and in discriminating both adult and juvenile sexual offenders from controls, high scores on these scales warrant therapeutic attention. Several guidelines for managing risk in adolescents (e.g., Epps, 1997; Lane, 1997; Ross & Loss, 1991) have recommended the need to assess and manage sexual preoccupation and compulsivity. Some (Johnson, 2005; Rich, 2003) have suggested that fluctuating and developing nature of sexualization in youth might make it less of a treatment target in youthful offenders than in adults, but its etiological and discriminatory role suggest that failure to attend to comparatively high levels of sexualization relative to other youth would not be wise.

Intervention strategies to manage deviant sexual arousal are a common feature of juvenile sexual offender specific treatment (Fanniff & Becker, 2006; McGrath, Cumming, & Burchard, 2003; Righthand & Welch, 2001, 2004). Programs that include cognitive behavioral treatments of deviant sexual arousal, such as vicarious sensitization, satiation, and covert sensitization, seem to have success in the treatment of deviant arousal (Fanniff & Becker, 2006), but it is difficult to know the specific efficacy of these techniques, because they are embedded in comprehensive programs (Hunter & Lexier, 1998). At least one study (Aylwin, Reddon, & Burke, 2005) found that having juveniles track their fantasies as part of a covert sensitization may increase the

reported rate of sexual deviant fantasies and masturbation to these fantasies, suggesting the possibility that focus on deviant fantasies may be reinforcing. With adult sexual offenders, addressing deviant sexual arousal, when present, is one of the essential targets of an integrated approach to treatment (Marshall, Marshall, Serran, & Fernandez, 2006), and it is recommended that several behavioral procedures including aversive, covert "association," directed masturbation, and verbal satiation be employed (see Marshall et al., 2006).

In addition to cognitive behavioral interventions (Fanniff & Becker, 2006; Maletzky, 2002), pharmacological interventions might also be considered (Bradford & Fedoroff, 2006; Hunter & Lexier, 1998; Kafka, 2003; Ryback, 2005). If pharmacological treatment is deemed appropriate, ethical issues and drug treatment effects should be carefully considered (see Bradford & Fedoroff, 2006; Hunter & Lexier, 1998).

The role these sexualization scales play in discrimination and etiology, and the hints of the predictive potency of as yet unspecified aspects of sexualization, suggest that the frequency and intensity of sexual fantasy and behavior measured by these scales are prime candidates as risk factors. Not surprisingly, the ERASOR includes the item, "Obsessive sexual interests/Preoccupation with sexual thoughts," and the J-SOAP II has for Scale I, "Sexual Drive/Preoccupation," the item, "Sexual Drive and Preoccupation." Both of these items correspond closely to the sexualization that is measured by the MIDSA scales. The Juvenile Sexual Offense Recidivism Risk Assessment Tool-II (JSORRAT-II; Epperson, Ralston, Fowers, & Dewitt, 2005) like its adult counterpart, the MnSOST-II, only assesses sexualization indirectly through several components of sexual offending behavior.

The measurement of sexual motivation in the most popular static actuarial scales for adults has remained primitive. As indicated in the Background section above most actuarials and structured risk guidelines only measure sexualization indirectly (e.g., the Mn-SOST-II, the RRASOR, the Risk Matrix, the Static 99 and 2000, and the SVR-20). The SORAG (Quinsey et al., 1998) includes deviant phallometric results, but this measure is best at identifying child molesters and not at assessing high sexualization. Global measures of "Sexual Drive and Preoccupation" have been introduced in both the A-SOAP-II (Prentky & Righthand, 2003b) and in a new experimental measure, the Structured Risk Assessment (SRA) Needs Assessment (Knight & Thornton, 2007; Thornton, 2002), but these simply assess basically the presence and absence of the constructs without differentiated assessment of severity.

Scales designed to measure dynamic rather than static risk (e.g., STABLE-2007 and ACUTE-2007; Hanson et al., 2007) have attempted to improve the assessment of sexualization. The STABLE-2007 has items for sexual drive and pre-occupations and for use of sex as a coping device, whereas the ACUTE has an item for sexual preoccupation. Both simply use a three-point metric —no problem (0) to significant problem (2). The data from research on the MASA and MIDSA (Knight et al., 2011; this manual) suggest that both static and dynamic risk assessments may profit both from a broadening of their sexualization constructs and a more differentiated assessment of the levels of the components of sexual behavior and fantasy.

Masculine Adequacy and Sexual Inadequacy Scales

Background of the Masculine Adequacy and Sexual Inadequacy Scales

Social competence is multifactored, comprising several components including general social skills, heterosexual and sexual skills and anxieties, capacity for intimacy, and motivation to seek friendships. Although social competence deficits have frequently been attributed to sexual offenders in general (Abel, Blanchard, & Becker, 1978; Prentky & Knight, 1991; Marshall, 1971), in adults these deficits have only been consistently found in offenders who sexually abuse children (Cortoni & Marshall, 2001; Emmers-Sommer et al., 2004; Segal & Marshall, 1985; Stermac, Segal, & Gillis, 1990). Marshall, Barbaree, and Fernandez (1995) found that child molesters, as compared to rapists reported higher social anxiety, underassertiveness, and low self-esteem. Consistent with these data both extrafamilial child molesters and incest offenders in the MIDSA standardization sample scored significantly lower than rapists on the Masculine Adequacy scale, and significantly higher on the Anxiety with Women, Sexual Performance Anxiety, and Erectile Dysfunction scales. Extrafamilial child molesters differed significantly from incest offenders only in masculine adequacy, scoring significantly lower than the incest offenders as well as the rapists on this scale. Extrafamilial child molesters who were high and low on fixation on children (i.e., offenders with high low sexual focus on children) did not differ on these scales, and the high socially competent extrafamilial child molesters (i.e., those with adult relationships and employment achievement) differed from low socially competent child molesters only on reporting significantly *higher* levels of erectile dysfunction. Men who have sexually assaulted women have been found to be 3.5 times more likely than those who have not assaulted women to report erectile dysfunction (Laumann, Paik, & Rosen, 1999).

Juveniles who have committed sexual offenses have shown increased levels of social anxiety and fear of heterosexual interactions (Katz, 1990), social avoidance (Napolitano, 1996), and fewer appropriate peer relationships (Bagley & Shewchuk-Dann, 1991; Milloy, 1994). Consistent with the adult data those juveniles who commit sexual offenses against children have been found more likely to be characterized as isolated and/or low in social competence (Awad & Saunders, 1991; Hunter et al., 2003). Consistent with data that have suggested a link between felt inadequacies and anxieties in heterosexual social situations and the propensity to develop deviant sexual fantasies about younger aged children (Katz, 1990), the MIDSA scales that measure perceived heterosexual inadequacies have proven to be important in models predicting a juvenile's preference for younger victims (Daversa, 2005; Daversa & Knight, 2007; Miner, Swinburne Romine, & Berg, 2006).

There is also some evidence that not attaining adequate social relationships contributes to recidivism for both adults and adolescents (Hanson & Bussière, 1998; Långström & Grann, 2000).

Description of the Masculine Adequacy and Sexual Inadequacy Scales

The MIDSA includes four factor scales that describe issues of masculine adequacy, heterosexual anxiety, and feelings of sexual inadequacy. Three of the scales are scored in the direction of inadequacy (Anxiety with women, Sexual Performance Anxiety, and Erectile Dysfunction). Masculine Adequacy is scored so that high scores mean higher perceived masculine adequacy. Note that these are standardized against community adults.

Masculine Adequacy. This scale consists of five items. Respondents who scored high on this scale report that they are manly, good in fights, and in sex. The internal consistency for juveniles was .73 and for adults .75. An example of an item on the scale is –

I think I am really manly.

Anxiety with Women. This scale consists of five items. Respondents who score high on this scale report feeling anxious, nervous, inadequate, and guilty around women and sex. The internal consistency for juveniles was .74 and for adults .80. An example of an item on the scale is –

I feel nervous around females.

Sexual Performance Anxiety. This scale consists of three items that measure anxiety about their penis and their sexual performance. The internal consistency for juveniles was .70 and for adults .76. An example of an item on the scale is –

I worry that there is something wrong with my penis.

Erectile Dysfunction. This scale consists of three items. Respondents who score high on this scale report difficulties with erection and ejaculation. The internal consistency for juveniles was .62 and for adults .80. An example of an item on the scale is –

I have had problems getting a hard-on during sex.

Generation of the Masculine Adequacy and Sexual Inadequacy Scales

These four factors were derived from a principal components analysis with iterations of items dealing with masculine and sexual adequacy. The adult offenders and the community sample yielded the same four factors, with the same items loading on each factor. For the juveniles the Masculine Adequacy and Erectile Dysfunction factors replicated the comparable adult factors. For the juveniles, however, the Anxiety with Women and Sexual Performance factors were more highly correlated, and to create independent scales that matched those of the adults, several items had to be deleted. The four resulting scales were comparable across samples.

Practical Considerations for the Masculine Adequacy and Sexual Inadequacy Scales

It is clear that youths who sexually offend present with a variety of social skills and deficits (Worling, 2001). Deficits in masculine and heterosexual adequacy may be found in youths who are emotionally reserved and overcontrolled or in youths who are socially awkward and isolated (Worling, 2001). These two types of youths may require different interventions. Whereas the former may profit more from an intervention that helps them express their emotions and thoughts appropriately, the latter may need a larger range of social skills interventions that include making substantial social skills training. Both these groups may profit from instruction in basic dating skills, especially in proper processing of information in a sexual situation.

Several social skills treatment programs are available commercially (Worling, 2004a). The Skillstreaming the Adolescent (Goldstein & McGinnins, 1997) and Adolescent Social Skills Effectiveness Training Programs (ASSET; Hazel, Schumaker, Sherman, & Sheldon, 1996) are among the programs described by Worling (2004a). Although there is some empirical support for these programs, none have been specifically validated with juveniles who have offended sexually.

There is evidence (e.g., Daversa & Knight, 2007) that the combination of low Masculine Adequacy, high Sexual Performance Anxiety, and high Anxiety with Women is more characteristic of youths with a preference for children rather than age appropriate victims. This combination of deficits should alert the clinician to other cues of child sexual fixation. As discussed in the Background section, deficiencies indicated on these scales are significantly more characteristic of child molesters and tend to be most pronounced in extrafamilial child molesters. Certainly, deviant scores on any of these scales should be addressed in an integrated therapy (e.g., Marshall et al., 2006).

The relation of the particular inadequacies measured by these scales to recidivism has not been directly studied. The ERASOR has one related psychosocial functioning item, lack of intimate peer relationships/social isolation and in the J-SOAP's dynamic risk intervention items include the quality of peer relationships, ranging from socially active to withdrawn or only involved with delinquent peers. It is preferable to assess these variables from the social history and the respondent's report of his social relationships rather than from the inadequacy scores. Nonetheless, the inadequacy scales should be helpful in any social competence training initiated.

In adults particular social and sexual anxieties and inadequacies have not played a role in the major actuarials. Being single was the only social variable to predict recidivism in Hanson and Bussière's (1998) meta-analysis. Living with an intimate partner (Static-99); single never married (Risk Matrix 2000), and relationship problems (SVR-20) are related constructs; and Scale IV (Community Stability) of the A-SOAP-II has a "social supports" item that indirectly evaluates relationships. These achieved social relationship levels can be assessed better from the MIDSA social history, which addresses these issues directly. For therapeutic intervention, however, the sexual and social inadequacy scales provide information about potential roadblocks to developing appropriate relationships.

Paraphilia Scales

Background of the Paraphilia Scales

Paraphilias are behaviors, fantasies, and urges that reflect deviant or atypical expressions of sexual gratification. To be classified as a paraphilic disorder according to the DSM-IV-TR the behavior or fantasy must have three characteristics. First, the specific mode of sexual gratification must clearly be deviant. Second, a recurrent pattern of intense arousal in response to this deviant mode of gratification must be evident. Third, the behavior must persist for at least 6 months and lead to either personal distress or serious social impairment. Paraphilias are to be distinguished from what Kafka and Hennen (1999; 2002) have called paraphilic related disorders. The latter are disinhibited heterosexual and homosexual behaviors that cause significant personal distress or social impairment, but they are socially sanctioned (e.g., compulsive masturbation, pornography dependence). By focusing on unique, highly distinctive sexually arousing stimuli or modes of expression, numerous paraphilias can be distinguished (Money, 1986). The MIDSA focuses on five of the most common paraphilias. The modes of gratification for these five paraphilias are considered deviant, but the MIDSA scales simply measure the overall reported frequency of the paraphilic behavior or fantasy, not the duration, physical distress, or social impairment that it causes. Thus, the scales cannot yield a paraphilic disorder diagnosis, but they do identify sexual proclivities that require clinical attention.

The high prevalence of paraphilias that has been found among sexual offenders (Abel et al., 1988; Abel & Osborn, 1992; Abel & Rouleau, 1990; Freund, 1988, 1990) has given rise to the hypothesis that these behaviors and fantasies play an important role in sexual aggression. The whisker plots for the MIDSA paraphilia scales corroborate the high prevalence of several paraphilias in both juvenile and adult sexual offenders. For juveniles the medians of the Voyeurism and Exhibitionism scales are significantly above the mean of the community controls. Although the juveniles' Transvestism and Scatologia scale medians are at the mean of the controls, the positive skew of their distributions, manifested in the extreme T Scores of the 75th percentile and the 90th percentile, indicate that there are a substantial number of juveniles with a very high frequency of these paraphilic behaviors and fantasies. Only the distribution of the Fetishism scale approaches that of the controls. The distributions of the Voyeurism and Transvestism scales for the adult sexual offenders parallels the comparable distributions of the juveniles. Unlike the juveniles, however, the adults' Exhibitionism scale follows the pattern of a median equivalent to the mean of the controls and a high positive skew. Both the Scatologia and Fetishism scales for the adult offenders have distributions that approximate that of the controls. Thus, there is evidence for high frequency of paraphilias in four out of five scales for the juveniles and three out of five scales for the adults.

In light of these data it is not surprising that the paraphilias and the high sexualization with which they correlate (Kafka, 1997; Knight, 1999a), have been afforded an important role in some theories of sexually aggressive behavior against women. Freund proposed in his courtship disorder theory that some forms of rape were distortions in normal courtship behavior (Freund, 1988, 1990; Freund et al., 1983, 1984, 1986). Here, aberrant sexual arousal was hypothesized to be a key motivational component at least for a subset of rapists, called preferential types (Freund

et al., 1972). The preferential rapist was defined as a person for whom rape, as opposed to consensual intercourse, was an erotic preference and not merely a surrogate. The preferential rapist was hypothesized to be a paraphiliac, like the voyeur, the exhibitionist, and the frotteurist. All of these paraphilias were hypothesized to represent distortions of the phases of normal courtship.

Although pedophilia is a diagnosable paraphilia (APA, 2000), the other paraphilias have not been salient in theories of child molestation. This is ironic, because the presence of these other paraphilias has been found to predict recidivism among child molesters (Prentky, Knight, & Lee, 1997; Knight & Thornton, 2007), but to have little predictive potency among rapists (Knight & Thornton, 2007). Among juveniles those offenders who engaged in non-contact sexual offences have been found more likely to sexually reoffend (Hunter & Figueredo, 1999). Such non-contact offenses are likely to be indirectly identifying paraphilic tendencies like exhibitionism, and might suggest an important predictive role for paraphilias among juveniles.

Description of the Paraphilia Scales

Voyeurism. This scale consists of five items. Respondents who scored high on this scale both engage in voyeurism and report having strong urges to do so. They also report masturbating while watching someone. The internal consistency for juveniles was .81 and for adults .87. An example of an item on the scale is –

I think about secretly watching people having sex.

Exhibitionism. This scale consists of five items. Respondents who score high on this scale report exposing themselves and report having strong urges to do so. They also may report reaching climax while exhibiting themselves. The internal consistency for juveniles was .81 and for adults .87. An example of an item on the scale is –

I have had sexual thoughts about exposing myself.

Transvestism. This scale consists of three items. Respondents who score high on this scale report becoming aroused by wearing women's clothes. The internal consistency for juveniles was .86 and for adults .89. An example of an item on the scale is –

When I have had sexual thoughts, I have thought about dressing as a woman.

Scatologia. This scale consists of two items. Respondents who score high on this scale report making obscene phone calls. The internal consistency for juveniles was .80 and for adults .85. An example of an item on the scale is –

I have made obscene or "dirty" phone calls (not including 900 numbers).

Fetishism. This scale consists of three items. Respondents who score high on this scale report becoming aroused by nonsexual parts of women's bodies, such as feet or hair and being aroused by a woman's smell or feel. The internal consistency for juveniles was .63 and for adults .65. An example of an item on the scale is –

I have gotten sexually excited while thinking about women’s shoes or feet.

Generation of the Paraphilia Scales

The MIDSA includes five paraphilia factor scales that describe the respondent's paraphilic fantasies and behaviors. These were generated by exploratory principal components analyses. The factor analyses of the paraphilia items yielded an impressively consistent set of factors across the sexually coercive juveniles and adults and the community controls. Except for the Fetishism scale, which only achieved internal consistencies among the sexual offenders in the .60s, the paraphilic factor scales had internal consistencies for the juvenile and adult sexual offenders that exceeded .80. All internal consistencies for the community controls exceeded .70, except for the Scatalogia scale, which was .64.

Practical Considerations for the Paraphilia Scales

The paraphilias do play a minor role in risk instruments for both juveniles and adults. The J-SOAP-II (Prentky & Righthand, 2003a), lists "paraphilias (exposing, peeping, cross-dressing, fetishes, etc.)" as one of the indicators for high sexual drive and preoccupation, which is an item on their Sexual Drive/Preoccupation Scale. Although Worling (2005) does not cite paraphilias as a specific concern in the ERASOR, his item, "deviant sexual interests" could certainly be interpreted to include paraphilias, though he does not specifically include these. For adults the A-SOAP-II has a parallel Sexual Drive/Preoccupation item to the J-SOAP-II. The Static 99 and 2002 and the Risk Matrix, 2000 only consider paraphilias in the context of criminal behavior. On the Static 99 and 2002 a paraphilia is often involved in a "non-contact" sexual crime, but this would only be counted in the scale, if there were a conviction. In the Risk Matrix 2000 non-contact behavior would be counted if it were an element of a sentencing for a sexual crime. The SVR-20 allocates an item to sexual deviance, which includes paraphilias that cause distress or social dysfunction, including sexual offending. In the SRA evidence of paraphilic behavior can count as one path to a high rating on the Sexual Preoccupation scale.

These risk instruments do not distinguish between rapists and child molesters in their assessment of paraphilias. The MTC adult recidivism data (Knight & Thornton, 2007) showed a clear relation to recidivism for child molesters, but not for rapists. This suggests that for both juveniles and adults the presence of paraphilic behaviors and fantasies may only be a significant risk factor for those who are fixated on children. The rapist/child molester distinction is often difficult to determine for juveniles because some of them choose younger victims opportunistically because of easy availability or simply from curiosity or naiveté (O'Brien & Bera, 1986), rather than from preference. The difficulty of this distinction is reflected in the DSM-IV-TR's exclusion of youths who are less than 16 from the diagnosis of pedophilia (APA, 2000).

Certainly, it is critical to identify the constellation of characteristics that includes high frequency of paraphilic behaviors and fantasies and high sexualization, and the paraphilias that are identified as frequent should be targets of treatment in interventions that are aimed at reducing problems in hypersexualization (Kafka, 1997). The interventions for the paraphilias should parallel those discussed in the practical considerations section for the Sexualization scales.

Sexual Sadism Scales

Background of the Sexual Sadism Scales

The salience and magnitude of the violence oftentimes associated with sadistic offenses has captured significant clinical attention. Sadism boasts a long and illustrious clinical history, starting in the 15th century (Marshall & Kennedy, 2003). Almost every classification system proposed for rapists and child molesters has included a category for the sadistic offender (Knight et al., 1985). The apparently widespread conviction that an empirically valid, theoretically cohesive set of behaviors can be specified that define a sexually sadistic type of offender has led to the inclusion of a diagnostic category for a sadistic paraphilia in both the DSM−IV−TR (American Psychiatric Association, 2000) and ICS−IV (World Health Organization, 1992). Despite the substantial attention in the clinical literature on sadism, empirical support for the construct has remained thin and controversial (Marshall & Kennedy, 2003). Attempts to operationalize the criteria for sadism have inevitably encountered difficulties in attaining adequate levels of interrater reliability (Knight, 1989; Knight & Prentky, 1990; Marshall, Kennedy, & Yates, 2002; Marshall & Hucker, 2006).

The vast array of criteria generated to define sadism has provided little basis for cross-study comparisons and generalization (Marshall & Kennedy, 2003). A wide variety of violent behaviors has been proposed to identify the sadistic offender, including, for example, a pattern of extreme, gratuitous violence in the offense that often focuses on erogenous areas of the body and is sometimes characterized as bizarre or ritualized; humiliation or degradation of the victim; torture or mutilation of the victim; acts in the offense manifesting domination and control over the victim (Knight & Prentky, 1990; Marshall & Hucker, 2006; Prentky & Knight, 1991). It is, however, considered central to the definition of sadism that the sadist derive pleasure either from the physical or emotional suffering that he inflicts on another or from his control of or domination over others. The core feature in the various proposed definitions of sadism has been a fusion of sexual arousal and a variety of aggressive and cruel behaviors (Knight & Prentky, 1990; Marshall & Kennedy, 2003). In most of the extant research archival records, often lacking information about the offender's cognitions, fantasies, and feelings, have been the source for making the diagnosis of sadism. Consequently, lacking appropriate information clinicians have drawn inferences about the motivation, arousal, and pleasure of the offender in the offense (Knight et al., 1994). Inferring sexual arousal to injury or distress even from detailed descriptions of offense behavior is a formidable task (Prentky & Knight, 1991). It was the absence of such introspective information that motivated the initial version of the MASA, which asked questions about sadistic fantasies, about the synergy between sex and aggression, about violence during sex, and about dominance and bondage.

The sadism data that were gathered using the MASA indicated that sadistic fantasies were more widespread among aggressive offenders than we had initially thought from prior archival research (Knight et al, 1994). Individuals high on the sadism scales were found to be high on expressive aggressive fantasies and behaviors in general, more likely to manifest other paraphilias, more sexually preoccupied and hypersexual, more likely to engage in extensive pornography use, and more likely to plan their offenses (Knight, 1999a; Knight & Cerce, 1999).

In community samples sadistic, aggressive fantasies have been found to mediate the relation of sexual fantasy and sexual coercive behavior against women (Knight & Sims-Knight, 2003), and in sexually aggressive samples it has been found that sadistic fantasies mediate the relation between sexual fantasy and the frequency of sexual aggressive behavior against women (Knight & Sims-Knight, 2004).

Although we have found in our self-report studies both more sadistic fantasies and behaviors than was anticipated from our archival investigations, the incidence of sadism remains comparatively low, as indicated in the standardization samples for the MIDSA. Among the community sample, 58% reported never having sadistic fantasies, and 46% reported never engaging in any sadistic behavior. Only 6% and 9% of the community sample, respectively for fantasies and behaviors, reported an average frequency of once or greater per item on each scale. Among the juvenile sex offender sample, 48% reported never having sadistic fantasies, and 42% reported never engaging in any sadistic behavior. Only 13% and 16%, respectively for fantasies and behaviors, reported an average frequency of once or greater per item on each scale. Among the adult sexual offender sample, 45% reported never having sadistic fantasies, and 37% reported never engaging in any sadistic behavior. Only 13% and 17% of adult offenders, respectively for fantasies and behaviors, reported an average frequency of once or greater per item on each scale. These data are consistent with the whisker plots presented in the scale plots for adults and juveniles. For the adult sexual offenders their medians for both fantasies and behaviors are approximately at the median of the community sample, whereas the medians for the juveniles are slightly below the median of the community. Both adult and juvenile offender distributions are somewhat positively skewed, indicating in both distributions a small subsample with extreme scores.

Description of the Sexual Sadism Scales

The MIDSA includes two scales, one focusing on sadistic fantasies and the other on sadistic behaviors. Note that these are standardized against community adults.

Fantasy. This scale consists of seven items. Respondents who scored high on this scale report becoming aroused by thoughts of scaring, hurting, humiliating, or killing women during sex. The internal consistency for juveniles was .80 and for adults .85. An example of an item on the scale is –

When I had sexual thoughts, I thought about threatening or frightening a woman or girl.

Behaviors. This scale consists of eight items. Respondents who score high on this scale report having scared, hurt, or humiliated women during sex. The internal consistency for juveniles was .76 and for adults .84. An example of an item on the scale is –

I have beaten a woman or girl while I was having sex with her.

Generation of the Sexual Sadism Scales

In the initial factor analysis of the sadism items, three factors emerged that were highly correlated, Bondage, Synergy/Sex and Aggression, and Sadistic Fantasy. In the analyses with larger samples, confirmatory factor analyses indicated that a single factor best accounted for the variance and was consistent across the adult and juvenile sexual offender and the community controls. Because we determined that clinicians would like to know whether the respondent admitted only fantasizing or actually engaging in sadistic behavior, we divided the single factor into two rational subscales—sadistic fantasy and sadistic behavior. It is important to realize, however, that the correlations between the two scales are substantial, ranging from .68 for the juvenile offenders to .79 for the adult offenders and .80 for the community controls.

Practical Considerations for the Sexual Sadism Scales

The problem of duplicity, a difficulty we discussed in the section on the lie scales, is especially pronounced in reporting sadistic behavior and fantasies (Fedora et al., 1992; Grubin, 1994; Hollin, 1997). Consequently, it is likely that some offenders engaging in sadistic acts or having sadistic fantasies will deny them, and the maxim that absence of evidence is not evidence of absence should be especially attended to in interpreting sadism scores. The high correlation between sadistic fantasies and behavior in this domain suggests that if the respondent only admits to sadistic fantasy, the likelihood of accompanying behavior is high. The co-occurrence of high sexuality, accompanying paraphilias, the high use of pornographic materials (including violent pornography), and high offense planning indicate a complex of issues that should be addressed therapeutically for individuals high on sadism. Because of the nature of the distributions and the likelihood that even those admitting low levels of sadistic fantasies and behavior may be mitigating their actual involvement, it is suggested that the therapist explore this issue even with respondents who produce T Scores in the high 50s and low 60s.

For juveniles Threats of, or use of, violence/weapons during sexual offense is rated by Worling and Långström (2006?) as a possible predictor of recidivism. Yet, it is nonetheless included as an item on the ERASOR. Such an item would is not isomorphic with sadism, but would be certainly be related to sadism. The J-SOAP-II includes Sexualized Aggression in the sexual preoccupation scale, a more direct measure of sadism. The J-SORRAT-II does not have a comparable item.

In the NIJ study (Knight & Thornton, 2007) sadism was only found predictive of sexual recidivism for the rapists. Force or injury to the victim, which is only indirectly related to sadism, was only significant as a predictor or recidivism in Hanson and Bussiere's (1998) meta-analysis when an outlying study was included. It is important to note that sadism is only one of multiple variables that contribute to the amount of damage done to the victim in a sexual offense (Knight, Robertson, & Neumann, 2011; Sitnikov, Goldberg, Daversa, & Knight, 2007), and such measures cannot adequately substitute for sadism.

Expressive Aggression Scales

Background of the Expressive Aggression Scales

Speculations about the role of expressive aggressive fantasies and behavior in sexually coercive behavior against women emerged in the early clinical literature about rapist typologies (Knight et al., 1985). Parallel systems proposed by Nick Groth (Groth & Birnbaum, 1979; Groth & Burgess, 1977) and Murray Cohen (Cohen, Seghorn, & Calmas, 1969; Cohen, Garafalo, Boucher, & Seghorn, 1971) posited a type of rapist (the Anger-retaliation type for Groth and the Displaced Anger type for Cohen) whose sexual assault was frequently accompanied by unnecessary violence, and whose offense hypothetically served to vent rage against women. Individuals in this group were hypothesized to display a great deal of anger and contempt for women generally and to be physically abusive in their characteristically conflictual relationships with women. Their offenses have been hypothesized to be attempts to seek vicarious revenge for mistreatment they perceive they have experienced from significant women in their lives. Although the attempt to differentiate a type of highly aggressive rapist identified solely by the exclusivity of his aggression against women has not been completely successful (Knight, 1999a; Knight & Guay, 2006), the construct of expressive aggression against women has continued to play an important role both in the differentiation of sexual offenders and in the etiological models of rape.

Expressive aggression (and most consistently expressive aggressive fantasies) has been found in several studies to be significantly higher in sexual offenders than in other groups. In the MIDSA standardization samples adult sexual offenders reported more frequent expressive aggressive fantasies and behaviors than the community sample. In contrast, whereas juvenile sexual offenders reported more frequent expressively aggressive fantasies than the community sample, they did not differ from the community controls in the frequency of their expressively aggressive behaviors. In a study comparing both residential and outpatient juvenile sexual offenders to comparable groups of non-sexual delinquents (Zakireh et al., 2008), residential juvenile sexual offenders were found to report significantly more expressively aggressive fantasies than the other three groups (outpatient juvenile sexual offenders and both outpatient and residential delinquents). Schatzel and Fletcher (2004) found that residential juvenile sexual offenders reported significantly higher levels of both expressively aggressive fantasies and behaviors than did outpatient juvenile sexual offenders. The outpatient juveniles in this study did not differ from community controls.

In contrast to etiological models mapping the developmental antecedents of sexual coercion against children (Daversa & Knight, 2007), in the models for the etiology of sexually coercive behavior against women and age-appropriate females expressively aggressive fantasies have played a pivotal role, mediating the relation between sexual fantasy and drive and sexually coercive behavior for adult and juvenile sexual offenders and community samples (Knight & Sims-Knight, 2003, 2004).

Description of the Expressive Aggression Scales

The MIDSA includes two factor scales that describe how hostile respondents are toward women in nonsexual situations. Expressive Aggression scales are scored so that high scores mean higher expressively aggressive fantasies or behaviors. Note that these scores are standardized against community adults.

Expressive Aggression Fantasy. This scale consists of five items. Respondents who scored high on this scale report having felt angry toward women and had thoughts of hurting or frightening them in nonsexual situations. The internal consistency for juveniles was .63 and for adults .80. An example of an item on the scale is –

When a female rejects me, I get angry.

Expressive Aggression Behavior. This scale consists of four items. Respondents who score high on this scale report they have beaten or harmed women in nonsexual situations. The internal consistency for juveniles was .60 and for adults .80. An example of an item on the scale is –

I have roughed up a woman or girl so that she would know that I meant business.

Generation of the Expressive Aggression Scales

In contrast with the sadism scales, where fantasies and behaviors were so highly correlated that they did not generate separate factors, the expressive aggression items naturally cohered into separate fantasy and behavior factors. These expressive aggression factors were derived from principal component analyses with iteration and varimax rotation of a larger set of items about aggressive fantasies about women, anger toward females, and aggressive behaviors toward women. In our initial factor analyses of the adult sexual offenders, in which we did not restrict the number of factors, three factors emerged—expressively aggressive behaviors, anger at females, and thoughts of aggressive acts against females. For the juveniles and the community controls, however, the anger and aggressive fantasy factors were not differentiated. Because forcing a two factor solution for the adult sexual offenders melded the anger and fantasy factors and allowed comparability of scales across the three samples, we settled on the two factor solution that is represented in the MIDSA.

Practical Considerations for the Expressive Aggression Scales

Among sexual offenders the correlations between Expressive Aggression Fantasies and both Sadistic Fantasies and Sadistic Behaviors are high, ranging from the *lowest*, .51 between Expressive Fantasies and Sadistic Behavior for juveniles, to the *highest*, .67 between Expressive Aggression Fantasies and Sadistic Fantasies for adult offenders. The correlations for Expressive Aggression Behavior and sadism range from .40 to .57. Because the mean admitted frequency of Expressive Aggression Fantasies is significantly higher for both adult and juvenile sexual offenders than that for sadism, high scores on this scale and low scales on sadism might indicate that an offender is responding defensively about his sadistic fantasies and behavior. This should

be explored in therapy. Certainly, indication of high scores on Expressive Aggression (T Scores ≥ 65) would indicate that the respondent's misogynistic hostility should be addressed in therapy. Targeting this anger would be even more critical in rapists or in juveniles whose victims are age-appropriate, where there is a closer relation to sexually coercive behavior. High scores on expressive aggression might also suggest that the complex of related dimensions cited in the discussion of sadism might profitably be addressed. It is not surprising that Expressive Aggression Fantasies correlates highly with Hostility toward Women ($r(526) = .604$, $p < .001$). The latter constitutes an item on the STABLE-2007 and has been found to predict sexual and violent recidivism (Hanson et al., 2007).

Psychopathy-Related and Hypermasculinity Scales

Overall Background

Psychopathy is a personality disorder whose origins can be traced to Cleckley's (1976) classic description of the syndrome. It comprises a distinct cluster of emotional, interpersonal, and behavioral characteristics (e.g., emotional detachment, callousness, irresponsibility, impulsivity) and is characterized by a disregard for the societal rules and the rights of others (Hare, 1996). Its association with violence (Porter & Woodworth, 2006) and its usefulness as a risk factor in predicting criminal recidivism (Douglas, Vincent, & Edens, 2006) have increased its prominence in the last decade in both criminology and psychopathology.

The evidence that psychopathy plays a significant role in sexual aggression, especially against women, has continued to accumulate (Knight & Guay, 2006). Psychopathy is overrepresented in samples of rapists (Brown & Forth, 1997; Prentky & Knight, 1991; Serin, Mailloux, & Malcolm, 2001). Its components (the affective-interpersonal and the impulsive-antisocial factors) have been found important in models predicting rape in community samples (Knight & Sims-Knight, 2003; Kosson, Kelly, & White, 1997) and predicting the frequency of sexual aggression against age appropriate females in both juvenile and adult sexual offender samples (Knight & Sims-Knight, 2004). Although its role among child molesters is less clear, it nonetheless plays a role in etiological models for child molestation (Daversa & Knight, 2007). In the typologies for sexual offenders that have been empirically validated, the construct of psychopathy has come to play a significant role either as an explicit discriminator among types (e.g., Knight & Guay, 2006) or as a covariate of type defining criteria (Knight, 1992). Moreover, psychopathy has emerged as a predictor of both general and violent (including sexual) recidivism among sexual offenders (Hanson, & Bussière, 1998; Knight & Thornton, 2007; Rice, Harris, & Quinsey, 1990; Serin, 1996; Serin & Amos, 1995; Seto & Barbaree, 1999).

The first formalized assessment tool for measuring psychopathy was Hare's (1980) operationalization of the construct in the Psychopathy Checklist (PCL) and its revision, the PCL-R (Hare, 1991, 2003). This checklist, based on a chart review and interview, has received sufficient validation that it is now perceived to be the gold standard for assessing psychopathy (Hare & Neumann, 2006). Although there has been some controversy about the defensibility of attempting to use self-report to assess psychopathy, a syndrome characterized both by the ability to lie without anxiety and guilt, and with impunity (Ekman, 1985) and by the psychopath's purported lack of insight (Cleckley, 1976), nonetheless a number of questionnaires have attempted the feat with varying success (cf. Lilienfeld & Fowler, 2006, for a review).

The MIDSA scales that assess specific components of psychopathy were not originally created with the intention of providing an overall assessment of psychopathy or of diagnosing an individual as psychopathic. They were created to measure behavioral and cognitive components of certain aspects of psychopathy. They emerged from our attempts to generate MASA scales to make sense of proposed typological differences in MTCR3, our rapist typology, and to link this typology to extant etiological models of rape (cf. Knight & Guay, 2006, for a summary of this

process). The initial scales were created in the early 90's before many of the current inventories were available.

Although controversies continue about the nature and number of the distinct facets of psychopathy (Cooke & Michie, 2001; Cooke, Michie, & Hart, 2006; Hare, 2003; Hare & Neumann, 2006), recent models converge on the existence of two overarching major components involving affective-interpersonal and impulsivity-antisocial behavior features. In the four factor solution (Hare & Neumann, 2006) the first overarching factor was found to yield two subfactors or facets, the Interpersonal and the Affective facets. The second overarching factor similarly divided into two facets, the Impulsivity and Antisocial Behavior facets. Because the two overarching components correlate with characteristics that are relevant to psychopathy, distinct models of specific underlying processes have been proposed for each (e.g., Bloningen, Hicks, Krueger, Patrick, & Iacono, 2005; Fowles & Dindo, 2006; Patrick & Zempolich, 1998). In our rapist typological work the importance of the Impulsivity-Antisocial factor was obvious in our earliest work (Knight et al., 1985). Awareness of the role of the Affective-Interpersonal features factor emerged from our attempts to integrate early etiological models (e.g., Malamuth, 1986; Malamuth et al., 1991) with our rapist typology (cf. Knight & Guay, 2006). The significant covariation between constructs like hostility toward women and negative (or hyper) masculinity with measures of the Affective-Interpersonal component lead to our current integrated model (Knight & Guay, 2006). In this manual therefore we present these related constructs of hostility toward women and negative masculinity along with scales directly assessing components of psychopathy. For each scale we will provide some brief summary background information.

Psychopathy-Related and Hypermasculinity Scales: Overall Generation

The MIDSA includes six scales that assess various components of psychopathy and negative masculinity, which are correlated domains related to increased probability of sexually coercive behavior against women and age-appropriate females. The scales were generated from a principal components analysis on 529 adult sexual offenders of all of the psychopathy-related items in Versions 3, 4, 5, and 6 of the MASA. Because a large number of psychopathy items had been introduced in Version 4 and the community sample had been administered only Version 3 of the MASA, the smaller common subset of items was selected for the current MIDSA scales so that community standardization could be calculated. This lack of community control data meant that two factors measuring grandiosity and risk taking had to be dropped from this version of the MIDSA. The factor analysis was replicated using the subset of items common to all four versions of the MASA. With the deletion of only a small number of items a six-factor solution was replicated on both the juveniles and community controls. The six scales derived from the highest loading variables on these factors are presented below. The comparability of factor analytic solutions across juvenile and adult samples is consistent with recent studies that have found similar factor structures for the PCL-R in adults and the Psychopathy Checklist-Youth Version (PCL-YV) in adolescents (Kosson, Cyterski, Steuerwald, Neumann, & Walker-Matthews, 2002; Neumann, Kosson, Forth, & Hare, 2006; Salekin, Brannen, Zalot, Leistico, & Neumann, 2006). It is also fits well with studies reporting high stability of psychopathic features both from age 10 to 14 (Frick, Kimonis, Dandreaux, & Farell, 2003) and 17 to 24 (Blonigen, Hicks, Krueger, Patrick, & Iacono, 2006).

Emotional Detachment Scales

Background of the Emotional Detachment Scales

Within the study of the emotional characteristics associated with sexual aggression, the notion of empathy has attracted considerable attention from sexual aggression researchers. Many theorists have argued that sexual offenders are deficient in empathy (e.g., Marshall & Barbaree, 1990; Williams & Finkelhor, 1990). For instance, Barbaree, Marshall, and Lanthier (1979) suggested that rapists could become sexually aroused during an assault because their arousal is not averted by recognition of or compassion for the victim's distress. It has consequently been consistently recommended that an important aim of treatment for sexual offenders is to increase empathic skills (Pithers, 1994), and the majority of programs attempt to train sexual offenders to develop empathy for the victims of sexual abuse. It is therefore reasonable to include an assessment of general empathic abilities in the evaluation of sexual offenders. Moreover, affective deficiencies also play a prominent role in psychopathy, which plays a prominent role in rape (Knight & Guay, 2006; Lalumière, Harris, Quinsey, & Rice, 2005). Cleckley's (1976) classic diagnostic criteria for psychopathy included absence of nervousness, lack of remorse or shame, egocentricity, incapacity for love, and a general poverty in major affective reactions, which can be best described as generalized emotional detachment or emotional deficit. Emotional deficits have been documented experimentally in psychopaths, especially in those high on the affective-interpersonal features factor (e.g., Levenston, Patrick, Bradley, & Lang, 2000; Patrick, 1994).

Some researchers, however, have been unable to find differences in empathy deficits between sexual offenders and non-offender controls. For instance, in a review of the recent literature measuring empathy deficits in sexual offenders, Marshall, Hudson, Jones, and Fernandez (1995) found that many studies using questionnaires to assess levels of empathy failed to differentiate sexual offenders from controls. They suggested that sexual offenders might have neither a global deficiency in empathy nor a failure in empathy for the class of potential victims (i.e., women and children), but rather their empathy deficiencies may focus primarily on their own victims. In subsequent studies Fernandez, Marshall, Lightbody, and O'Sullivan (1999) confirmed that sexual offenders were, indeed, most particularly deficient in empathy toward their own victim(s), although they also displayed less empathy than do others toward sexual abuse victims of other offenders.

In addition to problems differentiating sexual offenders from controls (McGrath et al., 1998), it is not clear how critical to predicting outcome empathy skills are. In their review Worling and Långström (2006) included empathy on their list of characteristics unlikely to be related to recidivism. Although the role of empathy in sexual aggression continues to be debated (Fernandez, 2002; Hanson, 2003), its theoretical relevance to abusive behavior to others, and its well-established role in psychopathy continue to warrant its assessment. In the MIDSA both the emotional component of empathy, modeled on existing scales (Davis, 1983; Mehrabian & Epstein, 1972), and a scale assessing perspective taking emerged from our factor analyses. These two scales were correlated, $r(327) = .376$; $r(526) = .393$, $p < .001$, respectively for juveniles and adults. Despite their correlation, the two scales have functioned quite distinctly in our research. As is evident in scale plots for both the adults and juveniles, whereas the community sample

scored significantly higher than both offender groups on lack of empathy (i.e., they reported *less* empathy), they rated themselves as significantly lower in lack of perspective taking (i.e., they more frequently took or attempted to take another person's perspective on an issue). In a study comparing residential and outpatient juveniles who offended sexually to both incarcerated and outpatient non-sexual delinquents (Zakireh et al. 2008), the residential sexual offenders showed poorer perspective taking than all other groups, but the differences missed significance for the comparisons with non-sexual delinquents. In a second study (Schatzel & Fletcher, 2004) the poorer perspective taking of residential juvenile sexual offenders as compared to outpatient sexual offenders was replicated. In the MIDSA standardization samples both juvenile and adult sexual offenders were poorer than community controls in perspective taking. Both scales correlate significantly, but only moderately, with chart review ratings for adult sexual offenders of the PCL-R affectivity-interpersonal Factor 1, $r(313) = .162$, $p < .005$ and $r(313) = .290$, $p < .001$, respectively for Lack of Perspective Taking and Lack of Empathy.

Roche, Shoss, Pincus, and Ménard (2011) recently demonstrated an interaction between empathy treatment effects and psychopathy among incarcerated sex offenders in a treatment program (approximately 75% child victims). Specifically, those who measured low on psychopathy exhibited higher empathy with longer treatment time, whereas those who measured high on psychopathy did not get better. Although this is only one study and did not measure actual change, it suggests that therapists might have greater success at treatment designed to improve empathy with clients who are not psychopathic.

Description of the Emotional Detachment Scales

Lack of Empathy. This scale consists of eight items. Respondents who scored high on this scale report they lack feelings of concern for the misfortunes of others. The internal consistency for juveniles was .75 and for adults .75. An example of an item on the scale is –

When I see someone being treated unfairly, I feel sorry for them.

Lack of Perspective Taking. This scale consists of six items. Respondents who score high on this scale report difficulty seeing another's perspective and considering both sides of an issue. The internal consistency for juveniles was .70 and for adults .78. An example of an item on the scale is –

I find it difficult to see things from the "other guy's" point of view.

Practical Considerations for the Emotional Detachment Scales

The self-report of empathic feelings has caused problems in other inventories (e.g., the Coldheartedness scale in the Psychopathic Personality Inventory – Dindo, 2007; Malterer, Neumann, & Newman, 2007). Although juvenile sexual offender have been found to score higher on Lack of Empathy than adult sexual offenders (Knight, 2004), both groups report more empathy than community controls. Moreover, there are no differences on this scale between residential and outpatient juveniles who had sexually offended (Schatzel & Fletcher, 2004; Zakireh et al., 2008). The scale should, therefore, be interpreted with caution, and it remains in the inventory because it is a potentially important construct that we will continue researching. In both youth and adults the presence of empathy has been associated with prosocial behaviors and its absence with aggressive behaviors (Cohen & Strayer, 1996; Flight & Forth, 2007; Sitnikov et al., 2007; Zahn-Waxler, Cole, Welsh, & Fox, 1995). The Affective facet of the PCL-R is an important predictor of both sexual and violent recidivism in rapists (Kim et al., 2007). Capturing this predictive variance in a self-report format has, however, remained elusive.

In contrast, the Lack of Perspective Taking is an effective scale, providing critical information that should be addressed in therapy. As indicated in the background section residential juvenile sexual offenders have poorer perspective taking than their outpatient counterparts, and both juvenile and adult sexual offenders are poorer than community controls. The scale correlates with items measuring the ability to consider the consequences of one's actions, suggesting that it may be tapping a more general ability to break set and consider multiple vantages.

Conning and Superficial Charm Scale

Background of the Conning and Superficial Charm Scale

As we indicated in our introduction to the psychopathy scales, Hare (2003; Hare & Neumann, 2006) has provided evidence that a four-factor solution best accounts for the variance in the PCL-R. The factors, called facets, are hierarchically organized with the Interpersonal and the Affective facets embedded in the overarching Affective/Interpersonal Features higher order factor, and the Impulsive and Antisocial Behavior facets embedded in the Impulsivity/Antisocial Behavior higher order factor. The PCL-R Interpersonal facet includes the items glib/superficial charm, pathological lying, conning/manipulation, and a grandiose sense of self-worth. The Conning and Superficial Charm Scale, which comprises items assessing conning others, taking advantage of others, manipulating others by lying, and charming others into doing what one wants is the best MIDSA scale for measuring this Interpersonal facet. The high correlation between the Conning and Superficial Charm Scale and the PCL-R Interpersonal facet in a sample of adult sexual offenders, r (313) = .590, $p < .001$, but lack of correlation between this scale and the Affective facet, r (313) = .096, *ns,* indicates its specificity to the Interpersonal facet of the Affective/Interpersonal Features Higher order factor.

Until recently most of the research on the correlates of the PCL-R has been done on the two overarching factors, which were the first components of the PCL-R assessment of

psychopathy that were identified (Harpur, Hakstian, & Hare, 1988; Harpur, Hare, & Hakstian, 1989). The Affective/Interpersonal Features factor, which has been described as assessing an emotionally detached, selfish, callous, and remorseless use of others, has been associated with low negative affectivity, low distress and fear, and high positive activity (Patrick, 1994; Patrick & Zempolich, 1998). The unique variance in Affective-Interpersonal features has been found to correlate negatively with measures of trait anxiety (Patrick, 1994; Verona, Patrick, & Joiner, 2001) and positively both with measures of social dominance (Hare, 1991; Harpur et al., 1989; Verona et al., 2001), and sometimes with measures of achievement (Verona et al., 2001). Hall, Benning, and Patrick (2004) recently reported that these relations are primarily due to correlations with the Interpersonal facet of the Affective-Interpersonal features. The Interpersonal facet's positive correlations with extraversion, social potency, and the agentic scale of the Multidimensional Personality Questionnaire (MPQ), as well as its negative relations with emotionality-distress and fearfulness, neuroticism, stress reaction, and negative emotionality have led some to propose that it represents a surgent personality style (Patrick, Hicks, Nichol, & Krueger, 2007).

There is evidence that the presence among youth of callous-unemotional (CU) traits, which is Frick's (1998) term for the Affective-Interpersonal features of psychopathy, identifies a subgroup of antisocial youth who are deficient in conscience development (Frick, O'Brien, Wootton, & McBurnett, 1994; Frick, Bodin, & Barry, 2000). These youth have been found to manifest more severe aggressive behavior in mental health, forensic, and community samples (Frick & Marsee, 2006). CU traits appear to contribute most to proactive aggression (Kimonis et al., 2006). When CU traits are accompanied by conduct disorder, these youths have been found to show characteristics that parallel those found in adult psychopaths (Barry et al., 2000; Blair, 1999; Frick, Lilienfeld, Ellis, Loney, & Silverthorn, 1999; Loney, Frick, Clements, Ellis, & Kerlin, 2003). Moreover, there is also evidence that in children with CU characteristics there is a stronger genetic contribution to the development of antisocial behavior than in those children without these characteristics (Viding, 2004; Viding, Blair, Moffitt, & Plomin, 2004).

Although studies on self-report measures of psychopathy have shown reasonably good convergence for Factor 2, Impulsivity/Antisocial Behaviors, they have yielded weaker convergence for Factor 1, Affective/Interpersonal Features (Derefinko & Lynam, 2006; Egan & Falkenbach, 2007; Lilienfeld & Fowler, 2006). Indeed, there is some controversy about whether the PCL-R conceptualization of Factor 1 is the most appropriate (Lynam & Widiger, 2007; Rogers, 1995), and differences in the assessment and interpretation of the PCL-R Factor 1 have emerged. Because the MIDSA is a self-report inventory, the differences in self-report measures from archival/interview PCL-R assessment are important for interpretation of the Conning and Superficial Charm Scale. Divergent from the PCL-R studies is the covariation found in self-report studies between charm/manipulation and impulsivity scales in both juveniles (Egan & Falkenbach, 2006) and adults (Benning, Patrick, Hicks, Blonigen, & Krueger, 2003; Dindo, 2007). This divergent covariation parallels the results of MIDSA studies, where in all three standardization samples the correlations between the Conning and Superficial Charm and Impulsivity scales have been consistently high and significant, r (325) = .659, r (527) = .518, and r (166) = .587, all $ps < .001$, respectively for the juvenile offenders, adult offenders, and community controls. A resent study by Patrick et al. (2007) provides a possible explanation for these divergent results. They isolated the unique variance on the PCL-R Interpersonal facet,

parsing out the variance for a general Externalizing factor. Glibness/superficial charm and grandiosity loaded primarily on this secondary Interpersonal factor with secondary, lesser loadings on the Externalizing factor, whereas pathological lying and conning/manipulative still loaded somewhat higher on the general Externalizing factor. These results suggest that the Conning and Superficial Charm scale may tap two correlated processes. It is likely that the glibness/charm subcomponent of the MIDSA Conning and Superficial Charm scale is more related to social potency and surgent personality style of the Interpersonal facet, whereas the lying/manipulative subcomponent of the Conning and Superficial Charm scale is more related to the thoughtless disregard aspects of the Interpersonal facet (Dindo, 2007). In light of these results in the Practical Considerations below we provide an interpretative strategy for the Conning and Superficial Charm scale.

In the MIDSA standardization samples both adult and juvenile sexual offenders scored significantly higher than controls, but adult sexual offenders had more extreme scores. In fact, adult sexual offenders have been found to score significantly above juvenile sexual offenders (Knight, 2004) on this scale. Schatzel and Fletcher (2004) found that residential juvenile sexual offenders scored higher on this scale than outpatient juvenile sexual offenders, but this difference did not reach significance in Zakireh et al. (2008). Indeed, in Zakireh et al. (2008) there were no significant differences among sexual and non-sexual delinquents on these characteristics, indicating the shared role of this scale in both sexual aggression and delinquency. In the etiological models for sexual aggression against age-appropriate victims and women (Knight & Sims-Knight, 2003, 2004) and in the model predicting child victim preference (Daversa & Knight, 2007), the Conning and Superficial Charm scale has loaded on important latent traits in the models. Whereas in the age-appropriate/women model it loaded on the PCL-R Factor 1 latent trait analogue, in the child preference model it loaded on a psychopathy latent trait analogue.

Description of the Conning and Superficial Charm Scale

Conning and Superficial Charm. This scale consists of six items. Respondents who scored high on this scale admit to conning others, taking advantage of others, manipulating others by lying, and charming others into doing what one wants. The internal consistency for juveniles was .74 and for adults .79. An example of an item on the scale is –

I have conned someone to get what I wanted.

Practical Considerations for the Conning and Superficial Charm Scale

Although a number of the items on Scale 3, the Intervention scale, of the J-SOAP-II and the A-SOAP-II (Prentky & Righthand, 2003a, 2003b) tap the affective characteristics of the Affectivity and Interpersonal features factor, none of the items on either instrument specifically assess the Interpersonal facet. Although the VRAG and the SORAG (Quinsey et al., 1998) have the total PCL-R score as one of their risk items, no specific attention is paid on these risk instruments to this interpersonal subcomponent. It is likely that most of the variance of the total score is accounted for by the overall Externalizing factor of the PCL-R (Patrick et al., 2007), which is likely also to account for most of the general criminal predictive potency (Kennealy et al., 2007; Walters, Knight, Grann, & Dahle, 2008). Consequently, the Interpersonal facet in general and Conning and Superficial Charm in particular have not been identified as specific risk factors for subsequent sexual aggression. Nonetheless, as we have indicated in the Background section earlier, this scale does play a significant role in the etiology of sexually aggressive behavior, and it contributes to aggressive behavior.

The recent research attempting to identify the underlying processes of psychopathy suggests a strategy for interpreting the scores of juveniles and adults on this scale. A high score (T Score $\geq$ 65) should be interpreted within the context of scores on the Impulsivity and Juvenile Delinquency scales. If the Conning and Superficial Charm scale is high and both other scales are moderate to low (T Score $\leq$ 55) the extraversion, social potency, and agentic characteristics identified by Patrick et al. (2007) are more likely to be dominant in the respondent, and because of the correlates of low stress reactivity, higher intelligence, and achievement orientation, one might want to explore in therapy the potential protective aspects of these characteristics and help the respondent to avoid the abusive potential of his social potency. If both Conning and Superficial Charm and Impulsivity scales are high (T Scores $\geq$ 65), the respondent is more likely to be characterized by thoughtless disregard (Dindo, 2007), and it becomes important in therapy to show the client that such disregard will not only hurt others, but will ultimately have negative consequences for him. If all three scales are high, it becomes more likely that the respondent is manifesting more overt signs of psychopathy and more intense and extensive therapeutic interventions are required (Frick, 2001; Lösel, 1998, 2002; Skeem, Monahan, & Mulvey, 2002).

Impulsivity Scale

Background of the Impulsivity Scale

Although the construct of "impulsivity" has had a confusing history and has been applied to a wide set of maladaptive behaviors (e.g., Webster & Jackson, 1997; Whiteside & Lynam, 2001), the aspect that has been the focus of psychopathy measures and is most related to sexual aggression can be more narrowly defined. Parker and Bagby (1997) have divided impulsivity into three broad dimensions—(a) acting without thinking, distractibility, quick decision-making, impatience, (b) a tendency to be disorganized, and (c) "happy-go-lucky" attitudes and behaviors. Clearly the first dimension maps best onto the construct that has been related to theorizing about the core of the PCL-R Factor 2, impulsivity-antisocial features. This dimension also overlaps substantially with the characteristics of the externalizing spectrum, an apparently unitary genetic factor (Kendler, Prescott, Myers, & Neale, 2003; Krueger, 2006; Krueger et al., 2002; Young, Stallings, Corley, Krauter, & Hewitt, 2000).

In studies examining the predictive validity of the PCL-R in adult sexual offenders, when the two factors have been examined separately, it has been the Factor 2, Impulsivity-Antisocial Behavior scores that have been found to predict sexual recidivism, but not the Factor 1, Affective-Interpersonal Features (Knight & Thornton, 2007; Langton, 2003; Serin et al., 2001). Other measures of impulsivity have also been shown to predict sexual recidivism (Knight & Thornton, 2007; Prentky, Knight, Lee, & Cerce, 1995). In Hanson and Morton-Bourgon's (2005) meta-analysis, which involved primarily adult sexual offenders, deficits in self-regulation predicted sexual recidivism. Research with juveniles has found that PCL scores predicted general or violent, but not sexual recidivism (Gretton et al., 2001; Långström & Grann, 2000). Among juveniles other related measures of impulsivity have been somewhat more successful at predicting sexual recidivism. Epperson et al., (2005) found that youths with diagnoses of impulse control disorder had increased rates of sexual recidivism. Scale 2 of the Juvenile Sex Offender Assessment Protocol-II (the J-SOAP-II: Prentky & Righthand, 2003a), the Impulsivity/Antisocial scale, has been found to be associated with sexual as well as nonsexual recidivism in some studies (Parks, 2004; Prentky, 2006) and to only overall recidivism in another study (Waite et al., 2005).

The items in the MIDSA Impulsivity scale ask about the respondent's losing both behavioral and emotional control, and doing things both that the respondent did not intend to do and that got him into trouble. Therefore it attempts to capture self-regulation and impulse control problems. Its correlates indicate that it achieves this goal. In adults the scale correlates with chart ratings of the PCL-R Factor 2, $r(313) = .346$, $p < .001$ and with the two facets of this overarching factor, $r(313) = .346$ and $r(313) = .210$, $ps < .001$, respectively for the Impulsivity and Antisocial Behavior facets. As can be seen in the whisker plots presented in the Impulsivity scale diagrams, the medians for both juvenile and adult sexual offenders are more than a standard deviation above the mean for the community controls indicating that impulsivity is a significant problem in both groups. In essence the median for both offender groups was higher than 87% of the scores for the community controls. Juvenile sexual offenders in residential facilities scored significantly higher on this scale than outpatient juveniles who had been sexually coercive, but they did not

differ from generic residential or outpatient delinquents who had no evidence of sexually coercive behavior (Zakireh et al., 2008).

Description of the Impulsivity Scale

Impulsivity. This scale consists of seven items. Respondents who score high on this scale report acting on impulse, losing control, and moodiness. The internal consistency for juveniles was .80 and for adults .79. An example of an item on the scale is –

I have acted impulsively or without thinking.

Practical Considerations for the Impulsivity Scale

As we have indicated above impulsivity in its many guises has been found to be an important predictor of recidivism among juveniles and adults. Not surprisingly in the risk assessment protocols for juveniles it constitutes a significant focus of the J-SOAP II (Prentky & Righthand, 2003a). In the ERASOR (Worling, 2004b) the item "poor self-regulation of affect and behavior" directly captures the MIDSA impulsivity scale, and the item "antisocial interpersonal orientation" would certainly be related. For adults three extant actuarials include items assessing psychopathy--the Sexual Violence Risk-20 (SVR-20; Boer et al., 1997), the Violence Risk Assessment Guide (VRAG; Quinsey et al., 1998), and the Sex Offender Risk Appraisal Guide (SORAG; Quinsey et al., 1998). The last two actually include the PCL-R as a criterion. Also, the Adult Sex Offender Assessment Protocol (A-SOAP-II; Prentky & Righthand, 2003b) includes impulsive lifestyle in its Impulsive, Antisocial Behavior Scale, and the Structured Risk Assessment (SRA; Thornton, 2002) evaluates the domains of dysfunctional coping and self-management, both of which involve behavioral and emotional regulation. Finally, impulsive acts is an item on the General Self-regulation scale of the STABLE-2007 that predicts sexual, violent, and general recidivism (Hanson et al., 2007). Consequently, consistent with both the risk and criminogenic needs principles (Andrews & Bonta, 2007), impulsivity should be an important treatment target for adolescents and adults high on the MIDSA Impulsivity scale (T score $\geq$ 65).

Self-regulation and impulse control problems are associated with a wide range of problems including learning difficulties, problematic parent-child relationships, peer rejection, risk-taking behaviors, aggression, anger, attention deficits, and delinquency (Borum, 1996; Hinshaw, 2006; Kendall & Braswell, 1993; Lipsey & Derzon, 1998). When planning interventions to enhance self-regulation, one should consider the level of impulsivity as measured by the MIDSA scale in the context of other MIDSA constructs with which the Impulsivity scale is correlated. In the MIDSA Impulsivity covaries substantially with Constant Anger, $r(325) = .764$, $r(526) = .780$, and $r(166) = .830$, $p < .001$, respectively for juvenile offenders, adult offenders, and the community males. It also correlates with the Attention Deficit scale, $r(189) = .271$, $r(278) = .386$, $p < .001$, respectively for juvenile and adult offenders; with the Inhibition Deficiency scale, $r(189) = .353$, $r(278) = .398$, $p < .001$, respectively for juvenile and adult offenders; and with the Oppositional Behavior scale, $r(189) = .478$, $r(278) = .484$, $p < .001$, respectively for juvenile and adult offenders. The successful treatments of impulsivity for both adolescents and adults, like the MIDSA scale that measures it, focus on a cluster of problems including ADHD, aggression, anger, psychopathy, and conduct disorder. The treatment

plan should address the cognitive, emotional, and behavior components that contribute to disregulation and individualize the intervention the components that are most dysfunctional in the client.

In his review of effective treatments for adolescent conduct disorder, a diagnosis that typically embodies significant impulsivity, Kazdin (2002) argues that parent management training, multisystemic therapy, cognitive problem solving skills training, functional family therapy, and brief strategic family therapy have strong efficacy evidence. Recently, Caldwell, Skeem, Salekin, & Van Rybroek (2006) found that adolescents with psychopathic features responded positively (lowered recidivism) to an intensive, lengthy cognitive-behavioral treatment program. In his discussion of the essential components of the treatment of impulse control problems in sexually abusive juveniles Worling (2004) recommended self-instructional strategies that divide problem situations into more manageable steps and therapist modeling in teaching problem-solving skills (Kendall & Braswell, 1993) and behavioral interventions such as self-monitoring and evaluation (Ervin, Bankert, & DuPaul, 1996). If treatment gains are to be generalized, it is essential that the adolescent's significant caregivers be involved in the treatment (Worling, 2004). Ford and St. Juste (2006) have developed a curriculum for children and adolescents who have experienced trauma that focuses both on helping them to identify their alarm reactions and on teaching them behavioral and emotional regulation coping skills (Trauma Affect Regulation: Guide for Education and Therapy – Adolescent version or TARGET-A). Lochman, Wells, and Murray (2007) have developed a school-based program (Coping Power Program) involving both child and parent group sessions. It has been effective in reducing impulsive and aggressive behavior and improving school functioning (Lochman, Powell, Whidby, & Fitzgerald, 2006). In conjunction with cognitive-behavior strategies, and especially when impulsivity is severe, psychopharmacological treatment may be considered (Barkley, 1998).

The treatment of impulsivity among adults has been enmeshed in the debates about the advisability of any interventions for psychopaths. Although the issue of the efficacy of treating psychopaths has generated significant controversy, with some naysayers remaining adamant (e.g., Harris & Rice, 2006), and arguing that management is the only viable solution (Gacano, 2000), mounting evidence belies this conclusion. Not only are the extant unsuccessful studies plagued with methodological limitations (see Lösel, 1998; Skeem et al., 2002; Wong, 2000), but some recent reviews (Lösel, 1998, 2002; Salekin, 2002) provide hope that psychopathic individuals can improve with treatment. Moreover, a recent study suggests that sufficient doses of treatment are critical for interventions with psychopaths. Skeem et al. (2002) found that psychopathic patients were as likely as non-psychopathic patients to benefit from adequate doses of treatment. Lösel (1998) has argued that structured behavioral, cognitive-behavioral, skill-oriented, and multimodal interventions based on social learning theories have superior effects on antisocial behavior than other modes of treatment. He concluded that successful programs should include modules that improve self-control, self-critical thinking, social perspective taking, victim awareness, anger management, interpersonal problem-solving, social skills, vocational competencies, non-criminal attitudes, and experiences of contingent reinforcement.

Negative Masculinity and Hostility to Women Scales

Background of the Negative Masculinity and Hostility to Women Scales

In studying the correlates of rape in non-criminal samples Koss and Dinero (1988) found that temporally proximal attitudes (e.g., Sexual Conservatism and Rape Myths) accounted for the variance of sexually coercive behavior and that more distal traits, like psychopathy (the MMPI Scale 4), did not apparently contribute additional explanatory power over proximal causes. The slightly higher predictive validity and apparently greater explanatory potential of these more proximal scales led researchers studying rape in non-criminal samples to focus their predictive models on these proximal attitudes (Malamuth, 1986, 2003) and to speculate that different models might be appropriate for community and criminal samples. Using structural equation modeling, Malamuth et al. (1991) developed and tested on a large sample of college men a two-factor confluence model of sexually coercive behavior. They predicted that hostile childhood experiences affected involvement in delinquency and led to sexual aggression through the confluence of two paths: negative or hostile masculinity, in which individuals held "macho" attitudes (e.g., risk taking, power seeking, overly competitive behavior, callous attitudes toward women, and grandiosity); and sexual promiscuity, supported by attitudes emphasizing sexuality and sexual conquest. Malamuth's model exhibited an excellent fit with the college student data and was replicated longitudinally in a sample of men followed for 10 years (Malamuth et al., 1995). Both negative masculinity and hostility toward women are important proximal constructs in understanding rape.

In our attempts to improve the predictive potency of Malamuth's model and create a unified model that worked for both criminal and non-criminal samples, we added a third path—Antisocial/Impulsivity/Aggression to his model. We also modified and broadened Malamuth's negative masculinity path. Because the scales measuring negative masculinity and hostility toward women correlated substantially with the MASA scales developed to index the interpersonal facet of the PCL (for adult and juvenile offenders and for community controls, the correlations ranged from .208 to .381, all $ps < .001$), we incorporated these two scales into the broader construct of the affective-interpersonal features of psychopathy (see Knight & Guay, 2006 for a summary) and used this factor to define our second path. Not only has this three-path model worked using two samples of adult sexual offenders (Knight & Sims-Knight, 1999) but it has also been successful in predicting rape in college students, generic non-sex offending criminals (Knight & Sims-Knight, 1999), juvenile sexual offenders (Knight & Sims-Knight, 2004), and blue-collar community controls (Knight & Sims-Knight, 2003). In the last two studies a comparison was made between the three-path model and Malamuth's two-path confluence model, and the three-path model was found to yield superior fit indices.

The hostility toward women and negative masculinity constructs have garnered support as covariates of rape proclivity from multiple sources. In a meta-analysis examining 11 different measures of masculine ideology across 39 studies, Murnen, Wright, and Kaluzny (2002) found that all but one measure of masculine ideology were significantly associated with sexual aggression. The strongest support for predictive potency, however, emerged for two scales, Malamuth et al.'s (1991) hostile masculinity and Mosher and Sirkin's (1984) hypermasculinity, both of which assess hostile beliefs about women, the desire to be in control, and an acceptance

of violence against women. Measures of simple gender adherence, which did not include the hostility and acceptance of aggression components, were not, however, strong predictors of sexually coercive behavior. In a recent cross-cultural, 38-site study Hines (2007) examined the roles of adversarial sexual beliefs, the status of women in society, and prior sexual victimization as risk factors for sexually coercive behavior against both women and men. She found consistent cross-cultural and cross-gender effects of both adversarial beliefs and sexual abuse in increasing the probability of sexually coercive behavior. Little support was found for the feminist theory that the status of women in society covaried with sexual violence against women. Thus, adversarial attitudes about relationships has cross-gender, cross-cultural, cross-sample (criminal and non-criminal), and cross-study support as a risk factor. The negative aspects of masculinity have garnered cross-study and cross-sample validation.

Negative Masculinity and Hostility Toward Women have not, however, proven important in models predicting sexual aggression against children (Daversa & Knight, 2007). Consistent with the hypothesis that these two scales are more important in rape. Rapists in the standardization sample scored significantly higher than community controls on both ($F\ (1, 464) = 5.02$, $p = .007$ and $F\ (1, 508) = 9.23$, $p < .001$; Newman-Keuls, $p < .05$, respectively for Hostility toward Women and Negative Masculinity), but they scored significant higher than child molesters only for Negative Masculinity ($F\ (1, 508) = 9.23$, $p < .001$; Newman-Keuls, $p < .05$).

Description of Negative Masculinity and Hostility to Women Scales

Negative Masculinity/Toughness. This scale consists of five items. Respondents who score high on this scale endorse attitudes of toughness and masculine honor defending. The internal consistency for juveniles was .62 and for adults .67. An example of an item on the scale is –

My friends think of me as being tough.

Hostility Toward Women. This scale consists of eight items. Respondents who score high on this scale report negative attitudes toward women and endorse cognitive distortions about rape. The internal consistency for juveniles was .81 and for adults .88. An example of an item on the scale is –

Females who get raped probably deserved it.

Practical Considerations for the Negative Masculinity and Hostility to Women Scales

Both of these scales could be categorized as cognitive distortions supportive of sexual aggression against women. Thus, they would qualify for the ERASOR item, "attitudes supportive of sexual offending" (Worling, 2004b). They do not, however, match up well with the description of the Cognitive Distortions item in the Intervention Scale of the J-SOAP-II or A-SOAP-II (Prentky & Righthand, 2003a, 2003b). For other adult static risk instruments only the SVR–20 (Boer et al., 1997) has an item, "attitudes that support or condone sex offenses." The presence of these items on risk instruments with some predictive validity (Knight & Thornton, 2007; Worling, & Långström, 2006) supports their role as potential criminogenic needs. More

recently, Hostility toward Women has been included as a separate item on the STABLE-2007 (Hanson & Harris, 2007), and preliminary results indicate that it predicts sexual, violent, and general recidivism (Hanson et al., 2007). Such cognitions are hypothesized to be implicit, unconscious beliefs, developed early in life, that increase the probability of sexually offending and subsequently support offense behavior (Ward, 2000; Ward & Keenan, 1999). Consequently, these attitudes should be challenged in cognitive behavioral interventions. Examining a related set of cognitive distortions, criminal thinking styles as captured by the Psychological Inventory of Criminal Thinking Styles, Walters (2006a) has been able to demonstrate that offenders' criminal thinking responds favorably to cognitively oriented intervention (Walters, Trgovac, Rychlec, Di Fazio, & Olson, 2002). More importantly, there is evidence that cognitive changes from these interventions improve skills and reduce recidivism in juveniles and young adult offenders (Antonowicz & Ross, 2005), and also have a positive impact on adult recidivism (Walters, 2005). Certainly, evidence for high scores on these two cognitive distortions in individuals, most particularly rapists, should justify that these criminogenic cognitions be grist for the therapeutic mill.

Pervasive Anger Scales

Background of the Pervasive Anger Scales

The assessment of anger has a long history in the clinical literature on sexual aggression. Nick Groth (Groth & Birnbaum, 1979; Groth & Burgess, 1977) labeled two of his rapist types, the Anger-retaliation and the Anger-excitation types, for their apparent and supposedly differentially extreme expressions of anger, and Cohen (Cohen et al., 1969; Cohen et al., 1971) posited a Displaced Anger type. Early cluster analytic studies of sexual offenders yielded Pervasively Angry and Vindictive clusters of offenders (Rosenberg & Knight, 1988) that eventually became part of a more empirically based typological solution (Knight, 1999a, 2010; Knight & Prentky, 1990).

Although anger as measured in the studies reviewed by Hanson and Bussière (1998) did not appear to pack much predictive clout, a more differentiated assessment of pervasive anger has proven a strong predictor of recidivism (Knight, 1999a; Knight & Thornton, 2007). Although pervasive anger does not apparently predict recidivism among child molesters (Knight & Thornton, 2007), it is a potent predictor among rapists (Knight, 1999a), and it adds predictive variance not accounted for in extant actuarials (Knight & Thornton, 2007). Hanson and Morton-Bourgon's (2005) meta-analysis, which primarily included adult samples, did find that problems with emotional regulation of mood states, of which anger is a part, were associated with sexual recidivism. Studies of adolescents using retrospective self-report have also suggested that negative emotions such as anger, frustration, sadness, and boredom may serve as immediate precursors to sex offending (Worling, & Långström, 2003).

High pervasive anger is prevalent in residential juvenile sexual offenders. As one can see from the whisker plots in the presentations of the scales, the medians of the residential juveniles on three of the four pervasive anger scales (cruelty to animals the exception) are substantially above the mean of the community controls. Even cruelty to animals is highly positively skewed, indicating that there is a contingent of juvenile sexual offenders with very high cruelty scores. On all four pervasive anger scales residential juvenile sexual offenders have been found to score significantly higher than outpatient juvenile sexual offenders (Schatzel & Fletcher, 2004; Zakireh et al., 2008). Also, on all of the scales except Constantly Angry they have been found to score significantly higher than both residential and outpatient non-sexual offending delinquents (Zakireh et al., 2008). In the MIDSA standardization samples both the median and the mean of the Constantly Angry scale of the adult sexual offenders were substantially above the mean of the community sample, and the other three scales, although not as extreme, nonetheless were positively skewed, indicating the presence of a contingent of adult sexual offenders with very high scores on each of the other scales. When we compared the residential juvenile and the adult sexual offenders, the juveniles were found to score significantly higher than the adults on three of the four scales, Constantly Angry being the sole scale on which they scored equally high. Outpatient juvenile sexual offenders do not differ from the adult community controls on any of the pervasive anger scales (Schatzel & Fletcher, 2004). These results indicate that anger is a significant problem for residential and adult sexual offenders, but it is most problematic in residential juvenile offenders.

Not only is pervasive anger a potentially important construct in recidivism, it is also related to the amount of damage done to victims in sexual crimes. In a recent study Sitnikov et al., (2007) rated 315 adult sexual offenders on the PCL-R and the DSM-IV-TR criteria for borderline personality (BPD; APA, 2000). In their factor analysis of the BPD criteria, an emotional dysregulation factor emerged as the first factor, comprising affective instability, inappropriate, intense anger, and impulsivity. This factor along with the PCL-R affectivity and antisocial behavior facets predicted the amount of damage done to a victim in a sexual crime for both child molesters and rapists. Each component contributed independent, significant variance to the prediction. Thus, emotional dysregulation, of which pervasive anger is a significant component, is implicated both in the behavior in sexual crimes and in recidivism.

Description of Pervasive Anger Scales

The MIDSA includes four Pervasive Anger scales that assess anger, fighting, aggression toward animals, and nonsexual aggressive fantasies.

Constantly Angry. This scale consists of eight items that assess instances of anger and failure to control one's temper. Respondents who score high on this scale report grouchiness, frequent anger, and temper tantrums. The internal consistency for juveniles was .86 and for adults .89. An example of an item on the scale is –

I get grouchy about little things.

Physical Fighting. This scale consists of four items that assess instances of assaultive behavior (physical fights) against both males and females as an adult. The internal consistency for juveniles was .75 and for adults .82. An example of an item on the scale is –

I enjoy getting into physical fights.

Cruelty to Animals. This scale consists of four items that assess the frequency that the respondent has been cruel to animals, other than in sport (hunting). The internal consistency for juveniles was .77 and for adults .76. An example of an item on the scale is--

I have tortured animals.

Fantasies of Hurting People. This scale consists of four items that assess the frequency of having fantasies of hurting other people or seeing them hurt. The internal consistency for juveniles was .74 and for adults .81. An example of an item on the scale is –

I enjoy seeing other people getting killed.

Generation of the Pervasive Anger Scales

The four Pervasive Anger scales were generated from a factor analysis of all the items that had been originally created to assess the five areas used in the MTC:R3 criteria to categorize

rapists as Pervasively Angry types (Knight & Prentky, 1990). In an exploratory factor analysis done on these items in Version 1 of the MASA, five factors emerged, corresponding to the five MTC:R3 areas, (Knight et al., 1994). A parallel analysis using the substantially larger adult sexual offender standardization sample yielded a four-factor solution. The Constantly Angry and Verbal Aggression areas were not differentiated in this more recent analysis and yielded a single factor. This four-factor solution was perfectly replicated on the juvenile standardization sample and almost completely replicated on the community sample. For the community controls one item, "I have fought or physically assaulted others (non-sexual)," double loaded almost equally on both the Physical Fighting and the Constantly Angry factors. We kept this item on the Physical Fighting scale, where it had strongly and uniquely loaded in both the adult and juvenile samples.

Practical Considerations for the Pervasive Anger Scales

Clearly high pervasive anger (T Score ≥ 65 on any scale) warrants clinical attention in both juveniles and adults. It is an important, differentiating variable for sexual offenders, and it is especially important for residential juvenile sexual offenders. In the adult risk assessment actuarials only the A-SOAP-II (Prentky & Righthand, 2003b) and the SRA (Thornton, 2002) directly assess anger. More recently, Negative Emotionality/Hostility, which includes assessments of hostility/aggression and explosive expressions of emotions, has been included as a separate item on the STABLE-2007 (Hanson & Harris, 2007), and preliminary results indicate that it significantly predicts both violent and general recidivism (Hanson et al., 2007). Other actuarials (e.g., the Static-99, the Static 2002, the RM-2000, and the SVR-20) assess it only indirectly by including violent crimes. For juveniles both the J-SOAP-II (Prentky & Righthand, 2003a) and the ERASOR (Worling, 2004b) include anger as a risk factor. The J-SOAP-II has pervasive anger as an item on the Impulsivity/Antisocial Behavior scale, and the ERASOR captures anger directly in the item, "Recent escalation in anger or negative affect." The J-SOAP-II also indirectly assesses anger in the sexualized aggression item on their Sexual Drive/Preoccupation scale. Likewise, the ERASOR captures it indirectly with its item, "Threats of, or use of, violence/weapons during sexual offense." It must be noted, however, that the use of violence or weapons during the offense has not been related to the risk for sexual recidivism (Epps, 1997; Lane, 1997; Perry & Orchard, 1992; Ross & Loss, 1991; Steen & Monnette, 1989; Wenet & Clark, 1986), but rather it appears only related to non-sexual recidivism (Långström, 2002).

The limited research available clearly indicates that effective emotional or affective regulation and expression may help reduce instances of sex offending and other criminal behavior. Consequently, when emotional dysregulation problems and intense anger are determined to exist, interventions designed to address these problems should be an important component of sexual-offense specific treatment. There is considerable empirical support for the use of cognitive-behavioral and behavioral therapy with youths to address anger control problems (e.g., Lochman et al., 2006; McMahon & Wells, 1998). Indeed, in a recent meta-analysis of the effect of treatment in reducing recidivism for adult and juvenile offenders, Landenberger and Lipsey (2005) found that cognitive-behavior treatment programs that included anger control and interpersonal problem solving were more effective than programs without these treatment components. Worling (2004a) has described a number of cognitive-behavioral

treatment manuals that assist youths with improving their anger management abilities. These modules include interventions that facilitate various skills such as relaxation strategies, assertiveness training, and problem solving approaches. Psychopharmacological interventions are also available (e.g., Barrios & O'Dell, 1998; Kazdin & Marciano 1998; McMahon & Wells, 1998).

Offense Planning Scales

Background of the Offense Planning Scales

Consideration of the degree to which sexual offenders plan their offenses first arose both in early sociological research that attempted to describe the patterns of rape or offense styles (Amir, 1971) and in early typological speculation, where particular offender types where characterized by premeditation and planning, whereas others were described as opportunistic and impulsive (see Knight et al., 1985 for a review of these speculative typologies). Subsequently, offense planning, conceived at first as a univocal construct, was incorporated into a more empirically based typology of rapists (Knight & Prentky, 1990). With the advent of the relapse prevention model and its application to treatment, clinical concern about the offense process including premeditation increased (Pithers, 1990; Pithers, Marques, Gibat, & Marlatt, 1983). Interest in the offense and in decision-making throughout the phases of the offense chain has led to a significant body of qualitative work that has attempted to organize semi-structured retrospective clinical interviews of sexual offenders into cohesive offense pathways in both child molesters and in rapists (Hudson, Ward, & McCormack, 1999; Polaschek, Hudson, Ward, & Siegert, 2001; Ward & Hudson, 1998; Ward, Louden, Hudson, & Marshall, 1995).

The analysis of the role of offense planning in MTC:R3 was limited by the difficulty of inferring the level of planning from the crime descriptions in the archival records. Although the archival offense planning measures that were generated were found important in predicting sexual offense recidivism for adult rapists (Knight, 1999a; Knight & Thornton, 2007), they did not provide sufficient detail for testing hypotheses about the distribution of offense planning across types (Knight, 1999a; Rosenberg & Knight, 1988). Consequently, we sought to measure aspects of planning using the MASA. As described in the generation section below, four consistent factors have emerged that were consistent across samples, indicating that planning is not a univocal construct. The first factor combines the respondent's fantasies about what sexual acts he would perform or would have the victim do to or for him with fantasies that Cohen et al., (1971) attributed to their compensatory rapist type, and Groth, Burgess, and Holmstrom (l977) saw as characteristic of their similarly defined power-reassurance rapist. Hazelwood (1987) has referred to these as pseudo-unselfish fantasies, and Marshall (1989) discussed them in the context of seeking intimacy; hence, its name, Intimacy-Seeking Sexual Fantasies. In these fantasies the rapist ignores the agonistic nature of the sexual assault and fantasizes that his sexual overtures will elicit a positive response in the victim. The second factor, Aggressive/Violent Fantasies, taps the offender's fantasies about physically harming, frightening, and even killing the victim. The third factor, Explicit Planning, captures both the offender's forethought in seeking a particular victim and his fantasies about a particular location for an assault. The fourth, Eluding Apprehension, taps his plans to elude apprehension after the crime. The greater differentiation of offense planning into distinct components of planning also provides potential resolutions to the problems we encountered with the clearly inaccurate global representation of this construct in MTC:R3 (Knight, 1999a).

The correlates of the four offense planning factors are informative, suggesting the motivations that may be driving offense fantasies and cognitions. Not surprisingly, for both

adults and juveniles the Aggressive/Violent Fantasies offense planning factor was highly correlated with the Sadistic Fantasies and Fantasies of Hurting People factors, r (519) = .778 and .517, $ps < .001$, respectively for adults, and r (318) = .617 and .396, $ps < .001$, respectively for juveniles. Although not as highly correlated, the other three offense planning factors were also significantly correlated with these sadistic/aggressive fantasies for both adults and juveniles, $M r$ = .376; range of r = .289 to .413, $ps < .001$. Again, not surprisingly, for both adults and juveniles the Intimacy-Seeking Sexual Fantasies offense planning factor correlated highly with the Sexual Compulsivity, Sexual Preoccupation, Hypersexuality scales and with an overall paraphilia scale, r (519) = .470, .464, .430, and .420, $ps < .001$, respectively for adults, and r (318) = .484, .497, .429, and .536, all $ps < .001$, respectively for juveniles. The other three offense planning factors, however, were also significantly correlated with these sexual fantasy and behavior scales for both adults and juveniles, $M r$ = .438; range of r = .269 to .557, all $ps < .001$. In contrast, the average correlation of the juvenile antisocial factors with offense planning was .110 and of the psychopathy related scales was .228. This pattern of correlations replicates the same pattern found in previous adult and juvenile samples (Knight, 1999a; Knight & Cerce, 1999). These results suggest that sexual and aggressive motivations and fantasies drive and sustain offense planning.

Description of the Offense Planning Scales

The offense planning section is given to those who admit to (a) manipulating or forcing someone to have sex, (b) being charged or convicted of a sex crime, or (c) having sexual contact with a child or with a teen when they were over 19 years of age. The MIDSA includes four factor scales that describe offense planning and fantasy. Because community samples cannot provide valid data about offense planning, the respondent's scores are reported as percentiles.

Intimacy-Seeking Sexual Fantasies. This scale consists of 17 items that assess fantasies in which the respondent ignores the agonistic nature of coercive sexual behavior and fantasizes that his sexual overtures will elicit a positive response. He fantasizes both about what he will say and do sexually to a women and what she will say and feel and do sexually to him during the offense encounter. The internal consistency for juveniles was .96 and for adults .97. An example of an item on the scale is –

My thoughts about how the person would act toward me included:
How the person would act toward me while I was having sex.

Aggressive/Violent Fantasies. This scale contains seven items that tap the respondent's fantasies about physically harming, frightening, and even killing someone during nonconsensual sex. The internal consistency for juveniles was .84 and for adults .82. An example of an item on the scale is –

My thoughts about what I would **do** to the person included:
Scaring or frightening the person.

Explicit Planning. This factor consists of seven items that indicate that the respondent has thought specifically about committing an offense, including who the victim would be and where he would commit the offense. The internal consistency for juveniles was .84 and for adults .89. An example of an item on the scale is –

When I thought about manipulating somebody to have sex, I **thought** about:
Where I would take the person or where I would commit the assault (such as my car, an apartment, the woods or a park, vacant building, somebody's house, etc.)

Eluding Apprehension. This scale contains five items that assess the respondent's plans to elude apprehension after sexually coercive behavior. High scores indicate high post-offense planning. The internal consistency for juveniles was .91 and for adults .91. An example of an item on the scale is –

My thoughts about what I would do **after** I made somebody have sex included:
What to do with the person after the sex.

Generation of the Offense Planning Scales

The four Offense Planning scales were generated from a principal component analysis with iterations on the adult offender standardization sample. We extracted all factors with eigenvalues greater than 1, and rotated these factors to VARIMAX criteria. Four factors emerged. Both items that did not load on any of the four factors and items that loaded on multiple factors were removed and the factor analysis was repeated, yielding four relatively clean, easily interpretable factors. The factor analysis with the subset of "clean" items was then calculated on the juvenile standardization sample. The same factor structure emerged for the juveniles as the adults with the exception of one item, "Talking to the person (going over specific things I was going to say)," which loaded on different factors for adults and juveniles. This item was dropped, and the exact same factor structure emerged for adults and juveniles. The community sample, which had never been convicted of a crime, was not asked about offense planning; hence the lack of a community control T Score background for this scale. The T Scores were created using only the relevant offender samples. In the MIDSA Report only percentile scores relative to the appropriate adult or juvenile sample are presented.

Practical Considerations of the Offense Planning Scales

Overall, the levels of offense planning in adult and residential juvenile samples appear to be quite comparable (Knight, 2004). Moreover, residential juvenile sexual offenders score significantly higher than outpatient juvenile sexual offenders on all four factors (Zakireh et al. 2008; Schatzel & Fletcher, 2004) and higher on all factors than both residential and outpatient non-sex offending juveniles. Although outpatient juvenile sexual offenders report less planning than residential sexual offenders, they still score significantly higher than the non-sex offending juvenile delinquents on the Intimacy Seeking Sexual and Eluding Apprehension factors. The higher level of offense planning in residential juvenile sexual offenders is consistent with their higher risk for recidivism (Righthand, Carpenter, & Prentky, 2001). Epperson et al. (2005) found that juvenile offenders whose offenses were preceded by grooming, play, deception, or enticement showed higher sexual reoffense rates than those without such offense precursors. Worling and Curwen (2000) also found that the presence of child victim grooming behavior was significantly related to sexual recidivism. For adult rapists, as indicated above, offense planning has been found to correlate with sexual recidivism (Knight, 1999a; Knight & Thornton, 2007). Consistent with these findings the degree of planning of sexual offenses is an item both on the A-SOAP-II (Prentky & Righthand, 2003b) and the J-SOAP-II (Prentky & Righthand, 2003a). Certainly the data that are available suggest that offense planning is a risk factor that deserves clinical attention.

Sexual offenders' implicit goals and needs as reflected in their offense fantasies and cognitive planning about offense behavior identify foci for specific interventions (Ward & Hudson, 1998). Recent studies that have failed to find support for the relapse prevention models that have traditionally been used to address offense related fantasies and cognitions (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005) suggest that other approaches like the cognitive behavioral interventions that have been successful in treating deviant sexual fantasies (Fanniff & Becker, 2006) and in reducing deviant aggressive and angry fantasies (Worling, 2004a) may be more successful in treating these deviant fantasies and cognitions. Percentile scores on any of the Offense Planning factors that put a respondent in the top 50% of residential or adult sexual offenders indicate problematic offense fantasies and cognitions that should be addressed in therapy.

Child Molestation Scales

Overall Generation of the Child Molestation Scales

Because the background information differs for each of the child molestation scales, in this section we will first describe the overall generation of the scales, and for each scale we will separately present background information and practical considerations.

The three child molestation scales were generated from a factor analysis of all child-sex related behavior, attitude, and fantasy items. The exact same three-factor solution emerged for the adult and juvenile offenders; only the order of factor extraction differed. For the adults the Cognitive Distortions factor was extracted first, and for the juveniles the Child Sexual Arousal factor emerged first. For the community sample a two-factor solution worked best. Whereas the Child Sexual Sadism factor was the same as the comparable factor for the offenders, the Child Sexual Arousal and Cognitive Distortions factors were not differentiated and constituted a single factor. Nonetheless, for the MIDSA three separate matching scales were constructed and the community Arousal/Distortion scale was subdivided according to the offender results. As can be seen in the internal consistency table, both offender groups yielded high alphas for all three scales. The community sample had high internal consistency on the Child Sexual Sadism scale and moderate alphas on the other two scales.

Child Sexual Arousal

Background of Child Sexual Arousal

Any deviant sexual interest, which includes sexual arousal to young children, has consistently been found to be an important factor associated with recidivism for sexual offenses both among adult and adolescent sexual offenders (Hanson & Morton-Bourgon, 2005). Prentky et al. (1997) found sexual fixation on children to be an important predictor of recidivism among adult child molesters. Several studies directly support a strong association between deviant sexual arousal or fantasies and sex offense recidivism among juvenile offenders (Kahn & Chambers, 1991; Kenny et al., 2001; Schram et al., 1991; Weinrott, 1996; Worling & Curwen, 2000) and Miner (2002) found that preoccupation with children was related to non-sexual and any recidivism. For instance, Worling & Curwen (2000) reported that sexual interest in children was significantly associated with sex offense recidivism in a sample of 58 adolescent males followed between 2-10 years. Consequently, in the sexual interests, attitudes, and behaviors section of the ERASOR Worling (Worling, 2004b; Worling & Curwen, 2001) included the item "deviant sexual interests (younger children, violence, or both)."

Description of Child Sexual Arousal

This scale consists of 5 items that assess being sexually aroused by children and fantasizing sexual activity with them. Respondents who score high on this scale report high sexual arousal to children. An example of an item on the scale is –

I have become sexually excited over thoughts of having sex with a child.

Practical Considerations of Child Sexual Arousal

Not only is Child Sexual Arousal correlated with the companion scales in this domain (Child Sexual Sadism and Cognitive Distortions), and to a higher probability of having younger victims, but it also correlates with scales in two other domains (see Daversa & Knight, 2007). It is correlated both with Anxiety with Women, which measures nervousness and embarrassment around females, and Sexual Performance Anxiety, which assesses concerns about sexual performance. It also correlates highly with Sexual Compulsivity and with Sexual Preoccupation and Hypersexuality. This constellation of sexual anxieties and high sexualization has been found linked both to parental emotional abuse and the experience of sexual abuse (Daversa & Knight, 2007). Child Sexual Arousal has been found to correlate with the amount of force used in the abuse experienced by the juvenile and with the number of related perpetrators who had abused him. Therefore, in treating high arousal to children, knowing the correlates of this arousal in the juvenile (feelings of sexual inadequacy, high general sexualization, and early victimization) are important in fashioning a treatment strategy that addresses the issues that are specifically critical for him.

In estimating risk, consistent with the ERASOR, high scores on this scale should be considered a risk factor. It should be noted, however, that sexual interest and arousal patterns appear to be more malleable in juveniles than in adults (Hunter & Becker, 1994), and high scores might not be as strong a predictor in juveniles as adults.

Child Sexual Sadism

Background of Child Sexual Sadism

Although the issue of sadism has attracted substantial clinical attention, as was indicated in the discussion of the generic sadism scales little empirical data have been generated on it (Marshall & Kennedy, 2003; Prentky & Knight, 1991), and among sexual offenders it has been difficult to measure reliably (Knight, 1989; 1999a). Sadistic fantasies and behaviors toward children among adolescents have received even less empirical attention. The MIDSA Child Sexual Sadism scale, like Child Sexual Arousal scale with which it is highly correlated, has been found in the juvenile sexual offender standardization sample to be predicted both by the amount of force present in the juvenile's reported sexual abuse experiences and by the number of relatives who enacted this abuse on him. It was also related to the amount of female emotional abuse he experienced and the amount and frequency of both the male and female caregiver vicarious violence that he observed.

For adolescents the Child Sexual Sadism scale was related both to the expressive aggression scales and the general sadism scales. It was related to all the pervasive anger scales, but most strongly to the Pervasive Anger Aggressive Fantasies scale.

Description of Child Sexual Sadism

This scale consists of 6 items that assess fantasies and behaviors involving hurting or frightening a child during sex. Respondents who score high on this scale report inclinations to high sexual sadism with children. An example of an item on the scale is –

I have gotten sexually excited when I have seen a child in pain.

Practical Considerations of Child Sexual Sadism

As is suggested by both the early family and concurrent correlations of the Child Sexual Sadism scale, high scores on this scale can reflect the experience of hostility in the juvenile's early life and both current general anger and the sexualization of this anger and the turning of anger toward children. Although it does not in itself provide direct evidence of violence in a sexual offense and therefore should not be used to rate the ERASOR's item, "threats of, or use of, violence/weapons during sexual offense" (Worling, 2004b), nonetheless, a high score should encourage the clinician to pursue the possibility that anger might play a motivating role in the youth's sexual behavior toward children and to explore the youth's sexual fantasies with sensitivity toward sexualized anger toward children.

Child Molester Cognitive Distortions

Background of Child Molester Cognitive Distortions

The construct of child molester cognitive distortions was first introduced in the 1980's (Abel, Becker, & Cunningham-Rathner, 1984). It was first broadly conceptualized as cognitions that justified child molestation behavior (Abel et al., 1989). Abel et al. (1989) hypothesized that these cognitions were attempts to justify socially disapproved sexual arousal to children both to the offender himself and to others. They did not hypothesize that these cognitions constituted core beliefs that contributed to the initiation of sexual offending (Ward, Polaschek, & Beech, 2005). In a more recent theory Ward (Ward, 2000; Ward & Keenan, 1999) proposed that these cognitions are implicit, unconscious beliefs, developed in childhood before any sexual behavior and supportive of offense behavior. He proposed that these cognitions can be subdivided into several subfactors, representing various themes such as the sexuality of children, the potential harm of sexual activity with children, the offender's ability to control his behavior, the offender's entitlement, or the offender's either seeking a safe haven from adults or dealing appropriately with hostile children. A recent variation of this theory (Ward, Gannon, & Keown, 2006) has expanded the notion of cognitions to include beliefs, values, and actions.

The theories, therefore, differ on three major issues--on origin of the cognitions (post-offense rationalizations versus core, offense-initiating beliefs), on the degree to which they are conscious and available to immediate recall, and on the factorial structure of the cognitions. Currently little convincing empirical evidence has been generated that would allow a clear resolution of these issues. First, on the origin of such distortions because no prospective studies have been carried out, we cannot determine whether they are all the cognitive by-products of sexual offending or whether some portion are pre-offense beliefs that contribute to the initiation of child sexual abuse. It is interesting that for the MIDSA Child Molester Cognitive Distortions scale juvenile offenders scored significantly lower than adult offenders, suggesting that such cognitions may increase over time, a result that would favor the offense rationalization model over the offense-initiating etiological model.

Second, the cognitive mechanisms responsible for such cognitions and the availability of their memorial traces to conscious processing remain undetermined. Thus far, studies testing the unconscious nature of child molesters' cognitive distortions do not unequivocally support either the conscious or unconscious nature of these beliefs. For instance, to find in an implicit memory task that child molesters had comparatively stronger associative cohesion among offense-supportive content (e.g., Mihailides, Devilly, & Ward, 2004) does not rule out, as the authors suggest, the hypothesis that the memories are available to conscious processes. One has to demonstrate the lack of availability to conscious processing, as well as the high association, before the inference that these are exclusively unconscious, implicit memories is warranted. If child molesters are highly, *consciously* fixated on children as sexual objects and spend considerable time fantasizing about them, one would also expect high associative strength and conscious memory access.

Third, it is not clear what the nomological structure of domain of child molesters' cognitive distortions is. To date only "grounded theory," qualitative studies have examined this issue (e.g., Mariziano, Ward, Beech, & Pattison, 2005). Such a method is reasonable in the context of discovery for the generation of hypotheses, but it contributes little in context of justification, where far better statistical methods like exploratory and especially confirmatory factor analysis have been developed.

What the empirical literature does support is the conclusion that child molesters, and especially extrafamilial child molesters, can be differentiated from other sexual offenders (Arkowitz & Vess, 2003; Bumby, 1996; Hanson, Gizzarelli, & Scott, 1994; Hayashino, Wurtle, & Klebe, 1995; Marshall, Marshall, Sachdev, & Kruger, 2003; Stermac & Segal, 1989) and from controls (Abel et al., 1989; Tierney & McCabe, 2001) on tests of cognitive distortions about child sexuality, even though the *direction* of the attributions of the child molesters do not differ from controls. That is, child molesters differ only in the degree of their support of such statements. These results have been replicated using the MIDSA Child Molester Cognitive Distortions scale. Both juvenile and adult sexual offenders scored significantly higher than community controls on this scale. Within the adult sex offender group extrafamilial child molesters scored significantly higher than incest offenders and the latter offenders scored significantly higher than rapists. Likewise, juveniles who molested younger children scored higher than juveniles who abused peers or older females. The overall means for all groups, however, still fell in the non-distorted direction.

It has been suggested that responses to cognitive distortion scales might be affected by a social desirability bias (Arkowitz & Vess, 2003; McGrath et al., 1998; Vanhouche & Vertommen, 1999), but Bumby (1996) found no correlation between his MOLEST scale, which parallels the MIDSA scale, and the Marlowe-Crowne Social Desirability scale (Crowne & Marlowe, 1960); and Gannon (2006) found that manipulating the social desirability demand characteristics did not affect child molesters' cognitive distortion acknowledgment. In our sample of juveniles there was no evidence of a relation between the Child Molester Cognitive Distortions scale and the Positive Image Scale, which assesses an attempt to project a positive image of oneself. Juveniles who scored lower on the Distortions scale were, however, *more* likely to deny sexual behavior (Sex Denial scale) and *more* likely to deny negative emotional behavior (Negative Emotion Denial scale), suggesting the possibility that acknowledgement of distorted cognitions is lower in individuals who do not admit to sexual behavior or the experiencing of negative emotions.

Description of Child Molester Cognitive Distortions

This scale consists of 6 items that endorse attitudes conducive to or supporting sexual behavior with children. Three of the items focus on the theme that children are sexual beings and sex with them is like sex with adults, and three downplay the possibility of any harm to the child (Ward & Keenan, 1999). Respondents who score high on this scale evidence high endorsement of such cognitive distortions. An example of an item exemplifying the minimization of harm theme is--

> Many children who are sexually assaulted do not have any major problems because of the assaults.

Practical Considerations of Child Molester Cognitive Distortions

For practical, clinical purposes if these distortions are high in the juvenile or adult being assessed, they certainly indicate an issue that should be addressed in therapy. Whether these are offense producing beliefs or rationalizations of offensive behavior, their modification is an important goal of therapy, and there is evidence that such cognitions are reduced with intervention (Bumby, 1996; McGrath et al., 1998). Although the specific contribution to prediction of recidivism of such cognitions has not been determined, there is evidence that cognitive distortions have been found to correlate with higher rates of sexual offending among juvenile sexual offenders (Kahn & Chambers, 1991; Schram et al., 1991). High scores on this scale would certainly count as an indication of "Attitudes supportive of sexual offending," an item in the Sexual interests, attitudes, and behaviors section of the ERASOR (Worling, 2004b). If a respondent is suspected of cognitive distortions, but scores low on this scale, one should check the respondent's scores on the Sex Denial and Negative Emotion Denial scales. High scores on these scales would suggest that the respondent may not be admitting his cognitive distortions.

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APPENDIX

Scale Item Stem Content

Lie Scales

Positive Image scale

I am always polite, even to people who are rude.
No matter who I'm talking to, I'm always a good listener.
I have never taken something that was not mine.
I am always willing to admit when I make a mistake.
Even if I am not likely to get caught, I always follow the law.
I do not ever swear.
I have never taken advantage of anyone.
I have never dropped litter where it did not belong.
I have never looked through sexy magazines.

Negative Emotion Denial scale

My mind doesn't work as well, when I get upset. (reverse scored)
I sometimes get upset, if I don't get my own way. (reverse scored)
Sometimes I am not completely honest with myself. (reverse scored)
I do not always know why I do some of the things that I do. (reverse scored)
Rather than forgiving and forgetting, I sometimes try to get back at someone. (reverse scored)
When my parents punished me, sometimes they were not fair. (reverse scored)
I have wished that something bad would happen to someone I didn't like. (reverse scored)
I do not like it when people criticize me. (reverse scored)

Improbability Scale

I have not taken a shower or bath in the last year.
I have not looked at a woman in the last year.
I have looked at a television set.

Sexual Denial Scale

Sex is on my mind. (reverse scored)
When I have sexual thoughts, I get sexually excited. (reverse scored)
I have been involved in sexual activity with another person (includes kissing, feeling, etc.) (reverse scored)
I masturbate. (reverse scored)
I have thought about watching someone undress, when they did not know it. (reverse scored)
I have thought about forcing someone to have sex. (reverse scored)

Caregiver Relationship Scales

Acceptance-Neglect (Biological Mother example when respondent was a child)

Did your mother know where you were and the kids you hung around with when you were a child?
How often do you feel that your mother took care of your needs as a child?
When you had problems, did your mother show concern and seem to care as a child?
When you were down or upset, how often was your mother able to make you feel better?
How often did your mother hug or kiss you as a child?
How often did your mother say that she was proud of you as a child?
How often did your mother make you feel loved as a child?
How often did your mother show you affection and tenderness as a child?

Emotional Abuse (Biological Mother example when respondent was a child)

How often did your mother frighten you as a child?
Did your mother have temper tantrums or fits of anger as a child?
Did your mother say that she wished you had never been born, or that you were a "mistake."
How often did your mother say things to scare or frighten you as a child?
How often was your mother really mean to you as a child?
How often did your mother say that she didn't love you as a child?
How often did you feel that your mother couldn't be bothered paying attention to you as a child?
How often did your mother say mean things to you that really hurt or make fun of you as a child?
How often did your mother tell you that you were no good or would never amount to anything as a child?
How often did your mother insult you or swear at you or yell at you as a child?
Did your mother use a weapon to threaten you?

Intimacy Scales

Friendship Intimacy

I tell my friend when I do something that other people disapprove of.
My friend does not make me feel better when I am down or upset (reversed item).
I can tell when my friend is worried about things.
I miss my friend when I am not around him or her.
I can be sure my friend will help me whenever I ask.
We hardly ever do things together (reversed item).
When something nice happens to me I share the experiences with my friend.
I can trust my friend to keep my secrets and not betray me.
My friend makes me feel better about myself.

Romantic Intimacy

I can trust her to keep my secrets and not betray me.

I don't talk about my feelings, thoughts and problems with her.
We influence each other in our ideas and our behaviors.
I can tell when she is worried about things.
I help her achieve her goals in life.
We hardly ever do things together.
She defends me against others and I defend her.
When something nice happens to me I share the experience with her.

Attention-Deficit/Hyperactivity Disorder and Oppositional Behavior Scales

Attentional Deficit

I did not follow through on instructions and failed to finish work.
I had difficulty organizing tasks and activities.
I avoided tasks that required mental effort like schoolwork or homework.
I was forgetful in my daily activities.
I had difficulty keeping my attention while doing tasks or playing.
I failed to give close attention to details or made careless mistakes in schoolwork.
I lost things that I needed for doing tasks or activities.
I was easily distracted.
I did not seem to listen when spoken to directly.

Inhibition Difficulties

I was "on the go" or acted as if I was "driven by a motor."
I talked a lot.
I blurted out answers before questions had been completed.
I found it difficult to wait my turn.
I interrupted or barged in on others.

Oppositional Behavior

I was hateful or wanted to get revenge
I was angry and resentful.
I argued with adults.
I blamed others for my own mistakes or misbehavior.
I was touchy or easily annoyed by others.
I lost my temper.
I refused to obey rules or actively opposed things I was asked to do.
I annoyed people on purpose.

Juvenile Antisocial Scales

Juvenile Alcohol and Drug Abuse (mean of 6 subscales)

Alcohol Use (child) – asked if drank as a child and if got drunk
Alcohol Use (juvenile) -- asked if drank as an adolescent and if got drunk
Weighted Drug Use (child) -- scale weighted by seriousness of drug (list below)
Weighted Drug Use (juvenile) -- scale weighted by seriousness of drug (list below)
Variety of Drug Use (child) – scale that counts the number of different drugs used (list below)
Variety of Drug Use (juvenile) – scale that counts the number of different drugs used (list below)

Drug list

- Gasoline/Kerosene, Glue (or Huffing)
- marijuana/THC
- uppers
- LSD/acid
- PCP/Angel dust
- cocaine/crack
- heroin

Juvenile Delinquency (mean of 8 subscales)

Stealing (e.g., stealing property or money including cars)
Trespassing and Breaking and Entering (e.g., trespassing on someone's property)
Damaging property (e.g., fire-setting or arson)
Traffic offenses (e.g., speeding, driving without a license)
Conduct disorder

- Before my 17th birthday I was charged with or convicted of:
  - Disorderly Conduct or Disturbing the Peace: verbally or physically annoying others so that they called the police.
  - Loitering or Vagrancy: hanging around in places where the police do not want you to be or wandering the streets without a place to stay.
  - Malicious Mischief: playing tricks or pranks that were harmful to people.

Alcohol-related crimes (e.g., illegal possession of alcohol)
Drug-related crimes (e.g., selling drugs)
Weapon crimes (e.g., carrying a concealed weapon)
Truancy/Running away (e.g., habitual truant)
Assaultive crimes (e.g., unarmed robbery)

Juvenile Behavioral and Aggressive Problems (mean of 5 subscales)

Generic fighting and aggressive behavior (e.g., starting fights, picking on others)
Impulsivity in grammar school (e.g., discipline problems, disrupting class, skipping school)
Impulsivity in junior high school (e.g., discipline problems, disrupting class, skipping school)
Aggressive behavior in grammar school (e.g., bullying, fighting, hurting a teacher)
Aggressive behavior in junior high school (e.g., bullying, fighting, hurting a teacher)

Adult Antisocial Scales

Adult Alcohol and Drug Abuse Scale (mean of 4 subscales)

Frequency and aggressive consequences of alcohol abuse (e.g., starting fights, being mean, committing a crime after drinking)
Variety of different drugs used -- scale that counts the number of different drugs used (list below)
Weighted scale of drug severity -- scale weighted by seriousness of drug (list below)
Frequency of illicit drug use (list below)

Drug list

Gasoline/Kerosene, Glue (or Huffing)
marijuana/THC
uppers
LSD/acid
PCP/Angel dust
cocaine/crack
heroin

Adult Conduct Disorder (mean of 4 scales)

Trespassing and B&E (e.g., convicted for trespassing, breaking and entering)
Conduct disorder (e.g., disturbing the peace, vagrancy)
Contributing to the delinquency of a minor
Property crimes (e.g., vandalism, arson)

Adult Fighting and Assaultive Behavior (mean of 5 scales)

Carrying weapons (e.g., carrying a gun, carrying a knife [as weapon])
Weapon charges/convictions
Assaultive crime charges/convictions (armed robbery, kidnapping, murder)
Robbery charges/convictions
Fight and assaultive behavior (e.g., involved in/starting fights, assaulting males)

Pornography Use Scales

Early Exposure to Pornography

As a **child (through age 12)** I looked at or read sexual materials (pictures of nudes, people making love, etc.).
The kind of sex materials I looked at as a **child (before my 13th birthday)** included:

Nude women
Sex between adults

X-rated sex movies or videos

My parents, brothers, sisters, or other relatives showed me sex materials (like nude pictures or videos) or made them available (bought them for me, etc.) when I was a **child** (through age 12).

Conventional Heterosexual Pornography

The kind of sex materials I looked at as a **teenager (from my 13th birthday to my 17th birthday)** included:

Nude women

X-rated sex movies or videos

As a **teenager (age 13 to 17)**,

I looked at or read sexual materials (pictures of nudes, people making love, etc.).

I masturbated when I looked at or read sex materials.

Homosexual Pornography

The kind of sex materials I looked at as a **child (before my 13th birthday)** included:

Nude men

The kind of sex materials I looked at as a **teenager (from my 13th birthday to my 17th birthday)** included:

Nude men

Child Pornography

The kind of sex materials I looked at as a **child (before my 13th birthday)** included:

Nude children

Sex acts involving children

The kind of sex materials I looked at as a **teenager (from my 13th birthday to my 17th birthday)** included:

Nude children

Sex acts involving children

Violent Pornography

The kind of sex materials I looked at as a **child (before my 13th birthday)** included:

Magazines showing sex acts where people were not really physically harmed, but the scenes included such acts as tying, handcuffing, spanking, or similar acts

Magazines showing sex acts where people actually appeared to be physically harmed

The kind of sex materials I looked at as a **teenager (from my 13th birthday to my 17th birthday)** included:

Magazines showing sex acts where people were not really physically harmed, but the scenes included such acts such as tying, handcuffing, spanking, or similar acts

Magazines showing sex acts where people actually appeared to be physically harmed

Sexualization Scales

Sexual Compulsivity

I am not able to control my sexual behavior.
I have not been able to stop myself from a sexual act, even when I wanted to stop.
I have had a problem controlling my sexual feelings.
I have to fight sexual urges.
Sexual feelings overpower me.
I need to masturbate or have sex every day so that I feel less tense.
I can't stop thinking about sex.
I am always thinking about sex, no matter where I go or what I do.
I have felt an overpowering urge to do a sexual behavior that I had thought about.

Sexual Preoccupation

While working at a job, my mind will wander to thoughts about sex.
I have sex dreams when I sleep.
When I am bored, I daydream about sex.
Before going to sleep, I think about sex.
I have thought about sex.
There have been times when I thought about sex all of the time.
I get sexually turned on easily.

Hypersexuality

I need to masturbate or have sex every day so that I feel less tense.
If I had my choice, I would prefer to have sex (choose the number that is most true for you):
At times I have almost been driven insane by my thoughts about sex.
There have been times when sex was on my mind so much that I had to make love or masturbate once a day or more.
I sometimes think about sex so much that it gets on my nerves.

Masculine Adequacy and Sexual Inadequacy Scales

Masculine Adequacy

When it comes to sex, I am just as good as my friends.
I think I am really manly.
Females think I am physically attractive.
I think that I am good at satisfying women or girls sexually.
I have always been able to defend myself in fights.

Anxiety With Women

I feel nervous around females.
It is hard to talk to women or girls.
I feel embarrassed if I talk about sex.
When I have sex with a woman or girl, I feel nervous.
I have had trouble finding someone to have sex with.

Sexual Performance Anxiety

I worry that I will not be able to satisfy a woman or girl sexually, because my penis is too small.
I worry that there is something wrong with my penis.
I am so afraid I might fail sexually with a female, that it hurts my sex life.

Erectile Dysfunction

I have had problems getting a hard-on during sex.
I have worried about not being able to have an erection (get a hard-on) when I have sex.
I have been unable to come after entering a woman or girl.

Paraphilia Scales

Voyeurism

I think about secretly watching people having sex.
When I have sexual thoughts, I think about secretly watching a woman or girl undress.
I have secretly watched people having sex (not counting movies and sex shows).
I have had a very strong urge to peep.
I have masturbated while watching someone secretly.

Exhibitionism

I have had to resist the urge to expose my penis.
I have had sexual thoughts about exposing myself.
I have come while exposing my penis.
I have thought about exposing my penis.
I have exposed my penis to a woman or girl who did not know me.

Transvestism

I have become sexually excited by wearing articles of women's clothing.
When I have had sexual thoughts, I have thought about dressing as a woman.
I have worn women's clothes or tried them on.

Scatologia

I have telephoned a woman or girl who did not know me to talk dirty or to talk about sex (do not include 900 number calls).
I have made obscene or "dirty" phone calls (not including 900 numbers).

Fetishism

I have gotten sexually excited by parts of the body like feet or hair that are not sexual.
I have gotten sexually excited while thinking about women's shoes or feet.
I have become sexually turned on by smelling or feeling a woman's underwear or shoes.

Sexual Sadism Scales

Sadistic Fantasy

When I have had sexual thoughts, I have thought of cutting a woman or girl with a knife.
I have thought about burning someone during sex.
I have thought about killing someone during sex.
I have thought about strangling a woman or girl during sex.
I have had sexual thoughts about tying my partner to a bed, legs and arms spread apart.
I have thought about embarrassing or humiliating a woman or girl during sex.
When I had sexual thoughts, I thought about threatening or frightening a woman or girl.

Sadistic Behavior

While having sex, I have used handcuffs, whips, or leathers.
I have tied someone up while we were having sex.
I have beaten a woman or girl while I was having sex with her.
I have purposely hurt a woman or girl physically during sex.
While having sex I have enjoyed scaring my companion so that she begged me to stop.
I have daydreamed about how good it would feel to hurt someone during sex.
It turns me on to think about overpowering someone sexually.
The more scared a person becomes, the more sexually turned on I get.

Expressive Aggression Scales

Expressive Aggression Fantasy

I have had thoughts about choking a female.
I have thought about threatening or frightening a woman or girl.
When a female rejects me, I get very angry.
When a woman or girl does not do what I want, I get very angry.
Females make me angry.

Expressive Aggression Behavior

I have beaten a woman or girl so badly that she had to see a doctor.
I have calmed a woman or girl down with a good slap when she was screaming or crying.
I have roughed up a woman or girl so that she would know that I meant business.
A woman or girl has made me so angry that I have beaten her up.

Psychopathy-Related and Hypermasculinity Scales

Lack of Empathy

It makes me sad to see someone who can't find anyone to hang out with. (reverse scored)
Seeing someone who is crying makes me feel like crying. (reverse scored)
I have felt very bad about myself after I cheated or did something wrong. (reverse scored)
When I see someone being treated unfairly, I feel sorry for them. (reverse scored)
I have felt sorry after telling people off, even if they deserved it. (reverse scored)
I have had thoughts that made me feel ashamed of myself. (reverse scored)
I feel sorry for people less fortunate than me. (reverse scored)
People who let themselves be conned deserve what they get.

Lack of Perspective Taking

I try to look at everybody's side of an argument before I make a decision. (reverse scored)
I believe that every issue has two sides and I try to look at both of them. (reverse scored)
I am always willing to admit when I make a mistake. (reverse scored)
I am quick to admit making a mistake. (reverse scored)
I find it difficult to see things from the "other guy's" point of view.
No matter who I'm talking to, I'm always a good listener. (reverse scored)

Conning and Superficial Charm

There have been times when I took advantage of someone.
I have conned someone to get what I wanted.
I have never taken advantage of anyone. (reverse scored)
I have lied to someone to get them to do what I want them to.
I use my charm to get people to notice me.
I can easily charm someone into doing almost anything for me.

Impulsivity

My moods change suddenly.
I have acted impulsively or without thinking.
I do things that make me feel really bad about myself.
I have hurt someone's feeling by saying something without thinking.
Even though I did not want it, I have lost control of myself.
I have had frightening feelings that I could not understand.
I have gotten in trouble for things that were not my fault.

Negative Masculinity/Toughness

I would beat on a guy who insulted my girl or wife.
My friends think of me as being tough.
I can take a beating as well as any man.
I can hold my own with anybody when it comes to drinking.
I say what's on my mind, no matter what others may think.

Hostility toward Woman

Females who get raped probably deserved it.
Girls or women who get drunk at a party are really responsible, if someone takes advantage of them sexually.
Girls or women who are raped often had "bad reputations" to begin with.
Because prostitutes sell their bodies for sex anyway, it is not so bad when someone forces them sexually.
If a woman or girl does not strongly resist sexual advances, she is probably willing to have sex.
A real man needs to have sex almost every day.
Most women are cold people.
A man must be boss in a relationship with a woman.

Pervasive Anger Scales

Constantly Angry

When I get mad, I say nasty things to people.
I get grouchy about little things.
I get angry or feel angry.
I have been so angry, I felt like breaking things.
I feel angry enough to swear.
I lose my temper easily.
If someone yells at me, I yell back.
I have gotten into verbal fights/arguments with other people.

Physical Fighting

There have been people who pushed me so far that we had a fight.
I have fought or physically assaulted others (non-sexual).
I enjoy getting into physical fights.
At times I feel like picking a fistfight with someone.

Cruelty to Animals

I have hurt an animal on purpose (not including while hunting).
I have tortured animals.
I enjoy seeing animals in pain or hurt.
I have killed an animal on purpose at least once in my life (not including hunting).

Fantasies of Hurting People

I enjoy seeing other people getting killed.
I enjoy seeing other people getting hurt.
I think about hurting or causing pain to other people.
I have fantasized about other people getting hurt.

Offense Planning Scales

Intimacy-seeking, Sexual Fantasies

My thoughts about how the person would act toward me included:
- How the person would act toward me while I was having sex.
- What the person would say to me.
- If the person would like me.
- If the person would enjoy having sex with me.
- If the person would have an orgasm.
- If the person would consider seeing me again.

My thoughts about what I would have the person **do to me** included:
- Having the person kiss me.
- Having the person fondle or touch me.
- Having the person blow me.
- Having the person strip for me.

My thoughts about what I would **do** to the person included:
- Kissing the person.
- Fondling or touching the person.
- Having sex with the person.
- Going down on the person (oral sex).

I found that the person's response sometimes was different from how I thought the person would react. I thought the person would be:
- More agreeable or willing.
- More passive or yielding (easier to control).
- More seductive or tempting.

Aggressive/Violent Fantasies

My thoughts about what I would **do** to the person included:
- Scaring or frightening the person.
- Whipping or spanking the person.
- Using rope or tape to tie up or restrain the person.
- Killing the person.

When I thought about manipulating somebody to have sex, I **thought** about:
- The things I would take with me (like rope, handcuffs, mask, tape, Vaseline, etc.)
- The kinds of weapons I would take with me.

My thoughts about what I would have the person **do to me** included:
- Having the person whip me.

Explicit Planning

When I thought about manipulating somebody to have sex, I **thought** about:
- Where I would take the person or where I would commit the assault (such as my car, an apartment, the woods or a park, vacant building, somebody's house, etc.).
- Where or how I would find the person (hitchhiking, at a party, near a college, in the park, at a shopping mall, etc.).
- Who the person should be -- the type of person, such as a certain race, social class, or what they looked like -- old, beautiful, short, blond, etc.

The thoughts that I have had about manipulating or making somebody have sex have changed over time (that is, the details about what would happen and who I would **manipulate** have changed).

I have thought about manipulating somebody to have sex with me long in advance, before I did anything (two weeks or more).

My thoughts about manipulating somebody to have sex were different from what actually happened when I did it.

I have **manipulated** or made somebody have sex after very little planning (thinking about it only on the day that I did it).

Eluding Apprehension

My thoughts about what I would do **after** I made somebody have sex included:
- What to do with the person after the sex.
- How the person would be discovered or whether the person would go to the police.
- What I would do after the incident.
- The possibility of getting caught.
- The involvement of the police and how I would keep from getting caught.

Child Molestation Scales

Child Sexual Arousal

I have thought about having sex with a child.
I have become sexually excited over thoughts of having sex with a child.
I get sexually turned on by little girls.
I have had sexual thoughts about putting my penis in a child's rear end.
I get sexually turned on by little boys.

Child Sexual Sadism

I have gotten sexually turned on when I have hurt a child.
I have physically injured a child during sex.
I have enjoyed hurting a child during sex.
I have gotten sexually excited when I thought about putting a child in fear.
I have gotten sexually excited when I have seen a child in pain.
I have really hurt a child during sex.
I have put my penis in a child's rear end.

Child Molester Cognitive Distortions

Sex with children can help the child learn about sex.
Sex with children is sometimes a lot like adult sexual relationships.
I believe that sex with a child is a way to make the child feel closer to adults.
Sometimes, someone can show affection and love to a child by touching them sexually.
Society makes a much bigger deal out of adults having sex with children then it really is.
Many children who are sexually assaulted do not have any major problems because of the assaults.

TABLES

Table 1

Average Test-retest Reliabilities for Adult and Juvenile Sexual Offenders in Ten Domains Tested using Version 3 of the MASA

		Adults (n = 50)	Juveniles (n = 71)
1	Social Competence	.97	.71
2	Juvenile Antisocial	.83	.82
3	Adult Antisocial	.89	.51
4	Pervasive Anger	.75	.72
5	Expressive Agg.	.90	.75
6	Sadism	.81	.83
7	Paraphilias	.91	.82
8	Sexual Drive	.84	.83
9	Offense Planning	.85	.72
10	Pornography Use	.86	.77

Table 2

Internal Consistencies for All Standardization Samples on All Scales in the 14 Domains of the MIDSA

	Community Controls	Adult Sex Offenders	Juveniles
Lie Scales			
Positive Image Scale	.39	.69	.65
Negative Emotion Denial	.72	.73	.70
Improbability			
Sexual Denial	.75	.74	.79
Caregiver Scales			
Mother Acceptance-Neglect	.81	.93	.90
Mother Emotional Abuse	.88	.94	.90
Father Acceptance-Neglect	.92	.95	.94
Father Emotional Abuse	.91	.94	.91
Other Female Acceptance-Neglect		.94	.92
Other Female Emotional Abuse		.95	.93
Other Male Acceptance-Neglect		.96	.93
Other Male Emotional Abuse		.96	.93
Attention-Deficit/Hyperactivity & Oppositional Behavior			
Attention-Deficit		.93	.89
Inhibition Difficulties		.85	.84
Oppositional Behavior		.92	.92
Juvenile Antisocial			
Juvenile Drugs/Alcohol	.75	.87	.86
Juvenile Delinquency	.86	.91	.90
Juvenile Assault	.81	.84	.81
Adult Antisocial			
Alcohol and Drug Abuse	.76	.90	
Conduct Disorder	.81	.70	
Fighting and Assaultive Behavior	.65	.71	
Pornography Use			
Early Exposure to Pornography	.85	.90	.89
Conventional Heterosexual	.92	.92	.84
Homosexual Pornography	.71	.83	.72
Child Pornography	.58	.92	.94
Violent Pornography	.79	.89	.81

Sexualization Scales			
Sexual Compulsivity	.83	.91	.85
Sexual Preoccupation	.87	.90	.90
Hypersexuality	.70	.81	.69
Masculine Adequacy and Sexual Inadequacy Scales			
Masculine Adequacy	.86	.74	.73
Anxiety with Women	.76	.80	.74
Sexual Performance Anxiety	.67	.76	.70
Erectile Dysfunction	.72	.80	.62
Paraphilia Scales			
Voyeurism	.83	.87	.81
Exhibitionism	.73	.87	.81
Transvestism	.71	.89	.86
Scatologia	.64	.87	.81
Fetishism	.78	.65	.63
Sexual Sadism Scales			
Fantasy	.73	.85	.80
Behaviors	.74	.84	.76
Expressive Aggression Scales			
Fantasy	.67	.80	.63
Behaviors	.79	.80	.60
Psychopathy-Related & Hypermasculinity Scales			
Lack of Perspective Taking	.64	.78	.70
Lack of Empathy	.73	.75	.75
Conning and Superficial Charm	.84	.79	.74
Impulsivity	.84	.79	.80
Negative Masculinity	.63	.67	.62
Hostility towards Women	.72	.88	.81
Pervasive Anger Scales			
Constantly Angry	.89	.89	.86
Physical Fighting	.72	.82	.75
Cruelty to Animals	.74	.76	.77
Fantasies of Hurting People	.82	.81	.74
Offense Planning Scales			
Intimacy-Seeking Sexual Fantasies		.97	.96
Aggressive/Violent Fantasies		.82	.84
Explicit Planning		.89	.84
Eluding Apprehension		.91	.91

Child Molestation Scales			
Child Sexual Arousal	.72	.88	.87
Child Sexual Sadism	.84	.85	.86
Cognitive Distortions	.72	.91	.80