SELF-BLAME, COPING, PERCEIVED CONTROL AND PSYCHOLOGICAL SYMPTOMS IN CHILD SEX OFFENDERS AND BATTERERS

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ABSTRACT

Psychological variables associated with higher risk for abuse perpetration in known sex offenders and batterers include emotional status, impaired coping, low self-blame and low perceived control. Research suggests that these variables could contribute to high recidivism rates seen in both populations. To date, not much information has been collected on abuse perpetrators and whether they differ according to their crime. In this study, 49 child sex offenders and 30 domestic batterers were assessed within one month of treatment contact. Abusive behavior occurred chronically and frequently. There were no group differences on race, marital or court ordered status. Sex offenders were older than batterers and age was used as the covariate in further analyses. There were no group differences in the victims' gender. Batterers reported using more alcohol and reported a higher number of DUIs. Four multivariate analyses of covariance (MANCOVAs) were run to assess emotional status, coping, self-blame and perceived control. Sex offenders were more depressed and more anxious than batterers. They reported more emotion-focused coping, self-distraction, denial and behavioral disengagement. Sex offenders had higher perceived control over current abusive behavior than batterers. They also scored higher than batterers in guilt feeling and external blame attribution measures. Batterers reported significantly higher dysfunctional impulsivity. In this study, sex offenders differed from batterers in variables predicting repeat offending in other studies. Greater understanding of variables distinguishing abuse perpetrators may help in tailoring treatment specific to offense type.

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DEDICATION

I would like to dedicate this thesis to my parents, Gerolf and Joyce, and brother, Markus, who have been there for me every step of the way and who have counted down these last days with me.

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INTRODUCTION

Abusive acts, including child sexual abuse and domestic violence, continue to be commonplace social problems. Clinicians working with offenders suggest that one way to decrease abuse is to identify individuals who may be at high risk for perpetration of violence (Campbell, 1995). Psychological variables associated with high risk for abuse perpetration in known child sex offenders and batterers include emotional status, impaired coping, low self-blame and low perceived control. These samples have rarely been directly compared on these variables. Research suggests that these variables could contribute to high recidivism rates seen in both populations.

Although these offender samples have rarely been compared, many researchers have assumed that violent offenders are similar and have grouped offenders together based on this assumption (Bancroft, 1997; Gudjonsson & Sigurdsson, 1999). Domestic violence treatment approaches have frequently been used as approaches for sexual offending treatment and group therapy is often done with generalized offender groups which can include sex offenders, batterers and even substance abusers (Schwartz & Cellini, 1995). Knowing how child sex offenders differ from batterers could be helpful in preventing violence by tailoring treatment specific to perpetration type.

Overview

Women and children experience violence in alarming rates. According to the American Medical Association, about half of all women will experience some type of domestic violence in their lifetime (American Medical Association [AMA], 1992). Almost four million women report being abused by their husbands, boyfriends or significant partners yearly (U.S. Department of Justice Statistics, 1998). Thirty-seven percent of women who sought emergency room treatment

for injuries relating to violence in 1994 were victims of domestic violence (U.S. Department of Justice, 1997). Domestic violence is the leading cause of injury to women between the ages of 15 and 44. Women ages 19 to 29 are the most likely victims of physical violence (Uniform Crime Reports, 1991). According to the National Clearinghouse on Child Abuse and Neglect, 30 to 60% of children whose mothers' experience violence, experience violence themselves (National Clearinghouse on Child Abuse and Neglect [NCCAN], 2000). Fifty percent of child sex offenders who abuse their children also batter their partner (Straus, 1983).

An estimated 879,000 children were victims of abuse and maltreatment in 2000 (NCCAN, 2000). A vast majority of the victims experienced neglect and a significant minority suffered physical, sexual or emotional abuse. According to the report, approximately half of all sexual abuse victims are abused by parents. Mothers are responsible for about 30% of sexual abuse reports. Fathers and other relatives are responsible for approximately 40% of sexual abuse, whereas 30% of sexual abuse victims were offended by non-relatives (NCCAN, 2000).

Child sexual abuse and domestic violence results in considerable financial cost. Estimated medical expenses for adult victims of domestic violence are 67 billion dollars a year (National Institute of Justice [NIJ], 1996). Abused women spend approximately 35 million dollars a year to replace or repair stolen or damaged property resulting from violent episodes (Bureau of Justice Statistics [BJS], 1998). Half of all domestic violence victims must take time off of work due to their injuries, leading to decreased work productivity (World Health Organization [WHO], 2000).

According to the National Institute of Justice the estimated cost of child abuse over a two year period was 56 billion dollars. Fourteen billion was incurred because of sexual abuse of children other than rape (NIJ, 1996). This study calculated the direct costs of victimization, such

as medical expenses and public programs for victims, as well as the indirect costs of child abuse, such as victim pain and suffering (NIJ, 1996). The cost of incarceration of a convicted child sex offender is approximately $50,000 a year. Sex offenders average about four years in federal custody, significantly increasing societal cost (Waters, 1994).

Perpetrators

Most individuals who commit domestic violence are male and injure their partners (McConnell, 2000). The majority do not have criminal records (Dutton, 1995). Gondolf (1999) studied typical characteristics of batterers. He found that batterers often abuse substances, are unemployed and tend to be in their late twenties and early thirties. Prior to incarceration, 29% of prison inmates had physically abused a family member (Dutton & Hart, 1993).

Male batterers are more likely to grow up in homes where domestic violence occurs (Rosenbaum & O'Leary, 1981). Most batterers report being victims of child abuse themselves (Groth, 1982). One study showed that batterers who were abused as children were more likely to abuse their children (Suh & Abel, 1990). Dutton (1995) concluded that the most powerful factors related to domestic violence were boyhood shaming by the father and past physical abuse.

Child sexual offending is defined by the National Clearinghouse of Child Abuse and Neglect as "contacts or interactions between a child and an adult when the child is being used for sexual stimulation of the perpetrator or another person when the perpetrator or another person is in a position of power or control over the victim" (2000). Child sex offenders are typically are approximately 35 years of age and know their victims at least casually. The vast majority are of normal intelligence. Most gain sexual access to their victims through seduction or enticement (Burgess & Groth, 1978). The U.S. Department of Justice Statistics indicates that the typical

child sex offender is white and married or divorced. Most crimes take place in the perpetrator's or child's home (BJS, 1996).

A significant minority of child sex offenders report childhood sexual abuse (BJS, 1996). According to the Bureau of Justice Statistics (1999), 39% of female inmates and 8% of male inmates report childhood sexual abuse; 17% of females and 5% of males in the general population report childhood sexual abuse. A significant minority of male children who were sexually abused, violently victimize others in adulthood (Lisak, 1994). Almost all child sexual offenders who go untreated recidivate at least once. It is not unusual for a pedophile to have victimized dozens of children (Abel, 1987).

Psychological Variables Associated with Abuse Perpetration

Researchers have studied a number of psychological variables associated with increased likelihood of abuse perpetration. These variables include emotional status, predominantly depression, impaired coping, self-blame and low perceived control. These findings are important because identifying psychological variables associated with increased perpetration risk may lead to improved treatment options and prevention of recidivism.

Batterers are more likely than non-perpetrators to report psychological symptoms, particularly depression (Hamberger & Hastings, 1986; Kaufman, Kantor, & Straus, 1990; Pan, Neidig, & O'Leary, 1994). Batterers tend to show more hostility towards women than control groups of non-batterers and child sex offenders. Batterers are also less likely than sex offenders to tolerate minor stressors (Dewhurst, Moore, & Alfano, 1992). Bland and Orn (1986) studied 2000 randomly selected households over a two-year period and found that having a psychiatric disorder, in particular depression and antisocial personality disorder, is associated with an

increased risk for domestic violence. The vast majority of wife and child batterers have a psychiatric diagnosis.

Male batterers show emotional dependency, social isolation and a low ability to express themselves (Sonkin, Martin, & Walker, 1985; Walker, 1979). Hale, Zimostrad, Duckworth, and Nicholas (1988) attempted to identify psychological characteristics specific to batterers. Although they found no evidence for an MMPI batterer profile, batterers in their study did exhibit impulsivity, disrespect for social standards, problems with the law, low self-esteem, a tendency towards substance abuse and situational depression.

Dinwiddie (1992) found that batterers have higher rates of alcoholism, antisocial personality disorder and depression then non-batterers. He found that domestic violence was associated with violence against others and against oneself. Approximately four times as many batterers had attempted suicide as among the average male population. Dinwiddie (1992) concluded that depression is a significant problem among batterers and that episodes of depression are usually comorbid with other psychological disorders, such as alcoholism and antisocial personality disorder.

Researchers commonly find three elevated Minnesota Multiphasic Personality Inventory (MMPI) scales in child sex offenders: psychopathic deviance, schizophrenia, and depression (Hall, Maiuro, Vitaliano, & Proctor, 1986). In one such MMPI study, the most common forms of psychopathology child sex offenders showed were depression, antisocial behaviors, somatization and cognitive confusion (Grossman & Cavanaugh, 1990). Yet another study indicated that juvenile sex offenders scored higher than a control group of non-offending adolescents on the Beck Depression Inventory (Becker, Kaplan, Tenke, & Tartaglini, 1991). Becker et al. (1991) proposed a framework of possible risk factors for sexual hostility including

depression and antisocial behavior. People showing these risk factors were more likely to engage in sexually aggressive acts.

A number of researchers have examined Axis I disorders in child sex offenders and have found that Axis I diagnoses are common (Johnston, Ward, & Hudson, 1997; Kafka & Hennen, 2002). Kafka and Hennen (2002) found that the most prevalent Axis I disorders among persons with paraphilias were mood disorders. Most males with paraphilias are diagnosed with a mood disorder. About half are diagnosed with early onset dysthymic disorder and a significant minority are diagnosed with major depressive disorder. According to Kafka and Hennen (2002), these diagnoses could be a contributing cause of recidivism among sex offenders and are often overlooked in treatment. Anxiety disorders, attention deficit hyperactivity disorder, substance abuse and alcohol abuse are also highly correlated with paraphilia diagnosis (Kafka & Hennen, 2002).

Gudjonsson and Sigurdsson (1999) compared batterers, rapists and child molesters. They found that rapists and batterers consistently scored higher than child molesters on psychopathy scales. Child molesters scored higher on social desirability measures and were significantly more introverted than non-sexually violent offenders. A significant majority of both rapists and batterers reported alcohol use at the time of the offense, but only a small minority of child molesters reported using alcohol.

In summary, the literature on emotional status in batterers and sex offenders suggests that child sex offenders differ substantially from batterers in psychological adjustment. Child sex offenders may be less likely to exhibit antisocial type traits (Gudjonsson & Sigurdsson, 1999). Both batterers and child molesters are likely to report depression. These findings are important because they may be related to recidivism likelihood (Kafka & Hennen, 2002). If abuse

perpetrators differ in emotional status, it suggests that treatment strategies can be tailored to the exact pattern of emotional symptoms manifested. To address this issue I will compare child sex offenders to batterers in emotional status.

Coping

Coping has been described as a way of managing and responding to the stress of everyday life by the use of cognitive and behavioral strategies (Arata & Burkhart, 1998; Finn, 1985; Folkman, & Lazarus, 1988). Margalit, Raviv, and Ankonina (1992) defined coping as "cognitions and behaviors used by the individual in evaluating stressors and in initiating activities with the aim of decreasing their impact" (p. 202). There have been numerous typologies of coping (Folkman & Lazarus, 1985; Sheir & Carver, 1985). According to Folkman and Lazarus (1985), coping can be categorized as problem-focused or emotion-focused. Problem-focused coping includes attempts to change the sources of stress or oneself. Examples include reducing the demands of the stressful situation or finding the resources to deal with stress. Emotion-focused coping may bring about a short-term reduction of stress but may not result in situational change. Examples include avoidance, self-blame and wishful thinking.

Coping serves many functions and is influenced by an individual's personality and available social resources (Folkman & Moskowitz, 2000). Coping may also be reliant on an individual's assessment of a stressful situation. The effects of coping have been emphasized in numerous literatures, including aging, alcoholism, depression, chronic illness and abuse (Gordon, Feldman, Crose, Schoen, Griffing, & Shankar, 2002; Tennen, Affleck, Armeli, & Carney, 2000). Coping is an important mediator of psychological adjustment to these stressors (Folkman & Lazarus, 1986; Vollrath & Angst, 1993).

Coping may influence how individuals control their impulses, particularly violence perpetration (Neidigh, Gesten, & Shiffman, 1988). Although coping has rarely been studied among batterers, theorists suggest that batterers learn to cope with stressful interpersonal situations by using aggression (Bandura, 1973; Dutton, 1998). Coleman (1994) used social learning theory to explain abuse perpetration. In his analysis individuals learned to use violence as a form of coping through observations and experiences. Children who grow up in families where violence is commonplace are more likely to use violent behavior as a coping strategy (Coleman, 1994). To the extent that domestic violence provides desired outcomes, it is likely to be repeated (Dutton, 1998). Learning to use aggression can occur as a result of violence being reinforced as an interpersonal problem-solving technique or from witnessing abuse in childhood.

Many treatment providers suggest that abusive men use violence to cope with stress (McKenzie, 1995; Pence & Paymar, 1993). Beresik (2001) compared batterers in treatment to non-batterers and discovered that abusive men used more coping strategies than non-abusive men. Batterers reported greater use of problem-focused strategies such as planning and seeking social support but also greater use of non problem-focused strategies such as denial, behavioral disengagement, drug use and aggression. Beresik (2001) suggested that batterers' use of more coping strategies may indicate greater overall attempts at coping due to recognition of problematic behavior.

Research shows that child sex offenders, non-offenders and violent, non-sexual offenders differ in coping. Marshall, Cripps, Anderson, and Cortoni (1999) reported that child sex offenders have lower self-esteem and make more use of emotion-focused coping strategies than violent offenders and non-offenders. Neidigh and Tomiko (1991) compared sex offenders to non-offenders in coping. Sex offenders used more coping strategies than non-offenders, perhaps

because their actions elicited a greater need for coping. Sex offenders also used more self-denigration strategies when dealing with stress. When dealing with impulses to abuse, offenders used self-denigration and avoidance.

The type of coping child sex offenders use may be associated with negative emotional states. Most researchers suggest that persons who use more coping strategies are at a lower risk of depression. However, greater use of strategies such as self-denigration may lead to increases in negative affect, stress and dysphoria (Pearlin & Schooler, 1978). Sex offenders who use avoidance as a primary coping strategy may never learn to control sexual impulses (Neidigh & Tomiko, 1991).

Kear-Colwell and Sawle (2001) reported that pedophiles are more likely than non-offenders to use escape-avoidance, distancing and confrontation to cope when separated from someone they care about. Escape-avoidance coping was used to avoid stressful situations. This was done by either wishful thinking or behavioral efforts to get away from the stressful situation. Distancing coping, present when pedophiles exhibited ambivalence toward social and emotional support, served to reduce the negative affect created when separated from a loved one. Confrontive coping was used when the pedophile became hostile as a way to deal with separation.

In brief, child sex offenders differ from batterers in coping. Marshall, Cripps, and Anderson (1999) found that sex offenders were more likely to use emotion-focused coping strategies. Batterers may use more problem-focused, or behavioral, types of coping strategies (Beresik, 2001). Both groups may use more coping strategies than non-offenders, perhaps because their perpetrator status demands greater coping efforts (Coleman, 1994; Neidigh & Tomiko, 1991). Understanding how perpetrators differ in coping may allow clinicians to

intervene with perpetrator specific strategies. To address this issue in this study I will compare child sex offenders to batterers in coping.

Blame Attributions

Self-blame is one form of coping that is studied in victims and victimizers (Meyer & Taylor, 1986; O'Neill & Kerig, 2000). Blame attribution is the process by which individuals place blame either on themselves or outside sources. Heider (1958) stated that people make internal or external attributions for blame. Self-blame is internal. External attributions for blame are explanations for behavior that place blame on other individuals, or social and environmental factors. For abuse perpetrators, using external attributions for blame may reduce guilt and anxiety associated with abuse (Wortman, 1976). Studying blame among offenders is important because it may promote taking responsibility for behavior (Briere, 1989).

Research suggests that violence against women is often associated with negative attitudes and beliefs toward women, rationalization of abusive behaviors, minimization and externalization of blame and a need to control and dominate relationships (Gudjonsson & Singh, 1988; Ptacek, 1988). Fincham and Bradbury (1992) developed an attributional model for self-blame in which causal attributions lead to judgments of responsibility that determine blame attributions for relationship troubles. For example, Holtzworth-Munroe and Hutchinson (1993) looked at differences in responsibility attributions, negative intent and marital satisfaction among three groups: non-violent, non-distressed; non-violent, distressed; and violent, distressed husbands. They found that violent husbands see their partners as more accountable for negative behavior. Violent husbands were more likely to attribute intent to their partner's negative behavior and to respond to this with violence. Batterers are also more likely to attribute their

partner's negative behavior as selfishly motivated, worthy of blame and unchangeable (Tonizzo, Howells, Day, Reidpath, & Froyland, 2000).

Many men who abuse their spouses do not even characterize themselves as "batterers" (Adams, 1990). They often attempt to attribute the abusive acts to self-defense, even when the abuse includes choking and punching the victim. Batterers in the early stages of treatment will present themselves as victims and surround themselves with individuals who support their cognitive distortions. Batterers in later stages of treatment are more likely to identify themselves as responsible and view the abuse as disrespectful (Adams, 1988).

In child sex offenders, there are inconsistencies in the literature as to whether external or internal attributions are employed. One reason for this may be that blame attributions are rarely studied among child sex offenders. Some researchers find that child sex offenders blame their victims for abuse (Mayer, 1993). They tend to view themselves as victims, forming cognitive distortions of children as seductive or implicitly sexual (Veach, 1997). Salter (1998) states that child sex offenders distort that they are teaching the child, which serves as a rationalization for sexual abuse. Because of distortions such as these, child sex offenders have trouble distinguishing between what is appropriate and what is inappropriate with children. Child sex offenders do not recognize their own cognitive distortions and deny responsibility for their abusive behavior (Veach, 1999).

Research has shown that sex offenders who offend against children are more likely than non-child sex offenders to approve of sexual activity with children (Abel, Gore, Holland, Camp, Becker, & Rathner, 1989). Cognitive distortions regarding sexual activity with children were measured in rapists, child sex offenders and non-sexually offending inmates (Bumby, 1996). Child sex offenders endorsed more cognitive distortions than rapists and non-sexually offending

inmates. Stermac and Segal (1989) reported that child sexual offenders perceived child-adult sexual contact to be beneficial. These offenders regarded children as having more responsibility than adults.

Other researchers find that child sex offenders make more internal, or mental element, attributions for relationship problems than rapists and adult sex offenders (Garlick, Marshall, & Thornton, 1996; Gudjonsson & Burns, 1999). Several investigators have found that child sex offenders have higher guilt scores on the Blame Attribution Inventory when compared to other violent offenders, including adult sex offenders (Gudjonsson & Petursson, 1991; Gudjonsson & Singh, 1988). A significant relationship was found between cognitive distortions and external attributions. This suggests that the more an abuser can socially justify the idea of offending, the more likely the abuser is to blame the abuse on the victim or other circumstances. Hall and Hirschman (1991) state that there is a general societal view that rape is more acceptable than child sexual abuse. Child sex offenders have a harder time finding cultural support for sexually abusing children, and therefore may be more likely to make internal blame attributions.

In sum, several studies have found that batterers use more external blame attributions than sex offenders (Garlick, Marshall, & Thornton, 1996; Gudjonnson & Singh, 1988). The literature on child sex offenders is inconsistent. Some researchers find that child sex offenders use external attributions, others find internal attributions. Overall, child sex offenders are thought to use internal attributions for blame (Garlick, Marshall, & Thornton, 1996). Studying self-blame in perpetrators is important because those who make external attributions for their acts may be more likely to blame the victim for the act, increasing their likelihood of re-offending. In this study, blame attributions in batterers and child sex offenders will be compared.

Perceived Control

Perceived control refers to individuals' views about their ability to significantly modify life events independent of their actual ability to significantly modify events (Burger, 1989). Research suggests that control perceptions are more critical determinants of psychological functioning than actual control (Alloy & Clements, 1992; Burger, 1989). High perceived control is related to improved emotional well-being, physical health and coping (Bisconti & Bergeman, 1999; Tafarodi, Milne, & Smith, 1999). High perceived control over negative life events is related to positive future expectations and a reduction in depressive symptoms (Tennen, Affleck, & Gershman, 1986; Wong, Heiby, Kameoka, & Dubanoski, 1999). Clements and Sawhney (2000) found that battered women who show high expectations for control over future abuse are less depressed than those women who show low expectations for control. Regher, Cadell, & Jansen (1999) found that rape victims with higher perceived control have lower rates of post-traumatic stress disorder.

Research has shown that people tend to experience negative affect when perceived control is low (Seeman, 1959; Seligman, 1975). Low perceived control is related to psychological difficulty and poor physical health (Alloy & Clements, 1992; Thompson & Spacapan, 1991). In studies conducted on individuals who suffer from arthritis, for example, low perceived control over the disability was found to lead to feelings of hopelessness and depression and a greater need for medication (McKee, 2000). Cardiac patients with low perceived control had higher levels of depression, anxiety, hostility and less emotional adjustment when compared to those patients with high perceived control (Moser & Dracup, 2000).

Conflict tends to increase as relationships becomes more serious. This occurs because the longer two individuals are together, the more likely it is the actions of one individual will

have implications for the other individual involved (Lloyd & Cate, 1985). Low levels of conflict can become a means for adjustment and understanding between partners. However, conflict at high levels is associated with perceived loss of control (Stets, 1993). In order to avoid negative feelings associated with perceived control loss, individuals may intensify their efforts to control situations, thereby making conflict worse.

Control and perceived control are important variables in the battering literature (Johnson & Ferraro, 2000; Milardo, 1998). Batterers may use violence to increase perceived control (Stets & Burke, 1996). Jacobson and Gottman (1998) conducted a longitudinal study of domestic violence. They found that batterers tended to fall into two "control" categories. One type of batterer exhibited antisocial personality type traits, had a history of an abusive childhood, was violent both in and out of marriages and desired total control in a marriage for instant self-gratification. The other type was not as likely to have a criminal record, desired total control in a marriage because of abandonment and rejection fears and most often abused during jealous rages.

Another important dimension in studying control among batterers is desire for control. Many researchers theorize that batterers have high desire for control (Pence & Paymar, 1993; Stets, 1995; Wexler, 2000). Desire for control is different from perceived control. Individuals who express a high desire for control are assertive and try to arrange situations so as to help themselves. Individuals who do not show high desire for control are more submissive and allow decisions to be made by others (Prince & Arias, 1994). Desire for control is important because it is thought to be one cause of aggression (Worchel, Arnold, & Harrison, 1978). Tedeschi, Gaes, and Rivera (1977) state that batterers may try to influence their partners by using coercive power when other means are lacking. In dating relationships, men with higher desire for control report

physically abusing their partners more than men with low desire for control (Mason & Blankenship, 1987).

Prince and Arias (1994) found two "clusterings" of abusive men. One group had high self-esteem, high desire for control and low perceived control. They wanted to be in control and were unable to do so in an appropriate manner. These men used violence to gain control and maintain self-esteem. Another group of men had low self-esteem, low desire for control and low perceived control. These men were prone to depression and resorted to violence in response to frustration.

There is very little research on child sex offenders and perceived control. Some theorists suggest that sex offenders may attempt to assert control by offending (Wolfe, 1985). Bugental, Blue, and Cruzcosa (1989) conducted a study on the relationship between perceived control and parenting outcomes and found that low perceived control was related to abusive parenting and negative affective reactions to difficult children. They concluded that low perceived control was an important moderator of positive or negative responses towards children.

Fisher, Beech, and Browne (1998) administered a locus of control scale to a group of sex offenders before and after treatment. Such a scale measures the extent to which an individual feels events are related to their own behavior or the extent to which an individual feels events are controlled externally. In this study, locus of control became more internal in offenders who benefited from treatment. These researchers concluded that having an internal locus of control prior to treatment was an important predictor of treatment success and that external locus of control correlates with a high rate of repeat offenses. Men who did not respond to treatment either did not change their locus of control or became more externally controlled.

In summary, physical or sexual abuse may be one means by which abusive men assert control (Stets & Burke, 1996). The literature on perceived control suggests that low perceived control may contribute to high recidivism rates seen in abuse perpetrators (Fisher, Beech, & Browne, 1998). Because low perceived control is known to be associated with negative affect and dysphoria, both child sex offenders and batterers may experience low levels of control perception (Seligman, 1975). In this study, perceived control and desire for control will be assessed in batterers and child sex offenders.

Rationale

Depression, coping, blame attributions and perceived control are variables commonly theorized to affect perpetration risk in child sex offenders and batterers. These samples have rarely been directly compared on these variables. A comparison of child sex offenders to batterers on these variables could therefore be helpful in preventing abuse by tailoring treatment specific to perpetration type.

Hypotheses

Consistent with the current scientific literature assessing batterers and child sex offenders the following predictions are made:

Hypothesis One: Child sex offenders and batterers will show high depression and anxiety levels. Sex offenders will show lower hostility and antisocial features than batterers.

Hypothesis Two: Child sex offenders will use coping strategies more frequently than batterers. Published studies assessing coping in batterers are rare, so batterer coping will be described and compared to sex offender coping in this study. No a priori hypotheses are made about this comparison.

Hypothesis Three: Child sex offenders will have higher levels of self-blame than batterers.

Hypothesis Four: Batterers will show low perceived control over abuse and high desire for control. There have been no published studies directly assessing perceived control in child sex offenders so perceived control in child sex offenders will be described and compared to batterer perceived control in this study. No a priori hypotheses are made about this comparison.

METHODS

Participants

Data were collected from 79 consecutively evaluated outpatient males seeking treatment for either child sex offending or domestic violence. Data were collected from Carolina Psychological Health Services in Onslow County, Donlin Counseling Services in Alexander County and the Family Service Center of the Lower Cape Fear, located in New Hanover County. Demographic variables such as age and race were investigated. Participants all signed informed consent forms and were assigned subject numbers so as to protect identity and insure privacy. Child sex offenders and batterers were not given any compensation for participation and all participation was completely voluntary. Participants were assessed within one month of contact with the treatment centers.

Materials

Demographics Questionnaire (DQ)

The DQ is a 17 item, self-report questionnaire assessing demographic variables. Examples include income, employment status, number of children and socioeconomic status. Participants were asked if they were currently attending counseling, how long they had been in treatment, whether they have had previous treatment and whether or not they had been court mandated into treatment.

The Conflict Tactics Scale (CTS)

The CTS is a widely used, reliable measure of interpersonal aggression (Holtzworth-Munroe & Hutchinson, 1993; Straus, 1993). The physical violence subscale was used in this investigation and consists of 16 self-report items, designed to assess the degree to which males have used physical violence in the past year (e.g., used a knife or gun on your partner). Responses are rated on 6-point Likert scales (0 = never to 6 = more than twenty times). Higher scores indicate more physical aggression. The CTS has demonstrated good reliability in previous research (α = .91, split-half = .86; Clements & Sawhney, 2000). Internal consistency was high in this study as well, α = 0.90.

Marlowe-Crowne Social Desirability Scale (MC)

The Marlowe-Crowne is a 33 item true-false measure designed to assess the tendency to skew one's responses to appear in a socially desirable light (Crowne & Marlowe, 1960). Examples include, 'Before voting, I thoroughly investigate the qualifications of all candidates' and 'I am always careful about my manner of dress.' The Marlowe-Crowne is widely used to assess social desirability among criminals (Slaton, Kern & Curlette, 2000). Crowne and Marlowe (1960) report an internal consistency alpha of 0.88 for this instrument.

Symptom Checklist – 90 - Revised (SCL)

The SCL is a 90 item self-report inventory designed to test for a broad range of psychopathology (Derogatis, 1992). The SCL includes nine major dimensions: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, anger-hostility, phobic anxiety, paranoid ideation and psychoticism (Schmitz, Hartkamp, Brinschwitz, Michalek, & Tress, 2000). Participants were instructed to rate each of the 90 items on a five point Likert Scale. Holcomb, Adams and Ponder (1983) found reliabilities for the nine identified factors to range between 0.75

and 0.96. Internal consistency was high in this study as well, with reliabilities ranging from 0.87 to 0.94.

COPE (COPE-B)

The COPE-B is a 30 item, self-report inventory which assesses the extent to which participants use 14 different coping strategies (Carver, 1997). COPE-B subscales contain strategies measured by more extensively used instruments including problem-focused activities, seeking of social support, self-blame and avoidance (Lazarus, 1993). The COPE-B also includes strategies not typically measured by other coping instruments, such as humor and denial (Carver, 1997). Participants rate how often they used each coping strategy using a four point Likert scale. Carver (1997) states that the subscales of the COPE-B have demonstrated high reliability (α's range from 0.54 for denial to 0.90 for drug use). Clements, Sabourin and Spiby (2004) demonstrated adequate reliability for this scale (α's range from 0.64 for self-blame to 0.92 for drug use). This study found reliabilities ranging between 0.56 and 0.79.

The Gudjonsson Blame Attribution Inventory (BAI)

The Gudjonsson Blame Attribution Inventory is a 42 item self-report, true/false inventory which measures how offenders form blame attributions for their criminal acts and the extent to which they feel remorse. The BAI includes three independent subscales in criminals: external attributions, internal attributions and guilt feeling attributions (Gudjonsson & Singh, 1989). According to Peersen, Gudjonsson & Sigurdsson (2000), reliabilities for each of the subscales were high (external attributions $\alpha = 0.73$, internal attributions $\alpha = 0.72$ and guilt $\alpha = 0.71$). This study found adequate reliabilities as well (external attributions $\alpha = 0.61$, internal attributions $\alpha = 0.63$ and guilt $\alpha = 0.62$).

Control, Attributions and Expectations Questionnaire (CAEQ)

A modified version of the Attributional Style Questionnaire (Peterson & Seligman, 1984) was developed by Clements (1990) to assess perceived control over actual life events, confidence in control perceptions and expectations of control for future events. Batterers were asked to make control attributions for their most recent and most severe battering episode. Sex offenders were asked to make attributions for their most severe and most recent sexual offense. Perceived control for each offense and expectations for control over similar episodes were measured. Clements (1990) has demonstrated adequate reliability for this instrument ($\alpha = 0.69$ for control perceptions about positive events and $\alpha = 0.62$ for perceptions about negative events). Adequate reliability for this instrument was also found in the present study ($\alpha = 0.77$ for control perceptions about positive events and $\alpha = 0.80$ for perceptions about negative events).

The Desire of Control Scale (DOCS)

The DOCS is a widely used 20-item self-report inventory assessing generalized desire for control over life events (Burger & Cooper, 1979). Responses are given on 7 point Likert scales ranging from 1 "This statement doesn't apply to me at all" to 7 "This statement always applies to me". This scale has demonstrated good reliability in previous studies ($\alpha = 0.81$, test-retest reliability over six weeks = .75; Burger & Cooper, 1979). Adequate reliability was also found in this study, $\alpha = 0.74$.

The Buss-Perry Aggression Questionnaire (BP)

The BP is a 29-item self-report questionnaire that provides four subscales: physical aggression, verbal aggression, anger and hostility. Only the hostility subscale was analyzed in this particular study. Responses are given on a scale of 1 ("extremely uncharacteristic of me") to 5 ("extremely characteristic of me") Likert scale. The Buss-Perry Aggression Questionnaire has test-retest

reliability ranging from 0.72 to 0.80 (Buss & Perry, 1992). Internal consistency for this instrument in the present study was 0.89 for the hostility subscale.

Dickman Impulsivity Inventory (DII)

The DII is a 23-item self-report, true/false measure that distinguishes between functional and dysfunctional impulsivity. Participants respond to statements such as, "People have admired me because I can think quickly." (Dickman, 1990). This scale has demonstrated good reliability in previous studies ($\alpha = 0.74$ for dysfunctional impulsivity and $\alpha = 0.85$ for functional impulsivity; Claes, Vertommen & Braspenning, 2000).

Procedure

Forty-nine child sex offenders and thirty batterers participated. Data were collected during regularly-scheduled group meetings from several area outpatient treatment facilities and included well-established self-report measures of emotional status, coping and perceived control. Questionnaires were administered only after informed consent was obtained. Child sex offenders and batterers were not given any compensation for participation and all participation was completely voluntary. Participants were assessed within one month of treatment contact. Questionnaire responses were entered into a Statistical Package for the Social Sciences (SPSS) file and each variable was analyzed.

RESULTS

Descriptive Statistics

Participants in this study were demographically similar to other studies of violence perpetrators (Gondolf, 1999; Gudjonsson and Sigurdsson, 1999; Kafka & Hennen, 2002; McConnell, 2000). Batterers reported a higher level of physical violence than child sex offenders. As can be seen in Table 1, most participants were single, white males who had been

Table 1

Percentages of Sample Reporting Demographic and Abusive Characteristics

Characteristic	Sex Offenders	Batterers
	%	%
Race		
White	77.6	70.0
Black	18.4	13.3
Hispanic	2.0	6.7
Asian	2.0	6.7
Other	3.3	0.0
Marital Status		
Single	42.7	36.7
Widowed	4.1	3.3
Married	30.6	36.7
Separated	16.3	6.7
Divorced	16.3	0.0
Unmarried but living together	2.5	6.7
Treatment		
Court required	91.8	80.0
Non-court required	8.2	20.0
Gender of Victim		
Male	22.4	6.7
Female	77.6	93.3
Alcohol Use		
Used at time of offense	16.3	40.0
Did not use at time of offense	83.7	60.0
DUI		
History of DUI	18.4	46.7
No history of DUI	81.6	53.3
Alcohol Abuse Treatment		
Received treatment	12.2	20.0
Never received treatment	87.8	80.0
Employment		
Unemployed	14.3	0.0
Employed	87.7	100
Current Independent Income		
<$10,000	20.4	26.7
$11,000-20,000	22.4	20.0
$21,000-30,000	28.6	20.0
$31,000-40,000	14.3	10.0
$41,000-50,000	4.1	10.0
$51,000-60,000	4.1	6.7
$61,000-70,000	0.0	0.0
$71,000-80,000	2.0	0.0
$81,000+	4.1	6.7
Most Severe Injury		
No medical attention	95.9	90.0
Minor/sought medical attention	4.1	10.0
Severe/medical attention required	0.0	0.0
1-5 hospitalizations	0.0	0.0
More than 5 hospitalizations	0.0	0.0

Note: Numbers may not add up to 100% because of missing data.

court-ordered to attend treatment. Offenders reported abusing females more than males. The mean age of child sex offenders was approximately 41 years and the mean age of batterers was approximately 30 years old. The mean age of child sexual abuse victims was 10 years and the mean age of domestic violence victims was 27 years of age. Education averaged 12 years for both offender groups. Most offenders reported knowing their victims between 45 and 70 months but reported abusing for only a small minority of that time. The mean number of abusive incidents was approximately two. Most offenders were in treatment for about three weeks and reported being in treatment only one time. Social desirability levels were in the average range for both offender groups.

Preliminary Analysis

A preliminary multivariate analysis of variance (MANOVA) was run to assess group differences on continuous demographic variables and social desirability. Offender status was the between groups factor. There was a significant multivariate effect when continuous demographic variables were analyzed, Wilks' Lambda, $\underline{F}$ (5, 74) = 3.27, $\underline{p}$ = 0.01. Univariate analyses showed significant between-group differences on age, $\underline{F}$ (1, 78) = 13.95, $\underline{p}$ = 0.01. Child sex offenders were older than batterers and this variable was used as a covariate in further analyses. There were no between group differences on social desirability, $\underline{F}$ (1, 78) = 1.20, $\underline{p} > 0.05$. Means and standard deviations of continuous variables can be found in Table 2.

Chi square analyses were used to assess between group differences on categorical demographic variables. Perpetrator status (child sex offender or batterer) was the between groups variable and demographic variables were the dependent variables (such as socioeconomic status and race). There were no between group differences on race, (χ^2 (4, 71) = 4.16, $\underline{p} > 0.05$) marital status (χ^2 (5, 70) = 10.73, $\underline{p} > 0.05$) or court ordered status (χ^2 (1, 78) = 2.358, $\underline{p} > 0.05$). There

Table 2

Means and Standard Deviations for Continuous Variables

Variable	Sex Offenders			Batterers		
	M	SD	N	M	SD	N
Age	41.38	11.99	49	30.10	8.72	30
Highest year of education	11.93	1.82	49	11.80	0.95	30
Length known victim (in months)	46.98	52.23	49	69.05	58.71	30
Time abusive (in months)	9.33	12.27	49	5.85	8.94	30
Abusive incidents (past year)	2.90	1.69	49	2.05	1.54	30
Length of time in treatment	3.18	0.90	49	2.80	1.06	30
Number of times in treatment	0.63	0.93	49	0.70	0.57	30

Note: Numbers may not add up to 100% because of missing data.

were no group differences in the victims' gender, (χ^2 (1, 78) = 0.12, $p > 0.05$). Batterers reported using more alcohol at the time of the offense (χ^2 (1, 78) = 0.32, $p = 0.02$) and reported a higher number of DUIs (χ^2 (1, 78) = 0.11, $p = 0.01$). Because of this difference, exploratory analyses were run after each hypothesis using alcohol use at the time of offense and number of DUIs as fixed factors. These results are presented after each hypothesis. Categorical variables can be found as percentages in Table 1.

Hypothesis One

According to hypothesis one, both child sex offenders and batterers would show high depression levels. It was also hypothesized that child sex offenders would show lower dysfunctional impulsivity and hostility than batterers. To address hypothesis one, a MANCOVA was conducted with participant group as the independent variable and age as the covariate.

Depression, anxiety, impulsivity and hostility were the dependent variables. There was a significant multivariate effect in the emotional status variables, Wilks' Lambda, F (5, 72) = 4.21, p = 0.02. Means, standard deviations and effect size can be seen in Table 3. Child sex offenders were significantly more depressed than batterers, F (1, 76) = 10.55, p = 0.00. Child sex offenders reported significantly more anxiety than batterers, F (1, 76) = 6.72, p = 0.01. Batterers reported significantly higher dysfunctional impulsivity, F (1, 76) = 5.58, p = 0.02. There were no between-group differences in hostility levels, F (1, 76) = 1.63, $p > 0.05$.

Table 3

Analysis of Variance of Psychological Symptoms

	Batterers	**Sex Offenders**	**F-value**
Functional Impulsivity	15.70(2.00)	16.00(2.18)	3.24
Dysfunctional Impulsivity	18.37(1.25)	17.69(2.03)	5.58*
Depression	9.87(8.83)	15.90(12.75)	10.55**
Anxiety	5.40(6.72)	8.29(9.20)	6.72*
Hostility	25.5(12.57)	24.94(12.68)	1.63

Values presented are means with standard deviations in parentheses.
* $p < .05$, ** $p < .01$, *** $p < .001$

An exploratory MANOVA was conducted to investigate whether offenders reporting DUIs and those offenders reporting alcohol use at the time of the offense would differ from those not reporting DUIs and alcohol use in psychological symptoms. There was a significant multivariate interaction of DUIs and offender status on depression and hostility, F (5, 70) = 3.24, p = 0.11 (see Tables 4 and 5). Child sex offenders reporting DUIs were more depressed and more hostile than child sex offenders reporting no DUIs. Batterers reporting DUIs were less depressed and less hostile than batterers reporting no DUIs. There were no multivariate effects for alcohol use at the time of the offense, F (5, 70) = 1.21, $p > 0.05$.

Table 4

Interaction of Alcohol and Depression

	Batterers	Sex Offenders	F-value
Yes (Reporting DUI)	5.42(2.91)	23.44(3.62)	5.40*
No (Not Reporting DUI)	10.52(2.86)	15.49(1.76)	

Values presented are means with standard deviations in parentheses.
* p < .05, ** p < .01, *** p < .001

Table 5

Interaction of Alcohol and Hostility

	Batterers	Sex Offenders	F-value
Yes (Reporting DUI)	19.92(3.13)	32.22(3.90)	4.32*
No (Not Reporting DUI)	25.53(3.10)	25.25(3.01)	

Values presented are means with standard deviations in parentheses.
* p < .05, ** p < .01, *** p < .001

Hypothesis Two

According to hypothesis two, child sex offenders would use coping strategies more frequently than batterers. Published studies assessing coping in batterers are rare, so hypothesis two also described and compared batterer coping to child sex offender coping. No a priori hypotheses were made about this comparison.

To address the second hypothesis, a MANCOVA was conducted with group as the between subjects factor and age as the covariate. Coping strategies were entered as the dependent variables. There was a marginally significant multivariate effect, F (14, 63) = 1.72, p = 0.08 (see Table 6). Univariate analyses indicated that child sex offenders used significantly more emotion focused coping (F (1, 76) = 11.64, p = 0.00), self-distraction (F (1, 76) = 5.44, p = 0.02), behavioral disengagement (F (1, 76) = 4.66, p = 0.03) and denial (F (1, 76) = 4.59, p = .04) than batterers. In general, child sex offenders were using coping strategies more frequently than batterers (M = 4.70, M = 4.02).

Table 6

Analysis of Variance of Coping Strategies

	Batterers	Sex Offenders	F-value
Active Coping	5.63(2.09)	5.96(1.74)	0.00
Planning	5.23(2.42)	5.59(1.66)	0.02
Instrumental Support	4.27(2.20)	4.96(1.89)	1.31
Venting	3.70(1.37)	3.98(1.61)	0.95
Self-Distraction	3.10(1.32)	3.96(1.37)	5.44*
Self-Blame	4.17(1.77)	4.67(2.06)	1.04
Partner Focus	4.27(2.33)	4.78(2.20)	0.12
Positive Reframing	4.46(2.32)	5.40(1.69)	1.10
Acceptance	5.47(2.18)	6.02(1.93)	1.29
Religion	4.37(2.17)	4.80(2.25)	0.00
Emotion-Focused	3.87(1.85)	5.53(1.77)	11.64***
Denial	2.77(0.97)	4.59(4.80)	4.59*
Behavioral Disengagement	2.73(1.17)	3.20(1.31)	4.66*
Substance Use	2.73(1.36)	2.86(1.62)	1.16

Values presented are means with standard deviations in parentheses.
* p < .05, ** p < .01, *** p < .001

An exploratory MANOVA was conducted to investigate whether offenders reporting DUIs and those offenders reporting alcohol use at the time of the offense would differ from those not reporting DUIs and alcohol use in coping strategies. There was no significant multivariate effect in the reporting of DUIs, Wilks' Lambda, F (4, 71) = 1.63, $p > 0.05$. There was no significant multivariate effect for alcohol use at the time of the offense, Wilks' Lambda, F (4, 71) = 1.31, $p > 0.05$.

Hypothesis Three

According to hypothesis three, child sex offenders would have higher levels of self-blame than batterers. To address this, a third MANCOVA was conducted. The dependent variables were self-blame attributions. Group was the between subjects factor and age was the covariate. There was a significant multivariate effect, Wilks' Lambda, F (3, 74) = 3.60, $p = 0.02$ (see Table 7). Child sex offenders had significantly higher guilt feeling attributions than batterers, F (1, 76) = 7.92, $p = 0.01$. Batterers reported higher external blame attributions than child sex offenders, F (1, 76) = 6.69, $p = 0.01$.

An exploratory MANOVA was conducted to investigate whether offenders reporting DUIs and those offenders reporting alcohol use at the time of the offense would differ from those not reporting DUIs and alcohol use in blame attributions. There were no significant multivariate effects for either number of DUIs or alcohol use at the time of the offense (Wilks' Lambda, F (3, 72) = 1.61, $p > 0.05$ and F (3, 72) = 0.26, $p > 0.05$, respectively).

Hypothesis Four

According to the fourth hypothesis, batterers would show low perceived control over abuse and high desire of control. There have been no published studies directly assessing perceived control in child sex offenders so perceived control in sex offenders would be

Table 7

Analysis of Variance of Blame Attributions

	Batterers	Sex Offenders	F-value
Guilt Feeling Attributions	27.20(2.41)	28.61(2.50)	7.92**
Mental Element Attributions	14.07(1.68)	14.12(1.07)	0.41
External Attributions	22.90(1.63)	21.67(1.84)	6.69*

Values presented are means with standard deviations in parentheses.
* $p < .05$, ** $p < .01$, *** $p < .001$

described and compared to batterer perceived control. No a priori hypotheses were made about this comparison.

To address hypothesis four, a MANCOVA was conducted with group as the between subjects factor and age as the covariate. Perceived control over current abusive behavior and control expectancies over future abusive behavior, as well as desire of control, were the dependent variables. There was a significant multivariate effect, Wilks' Lambda, F (4, 73) = 5.87, $p = 0.00$ (see Table 8). Child sex offenders had higher control perceptions over current abusive behavior than batterers, F (1, 76) = 15.44, $p = 0.00$. There were no between group differences in control expectancies or the desire of control (F (1, 76) = 0.01, $p > 0.05$ and F (1, 76) = 0.83, $p > 0.05$, respectively).

Table 8

Analysis of Variance of Perceived Control

	Batterers	Sex Offenders	F-value
Control	3.13(1.15)	4.35(1.41)	15.44***
Expectation for Similar Events	1.87(0.78)	1.69(0.87)	0.00
Expectation for General Events	4.78(1.35)	4.66(1.53)	1.86
Desire for Control	97.21(2.90)	93.75(2.22)	0.83

Values presented are means with standard deviations in parentheses.
* $p < .05$, ** $p < .01$, *** $p < .001$

An exploratory MANOVA was conducted to investigate whether offenders reporting DUIs and those offenders reporting alcohol use at the time of the offense would differ from those not reporting DUIs and alcohol use in control. There were no significant multivariate effects for either number of DUIs or alcohol use at the time of the offense (Wilks' Lambda, $\underline{F}$ (4, 71) = 0.68, $\underline{p} > 0.05$ and $\underline{F}$ (4, 71) = 2.12, $\underline{p} > 0.05$, respectively).

DISCUSSION

The purpose of this research was to conduct a controlled study of psychological symptoms, coping, self-blame and perceived control in batterers and child sexual offenders. Many researchers have assumed that violent offenders are similar and have grouped offenders together based on this assumption (Bancroft, 1997; Gudjonsson & Sigurdsson, 1999). Similarly clinicians tend to treat offenders as comparable and offer treatment options that are not specific to offender type (Bancroft, 1997; Campbell, 1995). Data from this study indicate that this approach may be problematic. Offenders were heterogeneous in regard to demographics, psychological symptoms, coping, self- blame and perceived control. Knowing how child sex offenders differ from batterers may help us better develop risk interventions specific to high-risk offenders.

Demographically, child sex offenders in this study were very different from batterers. Consistent with past literature, child sex offenders were older than batterers (Burgess & Groth, 1978; Gondolf, 1999). It may be important to investigate the extent to which age is associated with recidivism among offender groups in future research. Previous research has suggested that deviant sexual preferences are important risk factors for recidivism in sex offenders (Hanson & Bussiere, 1998). It is possible that deviant sexual interests in child sex offenders are more long-lasting than deviant violent impulses in batterers and this could be reflected in the age

differences found in this study. Additionally, child victims may be less likely to report abuse than victims of domestic violence. Thus, child sex offenders may be older when they enter treatment because they are older when their offenses are recognized. Further, antisocial behavior typically decreases with age. It is possible that such decreases occur more dramatically for batterers than for child sex offenders. If this is true, than child sex offenders should be considered more high-risk for offending at later ages than batterers (Hanson & Bussiere, 1998).

Child sex offenders differed from batterers on substance abuse characteristics. Child sex offenders reported fewer DUIs and were less likely than batterers to report alcohol use at the time of the offense. This is consistent with existing literature which suggests that alcohol may play more of a role in battering than in sex offending (Burgess & Groth, 1978; Gondolf, 1999). A significant majority of rapists and batterers reported alcohol use at the time of the offense, but only a minority of child sex offenders reported alcohol use (Gudjonsson & Sigurdsson, 1999). Stuart, Moore, Kahler and Ramsey (2003) found high rates of excessive alcohol use among batterers. Future research to study the extent to which alcohol use temporally precedes battering may be important in establishing whether alcohol use is a cause or consequence of abusive behavior.

Clinically, these results suggest that batterers may be more in need of alcohol interventions than child sex offenders. Certainly, they are reporting more characteristics consistent with substance abuse than child sex offenders. It may be important to assess whether treatment for substance abuse differentially affects recidivism in both these groups given that they present with different substance abuse profiles.

Psychological Variables

According to past studies, child sex offenders and batterers are more likely than non-perpetrators to report psychological symptoms (Hamberger & Hastings, 1986; Kaufman, Kantor, & Straus, 1990; Pan, Neidig, & O'Leary, 1994). In previous research, batterers showed higher rates of alcoholism and antisocial personality disorder than non-batterers (Dinwiddie, 1992). Child sex offenders in previous studies were more typically diagnosed with mood disorders, particularly major depressive disorder (Kafka & Hennen, 2002).

Consistent with past research, offenders in this study showed high rates of psychopathology, particularly depression, anxiety and dysfunctional impulsivity (Dinwiddie, 1992; Hale, Zimostrad, Duckworth & Nicholas, 1988; Hamberger & Hastings, 1986; Kafka & Hennen, 2002; Kaufman, Kantor, & Straus, 1990; Pan, Neidig, & O'Leary, 1994). Batterers reported lower rates of depression and anxiety than child sex offenders but higher rates of dysfunctional impulsivity. Dysfunctional impulsivity is the tendency to act without forethought. It is closely associated with aggression and both are considered to be traits of antisocial personality disorder (Swann & Hollander, 2002). This suggests that batterers in this study showed more characteristics of antisocial personality disorder than child sex offenders.

Similar to past findings, child sex offenders in this study reported symptoms of both depression and anxiety (Johnston, Ward, & Hudson, 1997; Kafka & Hennen, 2002). There were a greater number of depressed child sex offenders than batterers. It is unclear whether the depression and anxiety that child sex offenders reported temporally preceded the abuse or was a consequence of being recognized or labeled a child sex offender. It is possible that child sex offenders experience more anxiety and depression as a result of entering treatment for offending. Alternatively, negative affect may be a correlate of offending. It would be important to follow

child sex offenders over time to determine the exact nature of the relationship between negative affect and offending. If depression and anxiety are associated with increased recidivism, than treating depression and anxiety may result would result in decreased recidivism among child sex offenders.

Researchers find that approximately 41% of batterers re-assault within the first six months and almost half of child sex offenders sexually re-offend within four years (Gondolf, 2000; Marshall & Barbaree, 1988). It may be important to assess the extent to which depression, anxiety and dysfunctional impulsivity are differentially contributing to recidivism in each offender group and tailor treatment strategies to offender specific psychological deficits. Batterers who are higher in dysfunctional impulsivity may benefit from impulse control interventions. These interventions could help them deal with characteristics of dysfunctional impulsivity such as a limited tolerance for frustration and expressing emotion through violence that may lead to recidivism.

Similarly, the relationship between depression, anxiety and recidivism deserves further exploration. Child sex offenders may benefit from emotional regulation interventions tailored to reducing negative affect (Valazquez, 2002). These would be especially important if negative affect temporally precedes offending. Alternatively, it is possible that negative affect is associated with decreased recidivism as offender guilt and shame prevents future abuse. Indeed this is theoretical rationale behind victim impact therapies (Maude, 1996). If this is the case than clinicians may not want to focus on decreasing depression levels until clients develop the skill sets they need not to act on abusive impulses.

Coping

In the present study, batterers and child sex offenders were endorsing the use of strategies commonly thought of as effective or adaptive coping far more frequently than strategies commonly thought of as ineffective or maladaptive (Folkman & Lazarus, 1985; Sheir & Carver, 1985). Both groups reported frequently using strategies such as active coping, acceptance, positive reframing and planning and were less likely to report using strategies such as substance use and venting. This suggests that offenders are aware of effective, or adaptive, coping strategies. Therefore, it might be redundant to implement coping skills training interventions that focus on awareness of appropriate coping. It may be more important to focus interventions on the use of ineffective strategies.

One difficulty with self-report measures is that we do not know whether offenders are in fact using the strategies they are reporting. It may be important to investigate offender coping using behavioral observations. This will show whether offenders actually implement the appropriate strategies they generate. If this is true than interventions geared towards implementation may yield better coping among offender populations.

In general, child sex offenders used coping strategies of all types more frequently than batterers. Past research has suggested that batterers use more coping strategies than non-offenders. Neidigh and Tomiko (1991) suggest that this occurs because their actions demand a greater need for coping. Our data suggest that Neidigh and Tomiko's findings can be extended to child sex offenders. To the extent that Neidigh and Tomiko's data are accurate, child sex offenders may need more coping strategies than batterers. It may be helpful for future studies to include a control group to compare coping among offender and non-offender groups.

In this study, child sex offenders reported using coping strategies commonly thought of as ineffective more frequently than batterers. These included techniques such as denial, behavioral disengagement and self-distraction. This is problematic because these strategies all have the effect of allowing the offender to distance himself from acknowledgement of, or responsibility for, the crime. Clinicians should assess the extent to which sex offenders are using such distancing strategies prior to implementing appropriate coping skills training (VanderVoort, 2001). It may be the case that such distancing efforts need to be addressed before any effective clinical change can occur. This is consistent with the logic of victim impact interventions and may provide a rationale for their effectiveness (Maude, 1996).

Further, it may be important to assess whether such distancing strategies are associated with recidivism. Many investigators theorize that such strategies contribute to re-offending and there is a small amount of longitudinal data to support this (Kear-Colwell & Sawle, 2001). Our study confirms that offenders, particularly child sex offenders, do report the use of these strategies. If the use of distancing coping strategies proves to be related to repeat offending, than interventions aimed at reducing the use of such strategies may be important in reducing recidivism. Prospective studies are needed to assess the relationship between distancing coping and recidivism.

In this study, child sex offenders reported greater use of self-distraction to cope than batterers. Self-distraction is a way of avoiding problems by focusing attention on non-problem relevant activities (e.g., watching television or going to the movies; Carver, 1997). It is particularly problematic for abuse perpetrators because it is empirically associated with increased risk of violence (Neidigh, Gesten, & Shiffman, 1988).

Child sex offenders' greater use of self-distraction suggests that they may be even more likely to recidivate than batterers. Greater use of self-distraction may also decrease the likelihood that child sex offenders will focus on changing their abusive behavior in therapy, making it more difficult for them to benefit from clinical intervention. It may be important to investigate the relationship between self-distraction and recidivism risk. Prospective studies would be necessary to examine this relationship.

In this study, offenders were asked how frequently they had been using certain strategies to deal with stress, not impulses to abuse. At the outset of the study, it was assumed that abusers would use their current abuse situation as their most salient stressor. It is possible they did not do this. It may be important to assess abuse-specific coping. Offenders may use an entirely different set of coping strategies when dealing with impulses to abuse.

Blame Attributions

In this study, moderate levels of external attributions for blame were reported by both offender groups (Gudjonsson & Singh, 1989). Batterers and child sex offenders reported high levels of guilt feeling attributions and low levels of mental element, or internal, attributions for blame. Batterers often blame their victims for domestic violence, making external attributions for blame (Holtzworth-Munroe and Hutchinson, 1993). Moreover, sex offenders typically make external attributions for blame (Mayer, 1993).

Batterers reported higher external blame attributions than child sex offenders. In other words, batterers were more likely to blame factors other than the self for their actions than sex offenders. Batterers making external blame attributions may be less responsive to intervention. It may be important for batterers in treatment to learn to take responsibility if they are not taking

responsibility for their actions. Victim impact interventions may be important in this regard (Maude, 1996).

Many researchers speculate that external attributions are related to increased recidivism but this has never been confirmed in a prospective analysis (Holtzworth-Munroe and Hutchinson, 1993; Veach, 1999). If this relationship is confirmed prospectively, than external blame attributions could be one defining characteristic of offenders at high risk for recidivism. Further, prospective confirmation of such relationships would suggest that blame attributions should be assessed among offenders and interventions targeting reduced external blame should be implemented.

Child sex offenders reported significantly higher guilt feeling attributions than batterers. This is consistent with the high levels of depression and anxiety that child sex offenders also reported in this study. It may be important to assess the degree to which negative affective states, such as depression and guilt, are contributing to the utilization of distancing coping strategies for child sex offenders. If they are driving the use of such coping strategies, than distancing coping may increase as negative affect increases. One way victim impact therapies may fail is by increasing negative affect thereby increasing distancing coping.

It may be important to study the relationship between blame attributions and recidivism. If blame attributions are differentially associated with recidivism than clinicians might tailor treatment approaches to blame attributions. Child sex offenders, who report more guilt feelings, may be more responsive to therapeutic interventions designed to help regulate negative affect. Batterers, who report more external blame, may benefit from interventions emphasizing personal responsibility.

Perceived Control

Low perceived control has been associated with increased perpetration of violence in numerous studies (Prince & Arias, 1994; Wolfe, 1985). In the present study, batterers reported significantly lower perceived control over current abusive behaviors than child sex offenders. Some experts believe that batterers use violence or the threat of violence to achieve a sense of control, both over their victims and in general (Gondolf, 1995). This view implies that batterers have low perceived control. Our data support this view. Enhancing perceived control over abusive behavior may be one mechanism whereby batterers learn to control abusive impulses. Techniques which emphasize choice rather than loss of control may help increase control perceptions (Tolman, Edleson & Fendrich, 1996). It is also possible that self-reports of low perceived control over current abusive behavior represents one way of avoiding responsibility or self-blame. It may be important to assess the relationship between perceived control and external attributions to examine this possibility.

In this study, batterers and child sex offenders reported low control expectancies for similar abusive events and high control expectancies for abusive events in general. This inconsistency is rarely found in the research literature. People typically are consistent in their expectancies about control over future life outcomes (Clements & Sawhney, 2000). Again, it is possible that low expectancies for similar events are associated with decreased personal responsibility for such events. If this is the case, increased recidivism and poor response to treatment should be seen in those individuals showing low control expectancies. Prospective studies would be needed to assess this possibility.

In this study, there were no differences between child sex offenders and batterers in desire for control. Both groups reported low desire for control. The means of both offender

groups were less than norms for non-violent controls provided in previous research (Burger & Cooper, 1979). Past researchers have theorized that offenders have high desire for control. Stets (1995) suggested that individuals high in need for control use violence to compensate for low perceived control. Our data support Stets in regard to low perceived control but are inconsistent with Stets regarding desire for control. To our knowledge, this is the first study in which desire for control has actually been measured in abuse perpetrators. The role that desire for control plays in violence perpetration deserves further empirical investigation. If desire for control is not related to abuse perpetration then theoretical models may have to be re-visited.

It may also be important to examine the relationship between psychological symptoms, coping and perceived control to assess whether control perceptions are related to psychological symptoms and coping. Tennen, Afflack & Gershman (1986) found that high perceived control over the recurrence of controllable, negative life events was associated with what is typically known as effective coping. Low perceived control may mediate the relationship between negative affect, impaired coping and increased recidivism.

Implications for Treatment Planning

Of all the possible treatment modalities, the most common form of treatment for violent and non-violent offenders is group therapy (Wakefield & Underwager, 1991). Cognitive behavioral training programs are often used within offender groups, focusing on errors in thinking, skills training and anger management (Babcock & La Taillade, 2000). However, there is a lack of research on the treatment of offenders and little evidence for the effectiveness of many commonly used treatment approaches. Few reports actually compare offenders in order to determine treatment specific to perpetration type. By comparing offenders, treatment-specific

interventions can be created that may prove to be more effective in reducing recidivism among offender groups.

According to Pence and Paymar (1993), programs focusing on treatment of batterers often view desire for control within relationships as a cause of domestic violence. The focus of these programs is as much on changing the desire for control as it is on stopping the actual physical abuse. However, our data show that batterers are reporting lower than average desire for control and so programs that focus attention on this desire may not actually demonstrate a reduction in recidivism.

The most common treatment approach for child sex offenders has been group therapy that relies heavily on hostile confrontation and guilt (Wakefield & Underwager, 1991). Cognitive approaches are typically used to assist the sex offenders in dealing with feelings of remorse, guilt or shame. Frequently, the goal of child sex offender treatment programs is for the offender to apologize to the victim. Victim impact therapies, such as these, may fail by increasing negative affect, thereby increasing distancing coping. Child sex offenders in our study were more depressed and anxious than batterers and many fell within the moderate range of depression on the SCL-90-R. Child sex offenders also reported significantly higher guilt feeling attributions than batterers. Because of this, child sex offender therapy that relies on hostile confrontation may be unnecessary and counterproductive.

Limitations

There were several limitations in this study. There were fewer batterers than child sex offenders. Future studies with equal numbers of subjects in each group may enhance our ability to show group differences by increasing power.

Generalizability is limited by the self-report nature of the instruments. Previous studies using self-report questionnaires indicate that offenders tend to underreport abusive behavior, although neither offender group scored particularly high in social desirability (Heckert & Gondolf, 2000). Structured interviews may increase the validity of responses, allowing clinicians to gain a more complete picture of violent offenders.

These data are retrospective. It is possible that emotional status, coping, self-blame and perceived control significantly changed in the interval between abuse and assessment. To try to correct for this as much as possible, only participants who were in treatment for one month (or less) were used. This was not a study of treatment effects on offenders and treatment levels were kept as minimal as possible.

Finally, these data are cross-sectional in design. Changes in emotional status, coping, self-blame and perceived control may have just preceded the decision to begin treatment. Prospective studies are needed to assess the dynamic nature of these variables and the extent to which they're associated with recidivism.

CONCLUSIONS

Characterizing violent offenders and not specifying type of offense may have important clinical implications. The extant literature assessing sex offenders and batterers suggest that emotional status, coping, self-blame and perceived control are important correlates of recidivism in both groups. In this study child sex offenders differed substantially from batterers on each of these variables. An understanding of such differences may be helpful in preventing violence by tailoring treatment specific to perpetration type. Longitudinal research would be helpful in determining the extent to which changes in these variables are associated with reduced recidivism.

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APPENDIX

Appendix A. Demographics/History Questionnaire.

Please answer the following questions by either filling in the appropriate information or checking the appropriate response.

1) Age: ____
2) Race/Ethnicity:
    African American ____
    Asian ____
    White ____
    Hispanic ____
    Other ____
3) Employment status:
    employed ____
    unemployed ____
4) Current independent household income:
    0-$10,000 ____
    $11,000-20,000 ____
    $21,000-30,000 ____
    $31,000-40,000 ____
    $41,000-50,000 ____
    $51,000-60,000 ____
    $61,000-70,000 ____
    $71,000-80,000 ____
    $81,000+ ____
5) What is the highest year of education you completed? ____
    (Note – high school-12
    junior college-14
    college grad-16)
6) Marital status:
    single ____
    widowed ____
    married ____
    separated ____
    divorced ____
    unmarried but living together ____
    other ___
7) Number of children: ____
8) Have you experienced past violence yourself: ____
9) How long have you known the person you abused? ____ (in months)
10) How long have you been abusive with this person? ____ (in months)
11) Number of abusive incidents you have perpetrated with this person?
    One time ____
    Two times ____
    Three to five times ____
    Six to ten times ____
    Eleven to fifteen times ____
    More than fifteen times ____

12) Most severe injury of abuse perpetration (please pick one):

No medical attention required ____

Minor (e.g. laceration) but sought medical attention ____

Severe (e.g. broken bones) and medical attention required ____

One to five hospitalizations required ____

More than five hospitalizations required ____

13) Was abuse perpetration life threatening?

Yes ____

No ____

14) Is this the first time you have been in treatment for abusive behavior? Yes ____ No ____

15) How long have you been in your current treatment? ____ (in weeks)

16) Did the courts require you to come to treatment? Yes ____ No ____

17) How many times have you been in treatment for abusive behavior? ____