

EXAMINING THE DIFFERENCES AMONG THE MCMI-III PROFILES OF
INCARCERATED SEXUAL OFFENDER SUBGROUPS AND NONSEXUAL VIOLENT
OFFENDERS

A Dissertation by

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The following faculty members have examined the final copy of this dissertation for form and content, and recommend that it be accepted in partial fulfillment of the requirement for the degree of Doctor of Philosophy with a major in Psychology.

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DEDICATION

In the course of my current work, I recently came across a Victim Impact Statement that moved me deeply. This was a letter from a mother of a young boy asking the Court to issue the maximum allowable punishment for the man who, on a number of occasions, sodomized her young son and groomed him into believing that these sexual actions were in the service of love. This mother's letter described manipulation and betrayal on the part of the perpetrator—not just against her son, who clearly endured the most heinous of crimes, but also against her family and the community as a whole, who had believed this man's intentions to be pure, and allowed him to insert himself into the lives of their children. Reading this, I was again reminded of the far-reaching consequences of sexual crimes. Sexual violence is a community problem requiring a community response. This in mind, my dissertation is dedicated to those who have personally experienced sexual violence, their family members, and the community members/agents who try to ensure safe environments for rearing children.

My grandfather, Nicholas Rendinell, was among those community agents, fighting various types of injustice on the front lines as a police officer. On a more personal level, I remember my grandfather teaching me to read and repeatedly passing on important messages to my brothers and I as young children, including, “don't talk to strangers,” always say no to drugs,” and “always wear your seatbelt.” He was one of the best people I ever knew, and I miss him dearly. This dissertation is dedicated to him, and to the other law enforcement, court, and correctional officers who repeatedly face dangerous situations to protect our communities. It is also dedicated to those agents who strive to prevent violence of any kind, as well as those who help others cope with the consequences of such violence. Thank you for your service.

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I am so very blessed to have such a loving and supportive family. My husband, Justin Salamone, has sacrificed many personal opportunities to help make my education possible, yet has remained nothing short of positive and patient throughout the process. He is my stability—a rational, calm, and mindful man—and I feel as though I am a better person with him. Justin, thank you for always being there and for providing me with clarity when I have needed it most. I am so lucky to have you, and I can't wait to start the next chapter of our lives together. I love you, Bub.

I also want to thank my loving parents, James and Dina Rendingell, who taught me the value of education and hard work, and who have motivated and supported me in all my endeavors. They have always been the best role models and have worked hard to provide me with every opportunity to achieve my goals. I am also so grateful for my brothers, Nicholas and James Rendingell, who always make me laugh and remind me to be mindful of the present moment; my grandparents, including John and Ersillia Leone and Nicholas and Pully Rendingell, for their wisdom, encouragement, and unconditional love; and my Uncle Ted, who has taught me the importance of perseverance.

My graduate goals would never have been reached had it not been for the guidance and support of Dr. Dorr. Dr. Dorr was not just my advisor, my dissertation chair, my research supervisor, or my teacher; he has been my mentor—a man that I truly admire on so many different levels, both for his academic accomplishments, as well as more generally for his personal character. He is a genuinely kind, considerate, and patient man, who showed remarkable ability in dealing with my neuroticism, and I am so appreciative of all that he has

taught me. Thank you Dr. Dorr for believing in me. I am so very proud to call myself your student.

I also want to recognize and thank Drs. Ronald Partridge and Felecia Lee, two of my closest friends, who have been there for me throughout graduate school. The support, encouragement, and time you spent helping me get through this dissertation process meant everything. Finally, I would show my appreciation for the Kansas Department of Corrections administrators and staff who were so helpful and supportive of my research pursuits. My time working at the correctional facility was one of the most eye-opening and valuable professional experiences I have had, and I would like to thank my past supervisors for allowing me that opportunity.

ABSTRACT

Using archival data collected from subgroups of sexual and nonsexual incarcerated male offenders, this research sought to identify any clinically meaningful group differences in Axis I and Axis II psychopathology as measured by the Millon Clinical Multiaxial Inventory–III (MCMI-III; Millon, Millon, Davis, & Grossman, 2009). Statistical comparisons were conducted, first between child molesters (a subgroup of the sexual offender sample involved in this study) and nonsexually violent offenders, and then within the overall sample of sexual offenders, which was divided into subgroups based on each offender’s sexual recidivism risk score (higher versus lower risk), as measured by the Static-99 (Hanson & Thornton, 2000). Additional analyses were completed to determine the ability of the MCMI-III scales in predicting group membership between the child molesters and nonsexual violent offenders, as well as in predicting offender Static-99 score. Results generally supported many of the findings set forth by previous literature. In particular, child molesters produced significantly greater mean scores than did the nonsexual violent offenders on the Axis II personality scales of Avoidant, Borderline, Dependent, Depressive, Masochistic (Self-Defeating), Schizoid, and Schizotypal, as well as several of the Axis I scales, while the nonsexual violent offenders scored significantly higher than child molesters on only the Axis II personality scales of Antisocial, Narcissistic, and Histrionic. Overall, the MCMI-III Axis I and II scales were each generally successful at predicting offender membership into these groups, and the significant contributions of individual scales are discussed further. In terms of the comparisons between higher and lower risk sexual offenders, significant differences were identified on the Antisocial and Compulsive personality scales, as well as the Axis I scales of Alcohol Dependence and Drug Dependence, and the Antisocial scale in particular was found to be associated with an increase in offender Static-99 score.

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CHAPTER ONE

INTRODUCTION

Purpose of Study

The purpose of the present research was to identify any clinically meaningful personality and/or acute clinical differences within a sample of incarcerated sexual and nonsexual offenders, using the Millon Clinical Multiaxial Inventory–III (MCMI-III; Millon, Millon, Davis, & Grossman, 2009), a measure of both Axis I and Axis II¹ psychological pathology. This study incorporated two separate methodological approaches for accomplishing this goal, each utilizing different subgroups of offenders from the overall study sample, and each employing more than one analytical method of gaining insight as to the uniqueness of the subgroups involved.

The first approach sought to expand on existing literature (involving MCMI assessment measures; e.g., Ahlmeyer, Kleinsasser, Stoner, & Retzlaff, 2003; Chantry & Craig, 1994a, 1994b), which has generally grouped offenders according to the nature of their crimes. A common grouping compared individuals who committed sexual offenses against children, sexual offenses against adults, and nonsexual offenses. However, this study's sample yielded a fairly small number of convicted offenders with sex crimes against an adult (*rapists*), which compromised the statistical assumptions required for efficient statistical comparisons. Hence, the primary analyses only included those offenders who had committed a sexual crime against a child (*child molesters*), and those offenders who had committed violent, but nonsexual crimes (*nonsexual violent offenders*). Although the rapist subgroup was not included in the primary analyses, additional efforts were made within this approach to describe this subgroup, relative to the two other subgroups, in more of a qualitative fashion. (For a listing of offender convictions by offense type used in the present study, please refer to Appendix A.)

The second methodological approach of this study extended previous research by using additional offender data from the Static-99 (Hanson & Thornton, 2000), a well-known measure for predicting risk of recidivism among sexually offending adult males (Harris, Phenix, Hanson, & Thornton, 2003). Specifically, in the initial set of analyses within this approach, sexual offenders were grouped according to their respective Static-99 scores, into a high risk group and a low risk group. (More detailed information pertaining to the nature of this division into two groups from continuous Static-99 scores will be discussed in the “Methods” chapter.) As in the first approach of this study, the MCMI-III profiles of these subgroups were then compared to determine whether significant characterological and/or psychopathological differences existed. Subsequently, collateral analyses were also conducted without dichotomizing the Static-99 data into groups, attempting to determine which, if any, MCMI-III scales were predictive of offender Static-99 score.

Sexual Violence in the United States

According to the Federal Bureau of Investigation’s (FBI) Uniform Crime Report (UCR), law enforcement jurisdictions throughout the United States received an estimated 84,376 reports of forcible rape against females in 2012, not including reports of statutory rape or other types of sexual offenses (U.S. Department of Justice, FBI, 2013). Translated differently, there was approximately one occurrence of forcible rape against a female every 6.2 minutes that year (U.S. Department of Justice, FBI, n.d.-a). While this alone may be enough to give pause, these specific statistics fail to reflect the wide variety of sexual crime that actually exists in our society. They are also likely underestimating the true incidence of forcible rape against females, as recent research depicts rape/sexual assault victimizations as the most underreported type of violent crime (to law enforcement) in 2011 and 2012 (Truman, Langton, & Planty, 2013).

To provide a more comprehensive sense of the degree of sexual crime in this nation, estimates from the Bureau of Justice Statistics' National Crime Victimization Survey, which utilizes a different definitional and methodological approach than that of the UCR, reveal 346,830 rape and sexual assault victimizations against individuals aged 12 and older during 2012, an increase of more than 100,000 victimizations from 2011 (Truman et al., 2013). Results of this survey also indicate that only 28% of these 2012 victimizations and 27% of these 2011 victimizations were reported to law enforcement. Adding to this picture of sexual violence, a recent report published by the National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention estimated that, of the adult population in this country, the weighted lifetime prevalence of rape against women and men is over 18% and 1%, respectively, or almost 22 million women and 1.6 million men (Black et al., 2011). The lifetime prevalence rates of other types of sexual violence victimization (including forcing the victim to penetrate another individual, being sexually coerced, experiencing unwanted sexual contact, and experiencing unwanted sexual activity that does not involve contact) were identified as having affected 44.6% of women and 22.2% of the men in this country. Additionally, in the year leading up to being surveyed for this research, about one in 20 adults had been sexually victimized in some way, excluding rape.

With regard to childhood sexual abuse/assault specifically, results from the well-known Adverse Childhood Experiences (ACE) Study, initiated in 1995, suggest an overall prevalence rate of 20.7%, and estimates of 24.7% for females and 16% for males, based on the entire study sample ($N = 17,337$) (Centers for Disease Control and Prevention, n.d.). More recently, a meta-analysis released in 2013 (including six studies published between 2000 and 2011, none of which utilized child sexual abuse data before 1982) reported an overall prevalence range of 7.5% to

11.7%, as well as rates of contact sexual abuse ranging from 10.7% to 17.4% for females and 3.8% to 4.6% for males (Townsend & Rheingold, 2013). Finally, Finkelhor, Shattuck, Turner, and Hamby (2014) present estimates of 26.6% for females and 5.1% for males, and they also specify a lifetime rate of adult-only perpetrated sexual abuse/assault against female and male children, estimated at 11.2% and 1.9%, respectively.

Regardless of the exact rate with which sexual violence occurs in our society, the consequences of such violence, particularly those that affect the individual, are devastating. Research indicates significantly greater prevalence of unfavorable mental and physical health issues among individuals with victimization histories of intimate partner violence, rape, or stalking, as compared to individuals without such histories (Black et al., 2011). Specifically, adults with victimization histories show greater rates of endorsed activity limitations, chronic pain, difficulty sleeping, frequent headaches, generally poor physical health, and generally poor mental health; and women in particular have additionally reported higher prevalence of asthma, diabetes, and irritable bowel syndrome. Furthermore, a history of child sexual abuse has been linked to greater risk for affected individuals later developing substance abuse issues, experiencing depression, attempting suicide, marrying a spouse with alcohol problems, and experiencing marriage and family difficulties; and the likelihood of these unfavorable outcomes is even further heightened when the abuse involved sexual intercourse (Dube et al., 2005).

Perpetrators of Sexual Violence and Their Victims

Given the overall magnitude and consequences of sexual violence in society, one avenue for positively impacting the rate with which it occurs may be to continue to acquire the most up to date information on the individuals who perpetrate such crimes. That stated, males appear to be the primary perpetrators of most offenses that are sexual in nature, accounting for 99.1% or

13,840 forcible rape arrests and 92.2% or 48,647 arrests for other sexual offenses (excluding those for prostitution) made in 2012 (see Table 42 of U.S. Department of Justice, FBI, n.d.-b, for more information). In particular, research indicates that males are more likely than females to perpetrate any type of sexual violence against women and are most likely to be the offenders against male rape victims (Black et al., 2011). Also noteworthy, the racial makeup of adults arrested for forcible rape in 2012 was 65.2% Caucasian, 32.2% Black, 1.3% American Indian or Alaskan Native, and 1.2% Asian or Pacific Islander (see Table 43C of U.S. Department of Justice, FBI, n.d.-c, for more information). For sexual offenses other than forcible rape and prostitution, white individuals also constituted the majority of arrests (73%), followed by Black individuals (24.1%), individuals of Asian or Pacific Islander heritage (1.6%), and individuals of American Indian or Alaskan Native heritage (1.3%).

In terms of the relationship of the victim to the offender, research suggests that most rapists, in particular, do not sexually offend against strangers; their victims are more likely to be their present or past intimate partners and/or their acquaintances (Black et al., 2011). With regard to other types of sexual violence, Black et al. (2011) observed the majority of both female and male victims report sexual coercion by an intimate partner (followed to a lesser extent by an acquaintance) and unwanted sexual contact by an acquaintance (followed to a lesser extent by a stranger). Male victims of unwanted sexual experiences that did not involve contact also most commonly reported perpetration by acquaintance, followed by a stranger, whereas females victimized in this way most frequently reported strangers as the perpetrators, followed by acquaintances. Finally, males who were forced to penetrate another person most frequently reported intimate partner and acquaintance perpetration (at nearly equal rates), followed to lesser extent by stranger perpetration.

Sexual Offender Recidivism and Specific Offender Characteristics

A study conducted by the U.S. Department of Justice tracked 9,691 male sexual offenders following their releases from 15 state prisons in 1994, and found that slightly over 5% of them were arrested again for another sexual offense and 43% were rearrested for another offense of any type within three years of their release (Langan, Schmitt, & Durose, 2003). Furthermore, of the study's sex offender sample, reportedly accounting for nearly 67% of all state prison released male sex offenders in the nation in 1994, 3,115 were released rapists—almost 29% of whom had at least one prior arrest for a sex crime, and 5.7% of whom had at least one prior arrest for a sex crime against a child. The remaining portion of the sex offender sample consisted of 6,576 sexual assaulters, 28.4% of whom had at least one prior arrest for any type of sex crime and 12.5% of whom had at least one prior arrest for a sex offense against a child.

Some large-scale meta-analytic reviews, incorporating studies conducted both within and outside of the United States, have shown slightly larger rates of overall sexual recidivism, as compared to the previously discussed study, including 13.4% over a follow-up period averaging four to five years (Hanson & Bussière, 1998); 13.7% over an average of five to six years follow-up (Hanson & Morton-Bourgon, 2005); and estimates of 14%, 19.8%, and 24.2% after 5-, 10-, and 15-year follow-ups, respectively (Harris & Hanson, 2004). As for other types of recidivism among sexual offenders, Hanson and Bussière (1998) reported a nonsexually violent reoffense rate of 12.2% and a general (any type of reoffense) rate of 36.3%, after an average follow-up of four to five years. Sharing portions of the same and updated studies that were used in this 1998 review, Hanson and Morton-Bourgon (2005) also found similar nonsexually violent (14.3%) and general (36.2%) average recidivism rates after an average of five to six years.

In comparing the recidivism rates between subsets of sexual offenders, Hanson and Bussière (1998) identified rapists to have somewhat higher average rates of sexual (18.9%), nonsexually violent (22.1%), and general recidivism (46.2%) than that of child molesters (12.7%, 9.9%, and 36.9%, respectively). With specific regard to sexual recidivism over time, Harris and Hanson (2004) reported closer rates between rapists (14% within five years, 21% within 10 years, and 24% within 15 years) and a heterogeneous group of child molesters (13% within five years, 18% within 10 years, 23% within 15 years); however, the researchers also noted significant within-group differences among their sample of child molesters. In particular, child molesters who victimized males were observed to have the highest reoffense rates, with 23 out of 100 of these individuals reoffending within five years, 28 out of 100 reoffending within 10 years, and 35 out of 100 committing another offense within 15 years. Incestuous child molesters, on the other hand, were shown to have the lowest rates of reoffending, estimated at 6%, 9% and 13%, over these same time periods (i.e., five, 10, and 15 years). Additionally, Harris and Hanson (2004) also identified general sexual recidivism trends, including the increased likelihood of reoffending among those sexual offenders with a previous conviction for a sex offense, as compared to those without such a criminal history; the decreased likelihood of offenders over the age of 50 (at the time of their release) committing another sexual offense, as compared to offenders under the age of 50 (at the time of their release); and the decreased likelihood of sexually reoffending the longer one goes without an offense.

According to Hanson and Bussière (1998), “all sexual offending is, by definition, socially deviant, but not all sexual offenders have deviant sexual interests or preferences” (p. 349). While variables related to antisocial/nonsexual criminality have been found to correlate with sexual recidivism, sexual deviancy (including sexually deviant behaviors and interests) has been

identified as the domain most correlated with this type of recidivism (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005). Subsumed within this latter domain, Hanson and Bussière (1998) pinpoint phallometric assessments of sexual attraction to children as the greatest individual predictor of sexual recidivism (weighted average $r = .32$). These researchers also report several other specific predictors of sexual recidivism, including sexually deviant preferences, a history of past sexual offenses, not completing treatment, victimization of a stranger, victimization of a male, Antisocial Personality Disorder, past nonsexual offenses, young age of offender, sexual offending starting early in age, victimization of an unrelated child, and never having been married. (Please refer to this study for an exhaustive list of all variables examined.)

Paraphilic and Personality Disorders

Presumably, at least a subset of the male sexual offending population (especially those that reoffend) meet criteria for a paraphilic disorder. The most recently published *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013) describes paraphilias as, “any intense or persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners” (p. 685). Like its predecessor, the Fourth Edition- Text Revision version (*DSM-IV-TR*; APA, 2000), the *DSM-5* also stipulates that for one to meet diagnostic criteria for a paraphilic disorder, the individual must (1) be experiencing significant distress or functional or interpersonal impairment because of their paraphilia (including related thoughts, fantasies, or behaviors), or (2) their paraphilic behavior must have been harmful (or potentially harmful) to another person (APA, 2000, 2013). That stated, eight of the more common specific paraphilic disorders described by both versions of the *Manual*, include: (a)

Exhibitionistic Disorder (labeled “Exhibitionism” in the *DSM-IV-TR*), which involves revealing one’s genitals to an unsuspecting individual; (b) Fetishistic Disorder (labeled “Fetishism” in the *DSM-IV-TR*), involving the use of nonliving objects (or, according to the *DSM-5*, a focus on specific body part(s) that are not genitalia) for sexual arousal; (c) Frotteuristic Disorder (labeled “Frotteurism” in the *DSM-IV-TR*), entailing the nonconsensual touching or rubbing of oneself against another individual; (d) Pedophilic Disorder (labeled “Pedophilia” in the *DSM-IV-TR*), involving the sexual attraction/arousal to a prepubescent child; (e) Sexual Masochism Disorder (labeled “Sexual Masochism” in the *DSM-IV-TR*), where one is sexually aroused by being the recipient of humiliation or physical suffering; (f) Sexual Sadism Disorder (labeled “Sexual Sadism” in the *DSM-IV-TR*), where one is sexually aroused by the humiliation or suffering of another; (g) Transvestic Disorder (labeled “Transvestic Fetishism” in the *DSM-IV-TR*), involving dressing in clothes of the opposite sex to achieve arousal²; and (h) Voyeuristic Disorder, (labeled “Voyeurism” in the *DSM-IV-TR*), which entails watching the sexual activity, nudity, or undressing of another individual who is unaware of being observed.

Among those detained for a sexual offense, Exhibitionism, Pedophilia, and Voyeurism have been identified as the most common paraphilias (APA, 2000), with associated male population ceiling prevalence estimates of 2% to 4%, 3% to 5%, and 12%, respectively (APA, 2013). Additionally, the very nature of Frotteurism and Sexual Sadism would also appear to make individuals who engage in such related behaviors susceptible to legal consequences, but at least with regard to the later, the *DSM-5* informs that less than 10% of sex offenders civilly committed within this country would meet criteria for such a diagnosis. In general, some risk factors for paraphilias may include emotional and/or sexual abuse in childhood, substance abuse, antisocial behavior, and hypersexuality, and frequent comorbid conditions can include Antisocial

Personality Disorder, anxiety disorders, Attention Deficit Hyperactivity Disorder, bipolar disorders, Conduct Disorder, depressive disorders, other paraphilias, and substance use disorders (APA, 2013).

Although the *DSM-5* does not utilize an axial system like its predecessor, it does not differ from the *DSM-IV-TR* in terms of specific personality disorder types or the general criteria used in making such diagnoses (APA, 2013). Personality disorders are rigid and persistent cognitive, affective, and behavioral patterns that result in marked distress, interpersonal difficulties, and/or functional impairment (APA, 2000, 2013). These patterns generally take shape before or during the beginning of adulthood, occur within various contexts of an individual's life, and importantly, do not coincide with the beliefs of the individual's culture. Ten specific personality disorders are recognized in both of the aforementioned versions of the *DSM*, including: (a) Paranoid Personality Disorder, or a tendency to interpret the intentions of others as malicious, and thus, to disbelieve and be wary of others; (b) Schizoid Personality Disorder, exemplified by detachment from, and disinterest in, forming/maintaining interpersonal relationships, as well as a limited affective range; (c) Schizotypal Personality Disorder, as characterized by intense interpersonal unease, distortions in perceiving or thinking, and behavioral peculiarities; (d) Antisocial Personality Disorder, involving indifference toward, and transgressing against, other people's rights; (e) Borderline Personality Disorder, characterized by emotional and interpersonal volatility, instability of self-identity, and significant impulsivity; (f) Histrionic Personality Disorder, or exaggerated emotional and behavioral expression, including that which is attention seeking; (g) Narcissistic Personality Disorder, characterized by overestimated self-worth, a need to be esteemed/admired, and an unwillingness to empathize with others; (h) Avoidant Personality Disorder, as expressed through self-defeating feelings and

hypersensitivity to unfavorable criticism which contribute to an inhibited interpersonal style; (i) Dependent Personality Disorder, including an extreme need to be cared for, as demonstrated by behaviors that are clingy and acquiescent; and (j) Obsessive-Compulsive Personality Disorder, or a fixated need for control, fastidiousness, and neatness, despite resulting impairments in functioning.

Review of Relevant Literature Using the MCMI Tests

Despite the prevalence of studies using MMPI assessments, there is a relative dearth of research concerning the personality differences of sexual offenders as measured by the MCMI assessment instruments, and what research does exist (Ahlmeyer et al., 2003; Bard & Knight, 1987; Chantry & Craig, 1994a, 1994b; Langevin et al., 1988; Lehne, 2002) predates the most recent renorming of the MCMI-III in 2008 (Millon et al., 2009). Unlike other personality measures that commonly employ T scores (standard scores) to describe a respondent's performance, the MCMI-III (consistent with its predecessors, the MCMI and MCMI-II) uses Base Rates, which account for the unique prevalence rates of the clinical disorders being assessed (Millon et al., 2009). Additionally, the MCMI-III was normed (and renormed) on clinical samples (including both in- and outpatients), and thus, is intended for use on similar populations in which pathology is demonstrated or suspected.

Bard and Knight (1987) appear to have produced the earliest published study of this kind, using the first version of the MCMI (Millon, 1982) to detect offender subtypes that could lead to improvements in supervision and treatment approaches. The researchers cluster analyzed the eight personality scale profiles of 99 male sexual offenders, including mainly rapists and child molesters, and found four distinct clusters (Bard and Knight, 1987). They identified the following clinical types: (a) a "detached" group, evenly consisting of both types of offenders

(rapists and child molesters), which showed elevations on the Avoidant, Schizoid (Asocial), and Dependent (Submissive) scales; (b) a “typical” criminal type, consisting mostly of rapists with elevated Narcissistic, Antisocial (Aggressive), and Histrionic (Gregarious) scales; (c) a generally aggressive type with deficient social skills, with elevated Antisocial (Aggressive) and Passive-Aggressive (Negativistic) scales; and (d) a “healthy”³ type with only subclinical elevations on Narcissistic, Antisocial (Aggressive), and Compulsive (Conforming) scales.

Langevin et al. (1988) also recognized the aptness of utilizing a psychological assessment measure designed to capture Axis II pathology, given the fairly regular frequency with which personality disorders are diagnosed among male sexual offenders. Their sample consisted of 247 sexual offenders (including pedophiles, sexually aggressive men, incest offenders, and miscellaneous sexual offenders), as well as a comparison group of 172 participants (including police trainees, community volunteers, and nonsexual, nonviolent offenders). While the researchers found negligible differences within the group of sex offenders, they did find statistically significant differences between the sex offenders and comparison subjects on six of the personality scales and two of the Axis I clinical syndrome scales. Specifically, a greater number of elevations was found for the sex offenders on the Schizoid, Avoidant, Dependent, Passive-Aggressive, Anxiety, and Dysthymia scales, whereas the controls showed greater elevations on the Narcissistic and Compulsive scales.

Expanding on these initial studies, Lehne (2002) reported some consistency in the interpretations of test findings obtained from 99 sexual offenders who had completed both the MCMI and an instrument assessing broad personality factors- the NEO Personality Inventory (NEO-PI; Costa & McCrae, 1985). Lehne (2002) reported that the most frequent MCMI personality disorder scale elevations were on the Dependent and Passive-Aggressive scales, with

50% and 36% of his sample showing scores greater than or equal to the established cutoff of 75, respectively. Additionally, he reported 47% and 44% of the sample having shown clinical elevations on the Anxiety and Dysthymia Clinical Syndrome scales, respectively.

With regard to the NEO-PI, Lehne (2002) reported that this sample's mean scores on all of the subscales (facets) of the instrument's broad Neuroticism domain (Anxiety, Hostility, Depression, Self-Consciousness, Impulsiveness, and Vulnerability) were at least one-half standard deviation greater than that of the general population, and they also produced greater mean scores than the general population on the Excitement-Seeking facet scale of the Extraversion domain. For this sample of sexual offenders, Lehne (2002) found positive correlations between the Neuroticism domain and the Schizoid, Avoidant, Passive-Aggressive, Schizotypal, and Borderline personality disorder scales of the MCMI, as well as negative correlations between this domain and the Compulsive and Narcissistic scales. Furthermore, the Extraversion domain was found to be positively correlated with the Histrionic and Narcissistic scales, and negatively correlated with the Schizoid, Avoidant, Schizotypal, Passive-Aggressive, and Borderline scales.

Chantry and Craig (1994b) also used the first version of the MCMI to identify any significant personality differences between three groups of violent offenders, including child molesters, rapists, and nonsexually aggressive felons. They reported that both subgroups of sex offenders showed higher elevations on the Avoidant and Passive-Aggressive Scales, but compared to both the rapists and nonsexual felons, the child molesters scored significantly higher on the Passive-Aggressive, Anxiety, and Dysthymia scales. The child molesters were also found to have had higher scores on the Schizoid, Dependent, Borderline, Psychotic Thinking, and Psychotic Depression scales than the nonsexual offenders; however, greater elevations were

found on the Narcissistic, Compulsive, and Paranoid scales for both the rapists and nonsexually aggressive felons as compared to the child molesters.

Although both groups of sexual offenders obtained their highest scores on the Dependent scale while the nonsexual felons scored highest on the Histrionic scale, the researchers noted that, out of the three groups, only the child molesters' modal profile was clinically elevated. As such, the researchers explained that the child molesters, "...appear to be passive; submissive; insecure; docile; placating; and lacking in initiative, acquiescing to a strong adult authority figure for nurturance, affection, protection, and security" (Chantry & Craig, 1994b, p. 433). In contrast, the authors noted the relative absence of anxiety and depression in the rapist and nonsexually aggressive felon groups and they suggested that the narcissism exhibited by these groups of offenders might often conceal some of their more dependent traits. Thus, the authors asserted that their findings seem to support previous MMPI research, indicating that the personality structures of rapists appear to be more analogous to those of nonsexually violent offenders than similar to child molesters.

In a subsequent study, which appears to use the same data set, Chantry and Craig (1994a) conducted separate cluster analyses for each offender group, identifying three-cluster outputs for both sexual offender groups and a two-cluster output for the nonsexual felons. For the child molesters, cluster I revealed subclinical levels of compulsive and narcissistic traits; cluster II revealed clinical elevations on the Dependent, Passive-Aggressive, and Avoidant scales; and cluster III revealed clinical elevations on the Dependent, Schizoid, and Avoidant scales. Additionally, clinical elevations of the Anxiety and Dysthymia scales were also found in both clusters II and III for this group.

With regard to the rapists, cluster I showed a mild level of expression on the Compulsive scale; cluster II showed clinical elevations on the Narcissistic and Antisocial scales; and cluster III showed clinical elevations on the Avoidant, Dependent, and Schizoid scales (Chantry & Craig, 1994a). Elevations were also found for the Clinical Syndrome scales of Drug Dependence, Bipolar, and Alcohol Dependence in cluster II, and the Anxiety and Dysthymia scales in cluster III. Lastly, as for the nonsexually aggressive felons, cluster I indicated subclinical dependent traits with subclinical dysthymia; and cluster II indicated subclinical narcissistic traits.

Based on these results, Chantry and Craig (1994a) identified two general code types across the groups. Specifically, they noted a subclinical code characterized by compulsive and narcissistic or dependent traits, as well as another code with clinical elevations on the Dependent, Avoidant, and Schizoid scales. Furthermore, synthesizing across their own and previous research, the authors suggested at least two general types of sexual offenders, which they acknowledge are not necessarily specific to those who only engage in sexually deviant behaviors. Nevertheless, the first type, described as possessing a dependent style of personality, has a weak sense of self, harbors feelings of inadequacy, demonstrates strong desires for care and approval from others, and tends to exhibit a placating style of interaction with others.

The second type of sexual offender, as described by Chantry and Craig (1994a), possesses an independent style of personality with antisocial and narcissistic features, and thus, has an overly confident self-image and demonstrates a tendency to manipulate, control, and embarrass and shame others for gratification. While Chantry and Craig (1994a) reported that the inappropriate sexual practices of first type of sexual offender may be explained, at least to some extent, by their not being able to form bonds with other adults, the authors asserted that for the

second type of sexual offender, these practices may instead be partially due to, "...a sense that societal rules and taboos simply do not apply to them, as well as from a need to control and intimidate" (p. 224).

Most recently, Ahlmeyer et al. (2003) used the MCMI-III (Millon, 1994, 1997) to examine differences between samples of rapists (those convicted of sexual assault against an adult), child molesters (including those convicted of a sexual assault against a child), and nonsexual offenders (including those convicted of either violent or nonviolent offenses). Importantly, the researchers noted the inclusion of the Depressive, Sadistic, and Masochistic personality disorder scales, as well as the Axis I Post-Traumatic Stress Disorder (PTSD) scale in the MCMI-III, all of which had been absent from the first edition of the MCMI. Thus, these latter developed scales were not evaluated in the previous research discussed.

In their initial group comparisons of the personality disorder scales, Ahlmeyer et al. (2003) acknowledged that the Antisocial and Narcissistic scales had the highest mean scores for all groups (as well as the Depressive Scale for the child molesters); however, they also reported that the mean profiles of the child molesters and nonsexual offenders seemed to differ the most, with the latter group scoring significantly higher on the Histrionic, Narcissistic, and Antisocial scales. In terms of the Clinical Syndrome scales, the researchers described that the child molesters produced greater means on more of the scales than the other two groups. In fact, the researchers highlight that the Drug Abuse scale was the only Axis I scale to yield a significantly higher mean score for nonsexual offenders as compared to the other groups.

With regard to the prevalence of scale elevations, Ahlmeyer et al. (2003) found that, for each group, there were several scales with 20% or more of the group members exhibiting clinical elevations. Specifically, for the nonsexual offender sample these scales included the Antisocial,

Avoidant, Narcissistic, and Negativistic personality disorder scales, as well as on the Anxiety and Alcohol Abuse Clinical Syndrome scales. For the rapist and child molester groups, each had 20% or more of their group members obtain clinical elevations on the Avoidant, Depressive, Antisocial, Negativistic, Anxiety, and Alcohol Abuse scales. The child molesters also had clinical elevations on the Dependent and Dysthymia scales.

After merging the rapists and child molester groups into a single sex offender sample for comparison to the nonsexual offenders, the researchers (Ahlmeyer et al., 2003) completed a multivariate regression analysis using only personality disorder scales and identified the Dependent, Narcissistic, Antisocial, and Schizotypal scales as being most significant in predicting sex offender status. In particular, the authors described that high scores on Dependent and Schizotypal were associated with sex offender status, whereas high scores on Narcissistic and Antisocial were associated with being a nonsexual offender. Furthermore, in their comparison of the rapist and child molester groups, multivariate analysis revealed that only the Dependent scales was significantly predictive of child molester status, with high scores representing a higher likelihood of group membership.

Ahlmeyer et al. (2003) concluded that nonsexual offenders appear to possess “more ‘classic’ criminal personality styles” (p. 315), as well as greater rates of substance abuse, whereas the sexual offenders in this study displayed a broader array of psychological problems, including more Axis I pathology. Additionally, with regard to Axis I pathology, the researchers asserted, “the ‘neurotic’ trend from nonsexual offenders to sexual offenders generally continues when the sex offenders are differentiated into the two groups” (Ahlmeyer et al., 2003, p. 315). Also worthy of note, the researchers pointed out that all of the more recently added MCMI scales, including Depressive, Sadistic, Masochistic, and PTSD scales, contributed to

distinguishing between offender groups. (Please refer to Appendix B for a concise table summary of key findings from Ahlmeyer et al. (2003) and the other reviewed studies that specifically compared child molesters, rapists, and nonsexual offenders.)

The Ahlmeyer et al. (2003) study is the only one that employed the original MCMI-III to examine differences between samples of sexual and nonsexual offenders. This is especially relevant to research in this area because the MCMI-III was renormed in 2008 (Millon et al., 2009), after this latest publication (the Ahlmeyer et al., 2003 study). Millon et al. (2009) explained that the renorming of the MCMI-III served to, "...reflect changes in the test scores obtained by clinical patients and/or in their clinical characteristics over the 15 years since the test was developed" (p. 115). Thus, all of the previously described studies (including that of Ahlmeyer et al., 2003) were based on the norms used in developing the original MCMI. With the updated norms now in place, Millon et al. (2009) predicted an increase in the number of test takers with elevations on the Major Depression, Bipolar, and Drug Dependence scales, as well as a decrease in the number of elevations on the Masochistic scale.

Given the limited research on MCMI profile differences of sexual offenders and nonsexual offenders, and the absence of studies with the renormed MCMI-III, further investigation was essential. Additionally, none of these studies on sexual offenders have used any measure of recidivism tendencies. Thus, this present study served to expand on the methodology of previous work using another sample of offenders; the most current, renormed version of the MCMI-III (Millon et al., 2009); and a measure of recidivism risk, the Static-99 (Hanson & Thornton, 2000). Congruent with what has been recognized in previous studies of this kind (Ahlmeyer et al., 2003; Bard & Knight, 1987; and Chantry & Craig, 1994b), the results

of this present study could have significant implications for the way in which we conceptualize and assign offenders to therapy and other rehabilitation services.

Anticipated Outcomes

To recap, this present study incorporated two separate methodological approaches for identifying any possible personality and/or acute clinical differences between a specific subgroup of sexual offenders and a group of nonsexual offenders, as well as within a diverse group of sexual offenders. The first of these approaches grouped offenders based on their offense type, statistically comparing child molesters to nonsexual violent offenders and attempting to identify what (if any) MCMI-III scales best predict membership into these groups. Considering the relative lack of literature in this specific area, this research was exploratory in nature. However, it was anticipated that the results of the study would be consistent with previous studies, particularly those of Chantry and Craig (1994b) and Ahlmeyer et al. (2003). Specifically, it was anticipated that child molesters would exhibit significantly higher mean scores on the Dependent, Schizoid, Avoidant, Depressive, Borderline, Schizotypal, Masochistic (Self-Defeating), and Negativistic (Passive-Aggressive) personality disorder scales, and the Dysthymia, Anxiety, Major Depression, Thought Disorder, Post-Traumatic Stress Disorder, and Somatoform Clinical Syndrome scales, as compared to the nonsexual violent offenders, who were anticipated to show more signs of antisocial, histrionic, narcissistic, and paranoid personality features, as well as greater signs of drug dependence.

The second methodological approach of the present research grouped the subjects according to their respective Static-99 scores. This grouping allowed for comparison between a higher recidivism risk group and a lower risk group. Subsequent regression analyses assessed the ability of the MCMI-III scales to predict sexual offender Static-99 scores. It was anticipated

that the Axis II Antisocial, Histrionic, and Narcissistic scales would be associated with increasing Static-99 score, and that the higher risk group would tend to show more signs of these personality features than the lower risk group, who would show more signs of Axis I pathology.

CHAPTER TWO

METHOD

Participants and Setting

The present study involved the use of archival data, originally collected from adult male offenders who were newly admitted to a Midwestern maximum-security state prison as part of a routine reception and diagnostic process. This initial intake processing typically occurred within two weeks of each offender's arrival to the facility and generally included mental health testing using the MCMI-III, as well as recidivism risk assessment, measured by the Static-99, of any offenders with an identified past or index sexual offense. (The term "index" refers to the offense for which the offender was currently incarcerated.) Appendix C provides a complete listing of data sources referenced for the present study.

An initial sample of 340 subject cases fit the broader study parameters of either (a) having a past or index adult conviction for a sexual offense, potentially qualifying the subject case for classification as a sexual offender, or (b) having a past or index adult conviction for a violent offense without any sexual offense history, potentially meeting the study criteria for classification as a nonsexual violent offender. However, 22 of these initial 340 subject cases did not meet the study's finer requirements for inclusion. Namely, subject cases were excluded if (a) they had a juvenile sexual offense conviction and no other adult sexual offense conviction (regardless of whether they also had an adult conviction for a violent offense); (b) they were adjudicated as an adult for a sexual offense committed as a juvenile (when they were less than 18 years of age) and had no other adult sexual offense convictions (again, regardless of whether they also had an adult conviction for a violent offense); (c) there was clear indication through official documentation that an offender accepted a plea bargain reducing a sexual offense to a

conviction for a nonsexual offense, and they had no other adult sexual offense convictions; (d) there was missing information verifying the nature (sexual or violent) of the index offense and/or the criminal history; and (e) the case's MCMI-III profile was found to be invalid due to raw scores less than 34 or greater than 178 on the Disclosure (X) scale, greater than 1 on the Invalidity (V) scale, or greater than 9 on the Inconsistency (W) scale (as described in the testing manual (Millon et al., 2009); see the "Measures" section and Appendix D for more information as to the nature of these scales). As implied, offender cases with juvenile sexual offense histories were only included in the present study if they also had at least one conviction for an adult sexual offense. In essence, these finer inclusion requirements were used as a means of ensuring a relatively "clean" sample of sexual and nonsexual violent offenders.

The resulting total subject sample ($N = 318$) was composed of 191 nonsexual violent offenders, with histories (past or present) of at least one adult conviction for a violent offense and no sexual offenses; 101 child molesters, with histories of at least one adult conviction for a sexual offense against a child (or children) age 15 or below, and no other types of sexual offense convictions with victims outside of this age range; 18 rapists, with histories of at least one adult conviction for a sexual offense against a person (or persons) age 16 or older, and no other types of sexual offenses with victims outside of this age range; 5 sexual offenders of unknown subtype, with histories of at least one adult conviction for a sexual offense, as well as a Static-99 score, but no other information as to their sexual offense; and 3 mixed sexual offenders, with histories of at least one adult conviction for a sexual offense involving both adult and child victims in the same or different cases. (Visual depictions regarding the composition of these offender subtypes can be found in Figures 1 and 2.) Based on available data, the total subject sample was predominantly Caucasian (50.47%); had a mean age of 32.61 years; reached an average

educational attainment of almost 11 years; and were mostly never married. The following table and figures provide more detailed information pertaining to the age range distribution (Figure 3), educational profile (Table 1), racial profile (Figure 4), and relational status (Figure 5) of the total subject sample.

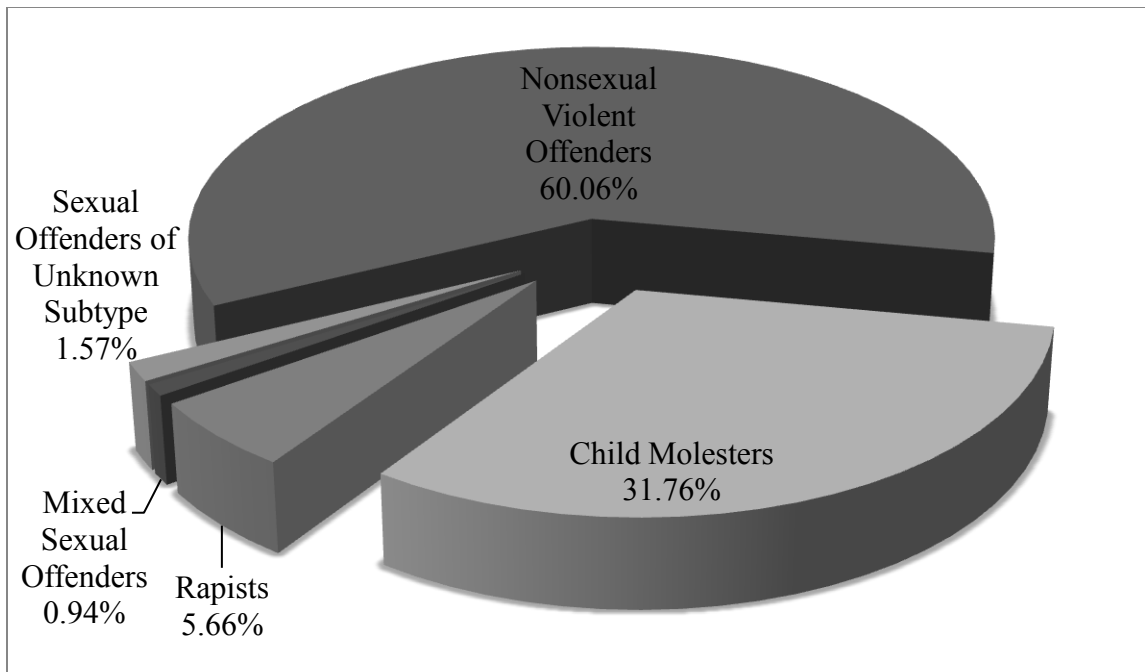


Figure 1. Percentages of offender subtypes in total offender sample ($N = 318$). Mixed sexual offenders include inmates with histories of sexual offenses against both adult and child victims. Sexual offenders of unknown subtype refer to offenders with at least one identifiable sexual offense, but for whom no information regarding victim age was obtained.

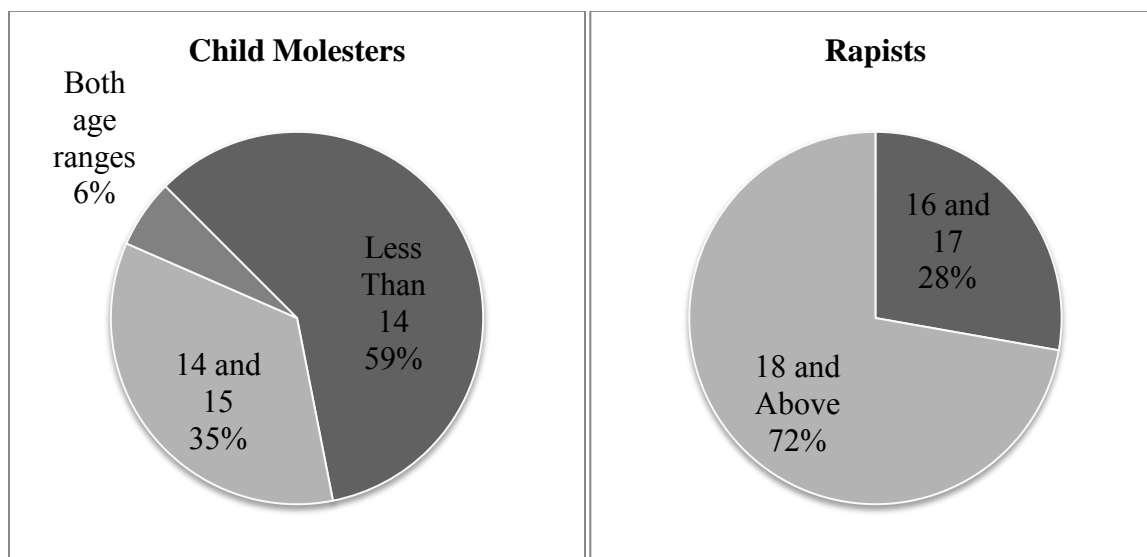


Figure 2. Composition of child molester and rapist subtypes. Right chart includes percentages of child molesters whose sex offenses involved victims less than age 14 only, ages 14 and/or 15 only, or victims that span both of these age ranges ($n = 101$). Left chart includes percentages of rapists whose sex offenses involved victims age 16 and/or 17, or victims age 18 or above ($n = 18$).

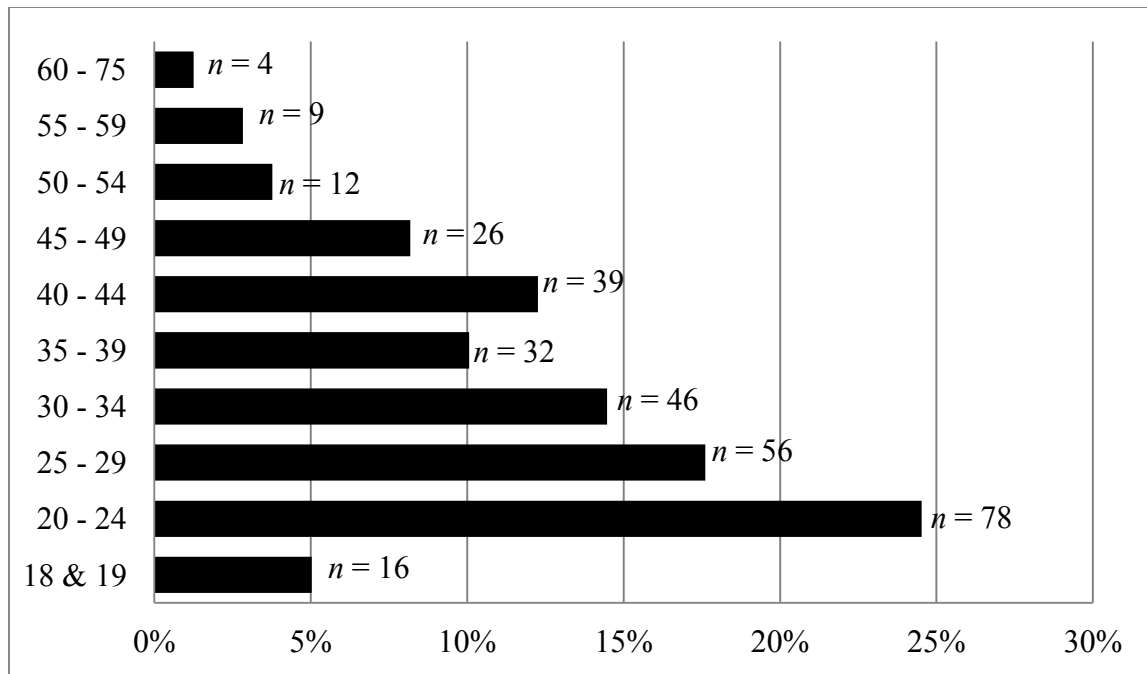


Figure 3. Age distribution of total offender sample ($N = 318$). Number of offenders (n) falling within each age range is listed to the right of each respective bar in the graph.

Table 1

Highest Level of Education Completed Among Total Offender Sample

Years of Education Completed	Frequency	Percent of Sample ^a
7 or Less	9	2.83%
8	25	7.86%
9	25	7.86%
10	47	14.78%
11	58	18.24%
12	121	38.05%
13	9	2.83%
14	9	2.83%
15 and 16	7	2.20%
Greater than 17	3	0.94%
Unknown	5	1.57%

Note. None of the subjects ($N = 318$) were found to have completed exactly 17 years of education.

^aCalculations were based on total sample size and have been rounded.

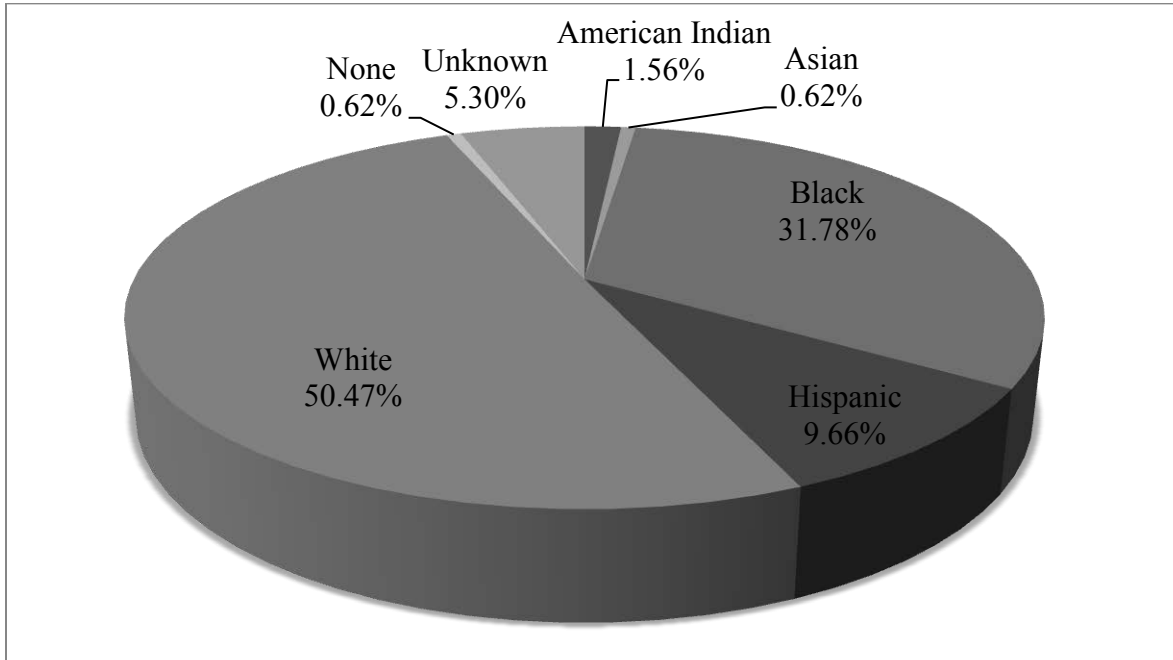


Figure 4. Racial profile of total offender sample ($N = 318$) according to designations on the MCMI-III.

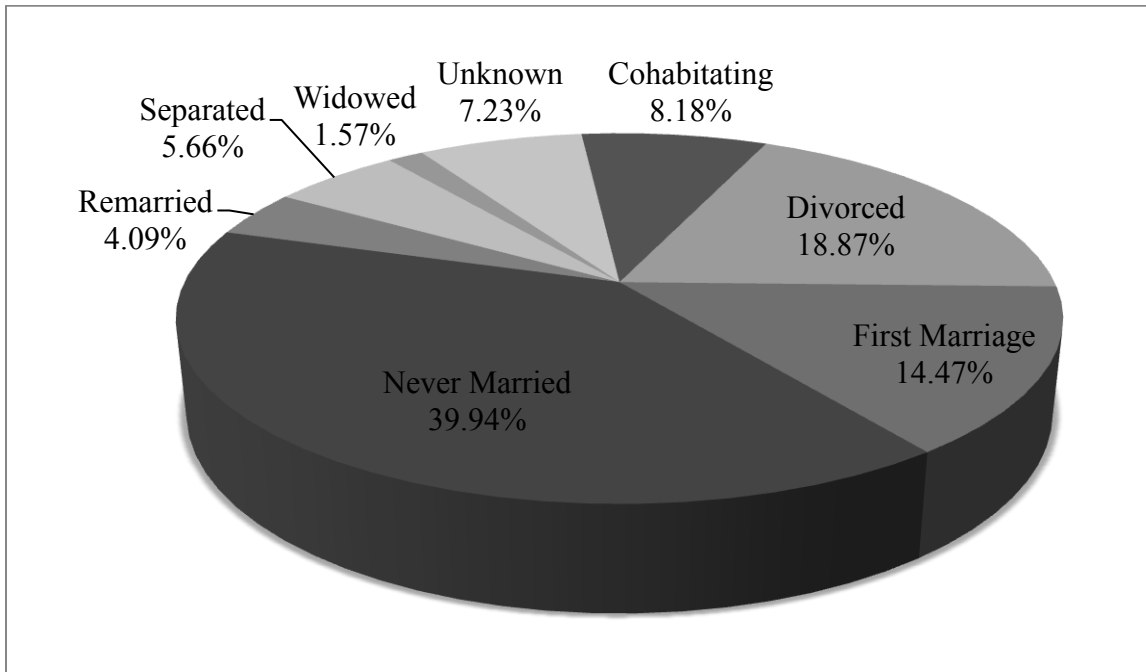


Figure 5. Relationship status profile of total offender sample ($N = 318$).

Data Collection Procedures

Permission was granted from the internal review boards of both Wichita State University and the Kansas Department of Corrections (KDOC) prior to gathering the archival data from within the mental health reception unit of the prison at which it was stored. During the collection process, the archival data were de-identified and transferred by hand from the servers and appropriate computer programs at the prison onto KDOC-approved removable storage devices. In particular, offender records were scoured for relevant study information which, as described earlier, included MCMI-III profile and (for sex offenders) Static-99 data, originally obtained as part of a routine prison intake process/evaluation. Additionally, collaborative archival information pertaining to the offenders' general demographics and their criminal histories (including the index offense(s) for which they presented to the reception unit and, for sex offenders, information on the sex and age of their victim(s)) was gathered from a state electronic repository and prison-wide offender information system, also operated by the KDOC. (As mentioned previously, a listing of data sources consulted for the present study is reported in Appendix C.)

Importantly, it should be noted that the personality assessment data obtained from the KDOC were based on the original MCMI-III, prior to the renorming of the instrument in 2008. As such, during the data cleaning and screening phase of this study, syntax was created to convert the raw scores of the collected original MCMI-III data to the BR scores reflective of the updated, collapsed-gender norms, according to transformation information provided in the *MCMI-III Manual Fourth Edition* (Millon et al., 2009). The subsequent section describes the renormed MCMI-III measure upon which the results of the present study are based.

Measures

Millon Clinical Multiaxial Inventory-III (MCMI-III). Based largely on the classification system of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*; APA, 1994), the MCMI-III is a self-report assessment instrument that consists of 175 True/False items measuring both acute psychopathology and long-standing personality dispositions (Millon et al., 2009). As such, this psychodiagnostic instrument provides a profile of the respondent's scores on a number of scales, including those that represent Axis I and Axis II symptomology. The Axis I scales include the Clinical Syndromes of Anxiety (Scale A), Somatoform (Scale H), Bipolar: Manic (Scale N), Dysthymia (Scale D), Alcohol Dependence (Scale B), Drug Dependence (Scale T), and Post-Traumatic Stress Disorder (Scale R), as well as the Severe Clinical Syndromes of Thought Disorder (Scale SS), Major Depression (Scale CC), and Delusional Disorder (Scale PP).

The Axis II scales include the Clinical Personality Patterns of Schizoid (Scale 1), Avoidant (Scale 2A), Depressive (Scale 2B), Dependent (Scale 3), Histrionic (Scale 4), Narcissistic (Scale 5), Antisocial (Scale 6A), Sadistic (Aggressive; Scale 6B), Compulsive (Scale 7), Negativistic (Passive-Aggressive; Scale 8A) and Masochistic (Self-Defeating; Scale 8B), as well as the Severe Personality Pathology scales of Schizotypal (Scale S), Borderline (Scale C), and Paranoid (Scale P; Millon et al., 2009). As indicated by their titles, Millon et al. (2009) considered the Axis I Severe Clinical Syndromes and Axis II Severe Personality Pathology scales as reflecting a greater level of pathology than the other scales of each respective Axis (including those subsumed under Clinical Syndromes and Clinical Personality Patterns). Additional information about the response style of the test taker can be gleaned from the Modifying Indices (Disclosure (Scale X), Desirability (Scale Y), and Debasement (Scale Z)) and

Random Response Indicator scales (Invalidity (V) and Inconsistency (W)). Please refer to Appendix D for a list of scale descriptions, as well as Appendix E for an example of a MCMI-III profile page.

As listed in the *Manual* (Millon et al., 2009), the internal consistency of the Axis I scales (measured using Cronbach's Alpha) was lowest for Bipolar: Manic (N; $r = .71$) and highest for Major Depression (CC; $r = .90$), which was also the highest of all the clinical scales (Millon et al., 2009). The test-retest reliabilities for the Axis I scales range from $r_{tt} = .84$ on Anxiety (A) to $r_{tt} = .96$ on Somatoform (H). Of the Axis II scales, alpha values range from $r = .66$ for the Compulsive (7) scale to $r = .89$ for both the Avoidant (2A) and Depressive (2B) scales, and the stability estimates range from $r_{tt} = .85$ for the Paranoid (P) scale to $r_{tt} = .93$ for the Depressive (2B), Antisocial (6A), and Borderline (C) scales. For more information, please refer to the *MCMI-III Manual*.

STATIC-99. The Static-99 (Hanson & Thornton, 2000) is an empirically derived risk assessment rating scale measure used to gauge the likelihood of sexual and violent recidivism among adult males (Hanson & Thornton, 2000; Harris et al., 2003). As such, this instrument can be used to inform the management/supervision and treatment of sexual offenders, so as to decrease their risk of sexual reoffending (Harris et al., 2003). It is composed of 10 items, assessing the following static, or stable, risk factors: (a) being a young offender (greater than or equal to age 18, but less than age 25); (b) never having sustained at least two years of cohabitation with an intimate adult partner; (c) having any nonsexually violent index convictions; (d) having any past nonsexually violent convictions; (e) having a history of sex offenses; (f) having (four or more) previous sentencing dates; (g) having any non-contact sex offense convictions; (h) having sexually victimized an unrelated individual; (i) having sexually

victimized a stranger; and (j) having sexually victimized a male. This instrument can be administered through an interview with the offender; however, scoring for many items, in most cases, requires official sources of information. As such, an informed observer scores this instrument based on extant behavioral data. Please refer to Harris et al. (2003) for a Static-99 Coding Form.

Each endorsed item is scored 1 point (indicating the presence of that risk factor), with the exception of Item 5 (or, if using the original coding rules in Hanson and Thornton (2000), Item 1), which inquires about number of past sexual offenses and can be scored from 0 to 3 (Harris et al., 2003). Thus, total Static-99 scores can range from 0 to 12, with higher scores generally indicating a greater probability of specific recidivism risk than lower scores corresponding to the same follow-up period (Hanson & Thornton, 2000; Harris et al., 2003). According to the original norms upon which this instrument was developed, and with specific regard to sexual recidivism over a period of five years, scores of 0 or 1 indicate “Low” risk, or an average 5% to 6% chance of re-offense; scores of 2 or 3 reflect “Moderate-Low” risk, or 9% to 12% chance of re-offense; scores of 4 or 5 refer to “Moderate-High” risk, or 26% to 33% chance of re-offense; and scores of 6 or greater indicate “High” risk, or an average re-offense rate of 39% or more. The 10-year sexual recidivism rate ranges for Static-99 risk categories (based on the original norming sample) include 7% to 11% for those who score “Low” risk; 13 to 14% for those who score “Moderate-Low” risk; 31% to 38% for those who score “Moderate-High” risk; and 45% or more for those who “High” risk. Finally, the 15-year original norm sexual recidivism rate ranges for Static-99 risk categories include 7% to 13% for those who score “Low” risk; 16% to 19% for those who score “Moderate-Low” risk; 36% to 40% for those who score “Moderate-High” risk;

and 52% or more for those who “High” risk. (Harris et al. (2003) explain that recidivism estimates for scores above 6, “High” risk, did not demonstrate any significant increases.)

The Static-99 has since been renormed on larger samples, which utilized logistic regression techniques and resulted in specific delineated recidivism range estimates for the individual scores of this assessment measure (Helmus, Hanson, & Thornton, 2009). As such, over a 5-year period, the newer sexual recidivism ranges for the broader (relative) risk categories include 2.3% to 10.3% for those who score “Low” risk; 4.3% to 15.7% for those who score “Moderate-Low” risk; 7.7% to 23.1% for those who score “Moderate-High” risk; and 13.4% to 50% for those who score “High” risk. The 10-year sexual recidivism ranges for these categories include 1.8% to 15.8% for “Low” risk offenders; 3.9% to 23.0% for “Moderate-Low” risk offenders; 8.2% to 32.1% for Moderate-High risk offenders; and 16.7% to 59.9% for “High-Risk” offenders. A more specific breakdown of these sexual recidivism ranges according to individual score, as well as additional information pertaining to the updated risk estimates for violent recidivism can be found in Helmus et al. (2009). (For information about violent recidivism according to the original norms, please refer to Hanson and Thornton (2000) and Harris et al. (2003)).

Upon development of the Static-99, Hanson and Thornton (2000) found the instrument’s ability to accurately predict sexual recidivism, as measured by the Receiver Operating Characteristic (ROC) area, to be .71 ($r = .33$) or of “moderate” accuracy. This accuracy rating was the same for rapists (ROC = .71), and close to that of child molesters (ROC = .72). Prediction accuracy of any type of violent recidivism, including that which is sexual, was also identified, with ROC = .69 and $r = .32$ (Hanson & Thornton, 2000). Similarly, Harris et al. (2003) report ROC values from several replication studies on the Static-99, resulting in a mean

ROC of approximately .72. With regard to inter-rater reliability, Harris et al. (2003) also provide estimates calculated by three independent studies, ranging from Average Item Kappa = .80 to $r = .96$.

CHAPTER THREE

RESULTS

First Methodological Approach

Descriptive statistics were examined to glean a better understanding of offender MCMI-III profile data. Figures 6 and 7 visually depict the mean scores of the three major types of offender subgroups—child molesters, rapists, and nonsexual violent offenders—on each of the Axis II and Axis I scales. (Consistent with the presentation of scales on an MCMI-III profile page, results of each statistical procedure will generally first be described for the Axis II scales followed by the Axis I scales.) Means of the other two subgroups, the mixed sexual offenders ($n = 3$) and sexual offenders of unknown subtype ($n = 5$) can be found in Appendix F.

As shown in Figure 6, among the Axis II scales, the child molester subgroup scored highest on Antisocial (mean BR score = 61.95) and lowest on Sadistic (mean BR score = 44.84). The greatest mean BR scores of both rapists and nonsexual violent offenders occurred on the Narcissistic scale (63.39 and 69.03, respectively); however, the rapist subgroup scored lowest on the Schizotypal scale (mean BR score = 39.50), while the nonsexual violent offenders produced their lowest mean score on the Depressive scale (32.63). In terms of the Axis I scales, depicted in Figure 7, Somatoform was identified as the scale for which the lowest mean BR scores were produced by all three subgroups (child molesters (35.00), rapists (26.50), and nonsexual violent offenders (21.44)). The child molester and nonsexual violent offender subgroups also shared Drug Dependence as the scale on which their highest mean BR scores occurred (60.24 and 65.19, respectively), while the rapist subgroup produced their highest mean BR score on the Alcohol Dependence scale (59.22). Out of all the Axis II and I scales, none of the mean scores of any offender subgroup reached clinical significance (i.e., BR score of at least 75).

Due to the lack of statistical power associated with the small sample size of rapists ($n = 18$), this subgroup was not included in the following quantitative statistical techniques of this methodological approach; however, a qualitative discussion regarding some of the more salient observations of this subgroup is provided in the following chapter.

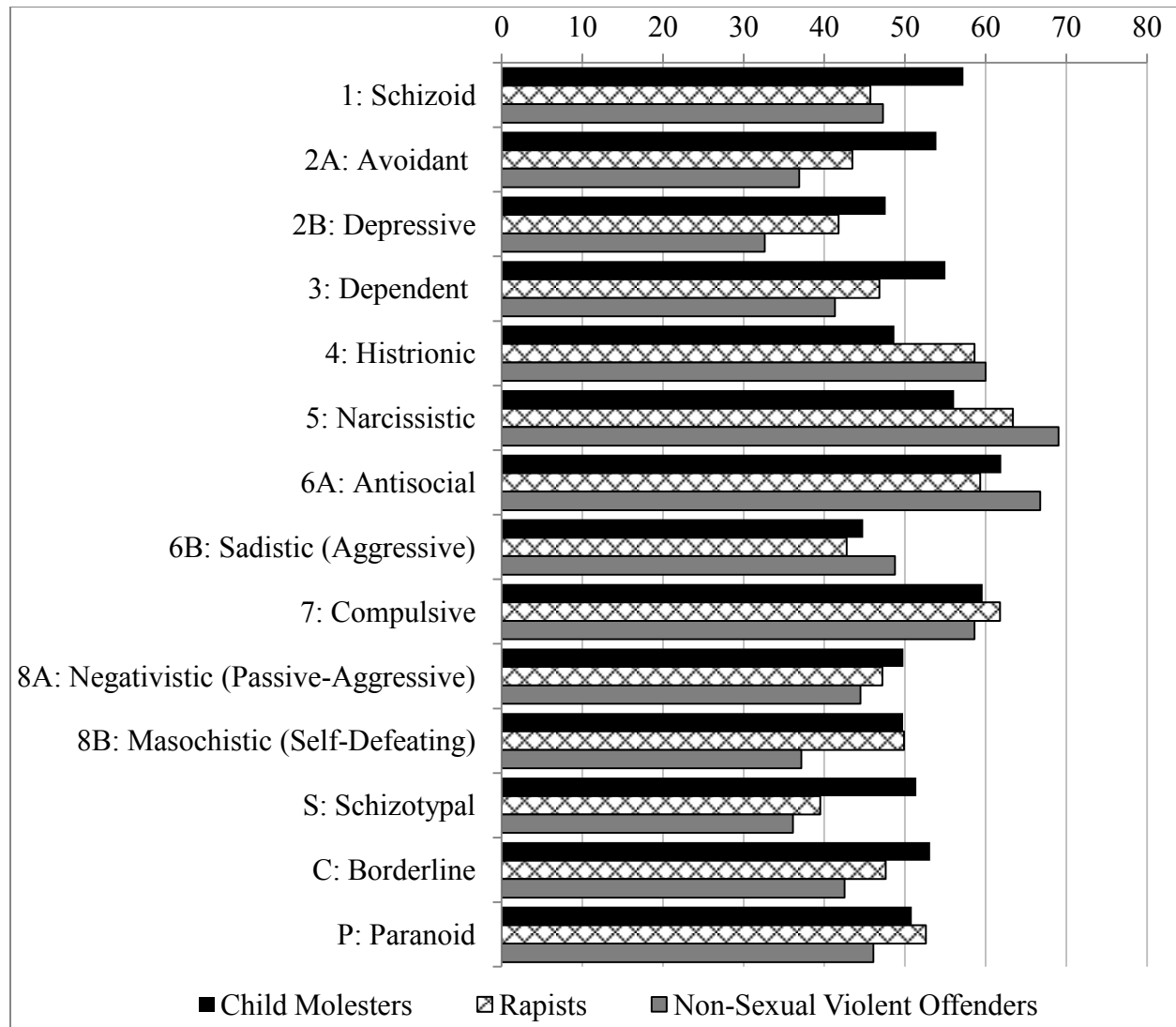


Figure 6. Mean MCMI-III BR scores by offender type on the Clinical Personality Patterns and the Severe Personality Pathology scales. Statistics included $n = 310$ cases ($n = 191$ nonsexual violent offenders, $n = 101$ child molesters, and $n = 18$ rapists; mixed sexual offenders ($n = 3$) and sexual offenders of unknown subtype ($n = 5$) are excluded from this visual display).

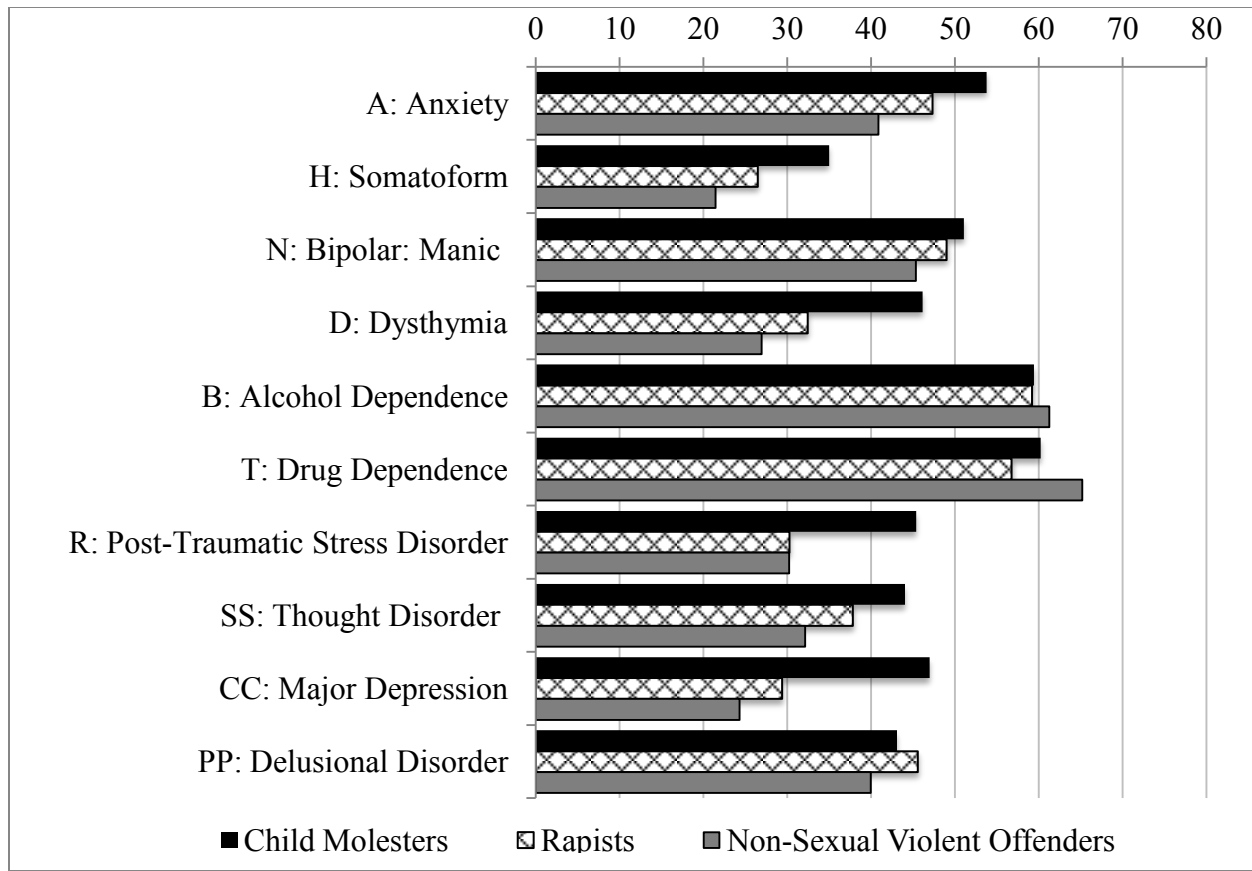


Figure 7. Mean MCMI-III BR scores by offender type on the Clinical Syndromes and the Severe Clinical Syndromes scales. Statistics included $n = 310$ cases ($n = 191$ nonsexual violent offenders, $n = 101$ child molesters, and $n = 18$ rapists; mixed sexual offenders ($n = 3$) and sexual offenders of unknown subtype ($n = 5$) are excluded from this visual display).

Independent Samples T-Tests. Independent samples t-tests were conducted to identify any significant differences in the mean BR scores produced by the nonsexual violent offender and child molester subgroups on each scale of the MCMI-III. This particular statistical technique was preferred for its ability to perform comparisons when data do not meet the assumption of homogeneity of variance, as was the case with a number of the present study's models (namely, in group comparisons on the Axis II scales of Avoidant, Depressive, Dependent, Histrionic, and Compulsive, as well as the Axis I scales of Somatoform and Major Depression). To gauge the reliability/meaningfulness of statistically significant results, effect sizes were calculated using

Cohen's *d*. Tables 2 and 3 summarize results of all of the comparisons on each of the Axis II and Axis I scales, respectively.

Among the Axis II scales, the most statistically reliable differences were found for comparisons on the Narcissistic ($d = .72$) and Histrionic ($d = .65$) scales, with the nonsexual violent offenders producing significantly greater mean BR scores than the child molesters. The former subgroup also scored significantly higher than the latter subgroup on the Antisocial scale, ($d = .31$); however, the remaining significant comparisons reflect higher scores by the child molesters. In particular, the child molester subgroup scored significantly higher than the nonsexual violent offender subgroup on the Avoidant ($d = .51$), Dependent ($d = .48$), Schizotypal ($d = .47$), Depressive ($d = .43$), Masochistic (Self-Defeating; $d = .38$), Schizoid ($d = .37$), and Borderline ($d = .36$) scales.

Several statistically reliable differences were also found between both groups on the Axis I scales. All of these differences reflected significantly greater BR scores by child molesters, and included the scales of Major Depression ($d = .67$), Dysthymia ($d = .62$), Post-Traumatic Stress Disorder ($d = .49$), Somatoform ($d = .49$), Thought Disorder ($d = .40$), and Anxiety ($d = .35$).

Table 2

Summary of Mean BR Score Differences Between Nonsexual Violent Offenders and Child Molesters on MCMI-III Axis II Scales

Scales	Nonsexual Violent Offenders		Child Molesters		Mean Difference	<i>t</i>	<i>p</i> ^b	Cohen's <i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>				
1: Schizoid	47.28	25.96	57.24	29.54	-9.96	-2.97	.003**	.37
2A: Avoidant	36.91	31.44	53.89	36.40	-16.98	-3.97 ^a	.000***	.51
2B: Depressive	32.63	33.44	47.62	37.35	-15.00	-3.38 ^a	.001**	.43
3: Dependent	41.31	27.21	55.03	31.51	-13.72	-3.71 ^a	.000***	.48
4: Histrionic	59.99	15.95	48.69	19.70	11.30	4.97 ^a	.000***	.65
5: Narcissistic	69.03	17.35	56.08	18.81	12.95	5.89	.000***	.72
6A: Antisocial	66.79	18.17	61.95	20.21	4.83	2.08	.038*	.31
6B: Sadistic (Aggressive)	48.78	24.88	44.84	25.44	3.94	1.28	.203	
7: Compulsive	58.62	16.51	59.64	13.11	-1.03	-0.58 ^a	.562	
8A: Negativistic (Passive-Aggressive)	44.47	29.66	49.80	30.51	-5.34	-1.45	.149	
8B: Masochistic (Self-Defeating)	37.17	31.52	49.78	35.70	-12.61	-3.11	.002**	.38
S: Schizotypal	36.10	31.46	51.41	33.87	-15.30	-3.85	.000***	.47
C: Borderline	42.53	28.77	53.12	30.02	-10.59	-2.95	.003**	.36
P: Paranoid	46.09	30.42	50.84	31.27	-4.75	-1.26	.210	

Note. Analyses included $n = 191$ nonsexual violent offenders and $n = 101$ child molesters for all scales. Table values have been rounded. Degrees of freedom for each comparison equaled 290.

^aComparison is based on unequal population variances. ^bTwo-tailed p values are reported.

* $p \leq .05$. ** $p \leq .005$. *** $p \leq .001$.

Table 3

Summary of Mean BR Score Differences Between Nonsexual Violent Offenders and Child Molesters on MCMI-III Axis I Scales

Scales	Nonsexual Violent Offenders		Child Molesters		Mean Difference	<i>t</i>	<i>p</i> ^b	Cohen's <i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>				
A: Anxiety	40.88	35.82	53.77	39.12	-12.89	-2.83	.005**	.35
H: Somatoform	21.44	26.02	35.00	31.22	-13.56	-3.73 ^a	.000***	.49
N: Bipolar: Manic	45.33	27.06	51.08	26.86	-5.75	-1.73	.084	
D: Dysthymia	26.94	29.87	46.16	33.54	-19.22	-5.01	.000***	.62
B: Alcohol Dependence	61.28	21.56	59.45	25.68	1.83	0.65	.519	
T: Drug Dependence	65.19	20.99	60.24	22.60	4.95	1.87	.063	
R: Post-Traumatic Stress Disorder	30.23	29.64	45.38	33.72	-15.15	-3.96	.000***	.49
SS: Thought Disorder	32.13	29.10	44.05	31.95	-11.92	-3.22	.001**	.40
CC: Major Depression	24.29	31.14	46.97	38.76	-22.68	-5.08 ^a	.000***	.67
PP: Delusional Disorder	39.98	30.00	43.08	32.31	-3.09	-0.82	.415	

Note. Analyses included $n = 191$ nonsexual violent offenders and $n = 101$ child molesters for all scales. Table values have been rounded. Degrees of freedom for each comparison equaled 290.

^aComparison is based on unequal population variances. ^bTwo-tailed p values are reported.

* $p \leq .05$. ** $p \leq .005$. *** $p \leq .001$.

Logistic Regressions. Logistic regression procedures were conducted to explore which, if any, MCMI-III scales were predictive of membership into either the nonsexual violent offender or child molester subgroups. Specifically, logistic regressions were completed for both sets of Axis II and Axis I scales separately, utilizing the MCMI-III scales as the predictor variables in each regression model, with offender subtype (nonsexual violent offender and child molester) serving as the dependent variable. Tables 4 and 5 summarize the results of the first full model, using all Axis II scales only, and Tables 6 and 7 show the results of the second full model, using all Axis I scales only.

In the first full model, offender status was significantly predicted by the set of Axis II scales, omnibus $\chi^2 = 68.44$, $df = 14$, $p < .001$. The model explained 20.9% to 28.8% of the variance among offender status, resulting in an overall predictive accuracy of 72.9%. As indicated in Table 4, 167 of the 191 nonsexual violent offenders (87.4%) were correctly classified, but only 55 of the 101 child molesters (45.5%) were classified accurately.

Based on the individual statistical contributions by each of the Axis II scales described in Table 5, only the Borderline ($\chi^2 = 9.69$, $df = 1$, $p = .002$), Antisocial ($\chi^2 = 5.72$, $df = 1$, $p = .017$), Narcissistic ($\chi^2 = 4.12$, $df = 1$, $p = .042$), and Schizotypal ($\chi^2 = 4.02$, $df = 1$, $p = .045$) scales were identified as significant predictors of offender status. In particular, increasing BR scores on the Antisocial and Narcissistic scales indicated decreased likelihood of classification as a child molester, such that an increase in one unit on either of these scales is associated with decreased odds of classification to this subgroup by factors of .97 and .98, respectively. Increasing BR scores on the Borderline and Schizotypal scales indicated decreased likelihood of classification as a nonsexual violent offender, such that an increase in one unit on either of these scales is

associated with decreased odds of classification to this subgroup by factors of 1.03 and 1.02, respectively.

Offender status was also significantly predicted in the second model (using only Axis I scales; omnibus $\chi^2 = 52.12$, $df = 10$, $p < .001$), which explained between 6.3% to 22.6% of the variance among this dependent variable and resulted in an overall predictive accuracy of 72.3%. Similar to the first model, the second model correctly predicted 165 of the 191 nonsexual violent offenders (86.4%), but only 55 of the 101 child molesters (45.5%; see Table 6). As shown in Table 7, Drug Dependence ($\chi^2 = 9.155$, $df = 1$, $p = .002$), Major Depression ($\chi^2 = 6.39$, $df = 1$, $p = .011$), and Dysthymia ($\chi^2 = 4.54$, $df = 1$, $p = .033$) were the only significant individual predictors of offender status in this model. More specifically, increasing BR scores on the Drug Dependence scale indicated decreased likelihood of classification as a child molester, such that an increase in one unit on this scale is associated with decreased odds of classification of this subgroup by a factor of .97. Increasing scores on the Dysthymia and Major Depression scales indicated decreased likelihood of classification as a nonsexual violent offender, such that an increase in one unit on either of these scales is associated with decreased odds of classification to this subgroup by factors of 1.03 and 1.02, respectively.

Table 4

Offender Type Classification Predictions by MCMI-III Axis II Scales

Observed Offender Groups	Predicted Offender Group Membership	
	Violent Offenders	Child Molesters
Violent Offenders	87.4% ^a	12.6%
Child Molesters	54.5%	45.5% ^a

Note. Analyses included $n = 191$ nonsexual violent offenders and $n = 101$ child molesters. Overall percentage of Observed Offender Groups correctly predicted is 72.9%.

^aPercentage of correct group predictions.

Table 5

Prediction Contributions of MCMI-III Axis II Scales Toward Offender Type

Predictors	<i>B</i>	Wald Chi-Square	<i>p</i>	Odds Ratio	95% CI for Odds Ratios	
					Lower	Upper
1: Schizoid	0.00	0.01	.906	1.00	0.98	1.02
2A: Avoidant	0.00	0.08	.784	1.00	0.98	1.02
2B: Depressive	-0.01	0.68	.409	0.99	0.98	1.01
3: Dependent	0.01	1.82	.177	1.01	1.00	1.03
4: Histrionic	-0.01	0.51	.476	0.99	0.96	1.02
5: Narcissistic	-0.02	4.12	.042*	0.98	0.95	1.00
6A: Antisocial	-0.03	5.72	.017*	0.97	0.94	0.99
6B: Sadistic (Aggressive)	-0.01	1.29	.255	0.99	0.97	1.01
7: Compulsive	0.01	0.69	.408	1.01	0.99	1.04
8A: Negativistic (Passive-Aggressive)	0.00	0.05	.816	1.00	0.98	1.02
8B: Masochistic (Self-Defeating)	0.00	0.22	.639	1.00	0.98	1.01
S: Schizotypal	0.02	4.02	.045*	1.02	1.00	1.04
C: Borderline	0.03	9.69	.002**	1.03	1.01	1.06
P: Paranoid	-0.01	1.49	.222	0.99	0.97	1.01

Note. Analyses included $n = 191$ nonsexual violent offenders and $n = 101$ child molesters for all scales. Table values have been rounded. CI = confidence interval.

^aDegrees of freedom for each predictor equaled 1.

* $p \leq .05$. ** $p \leq .005$. *** $p \leq .001$.

Table 6

Offender Type Classification Predictions by MCMI-III Axis I Scales

Observed Offender Groups	Predicted Offender Group Membership	
	Violent Offenders	Child Molesters
Violent Offenders	86.4% ^a	13.6%
Child Molesters	54.5%	45.5% ^a

Note. Analyses included $n = 191$ nonsexual violent offenders and $n = 101$ child molesters. Overall percentage of Observed Offender Groups correctly predicted is 72.3%.

^aPercentage of correct group predictions.

Table 7

Prediction Contributions of MCMI-III Axis I Scales Toward Offender Type

Predictors ^a	<i>B</i>	Wald Chi-Square	<i>p</i>	Odds Ratio	95% CI for Odds Ratios	
					Lower	Upper
A: Anxiety	0.00	0.00	.950	1.00	0.99	1.02
H: Somatoform	-0.01	1.43	.231	1.00	0.97	1.01
N: Bipolar: Manic	0.01	3.54	.060	1.01	1.00	1.03
D: Dysthymia	0.02	4.54	.033*	1.02	1.00	1.03
B: Alcohol Dependence	-0.01	1.19	.275	0.99	0.98	1.01
T: Drug Dependence	-0.03	9.55	.002**	0.97	0.96	0.99
R: Post-Traumatic Stress Disorder	0.00	0.00	.964	1.00	0.98	1.02
SS: Thought Disorder	-0.01	1.06	.304	0.99	0.97	1.01
CC: Major Depression	0.03	6.39	.011*	1.03	1.01	1.02
PP: Delusional Disorder	-0.01	1.38	.240	0.99	0.98	1.00

Note. Analyses included $n = 191$ nonsexual violent offenders and $n = 101$ child molesters for all scales. Table values have been rounded. CI = confidence interval.

^aDegrees of freedom for each predictor equaled 1.

* $p \leq .05$. ** $p \leq .005$. *** $p \leq .001$.

Second Methodological Approach

As described previously, in this approach, all of the sex offenders with available Static-99 data (including child molesters, rapists, mixed sexual offenders, and sexual offenders of unknown subtype) were divided into one of two groups based on their total Static-99 scores. This allowed for a total of 120 sexual offenders (out of a possible 127 sexual offenders) to be included in the analyses to follow. The resulting groups distinguished between offenders who scored 3 or below on the Static-99, termed the lower risk group, and offenders who scored above 3, or the higher risk group. This particular point of division separating the two risk groups was chosen on the basis of its correspondence to the Static-99's demarcation between "Moderate-Low" and "Moderate-High" score descriptors.

The mean BR scores of these two groups on each of the Axis II and Axis I scales are visually depicted in Figures 8 and 9, respectively. None of the mean BR scores of any offender subgroup reached a level of clinical significance (BR score of at least 75). The lower risk group produced their highest mean BR scores on the Axis II Compulsive scale (61.80) and the Axis I Alcohol Dependence scale (56.73). Alcohol Dependence was also found to be the most elevated Axis I scale for the higher risk group (BR = 68.36), although for the Axis II scales, this group produced their greatest mean BR score on Antisocial (69.61). In terms of lowest BR scores produced by each group on the Axis II scales, the Sadistic (42.77) scale was identified for the lower risk group, while the higher risk group scored equally low on the Masochistic (Self-Defeating) and Schizotypal scales (48.86). Among the Axis I scales, both the lower risk and higher risk groups produced their lowest BR scores on Somatoform (35.50 and 35.19, respectively).

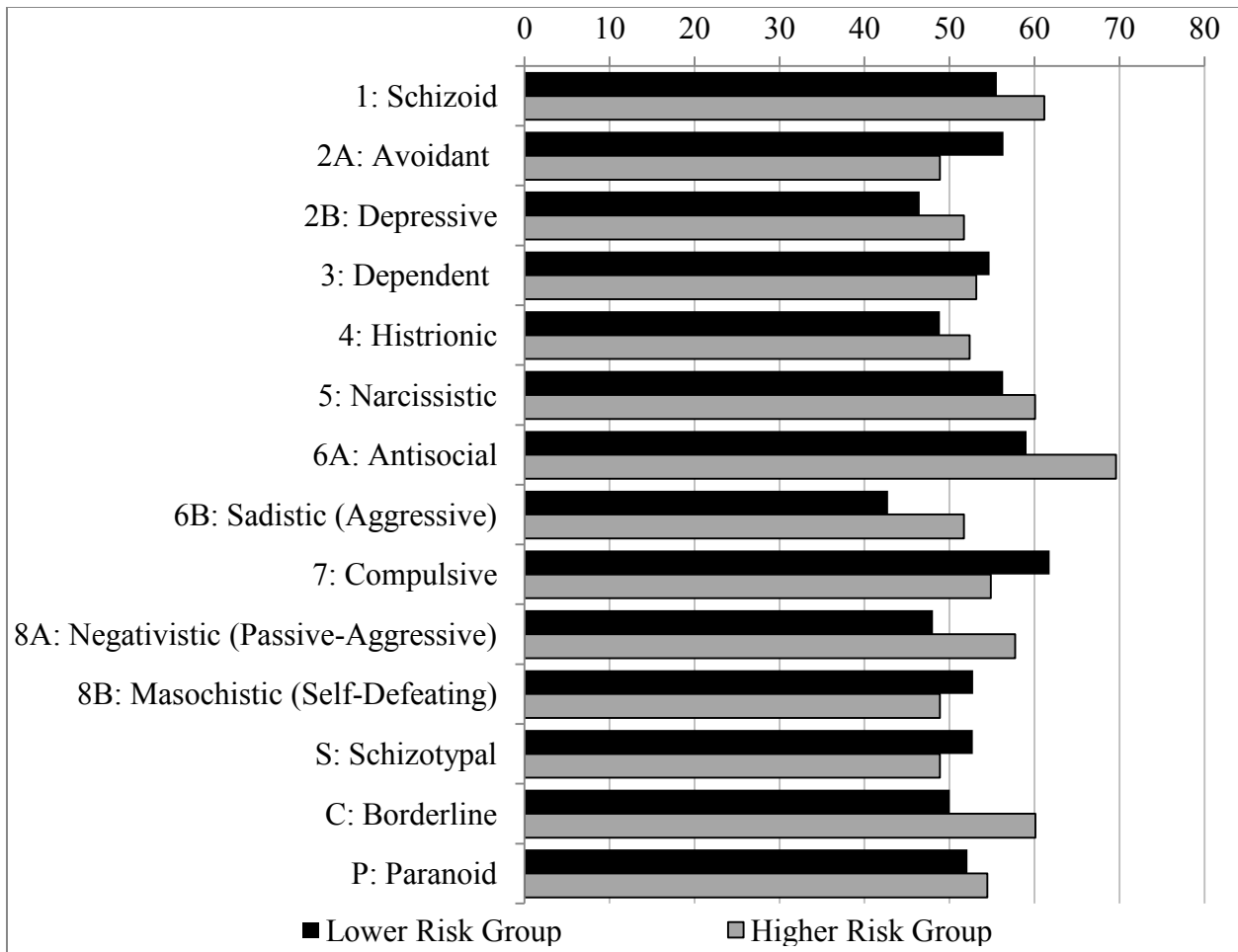


Figure 8. Mean MCMI-III BR scores by offender risk group (higher risk group or lower risk group) on the Clinical Personality Patterns and the Severe Personality Pathology scales. Statistics included $n = 120$ cases ($n = 84$ lower risk sexual offenders and $n = 36$ higher risk sexual offenders).

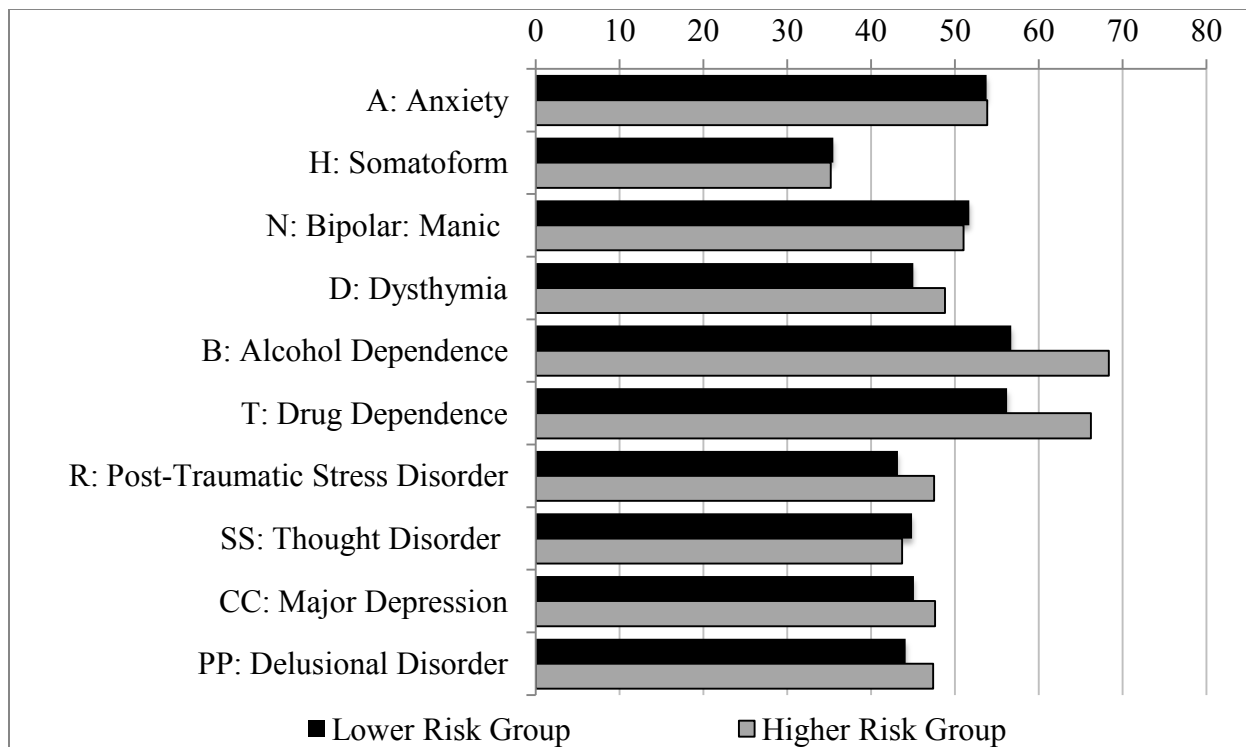


Figure 9. Mean MCMI-III BR scores by offender risk group (higher risk group or lower risk group) on the Clinical Syndromes and the Severe Clinical Syndromes scales. Statistics included $n = 120$ cases ($n = 84$ lower risk sexual offenders and $n = 36$ higher risk sexual offenders).

Independent Samples T-Tests. To identify any significant differences in the mean BR scores produced by the lower risk group as compared to the higher risk group of sexual offenders for each scale of the MCMI-III, a series of separate independent samples t-tests were completed. As in the first approach of this study, effect sizes were calculated using Cohen's d , to gain a better understanding of the reliability/meaningfulness of statistically significant results. Tables 8 and 9 summarize results of all of the comparisons on Axis II and Axis I scales, respectively. It should be noted that some of the models conducted in the present study did not meet the assumption of homogeneity of variance, including comparisons on the Schizoid, Antisocial, Sadistic, Negativistic (Passive-Aggressive), Borderline, Alcohol Dependence, and Drug Dependence scales, and in such cases, results are based on an assumption of unequal variances across the grouping variable of offender risk status.

Mean scores on only 2 of the Axis II scales—Antisocial and Compulsive—were found to be significantly different between the risk status groups. In particular, the higher risk group produced significantly greater mean BR scores than the lower risk group on the Antisocial scale, while the lower risk group scored, on average, significantly greater on the Compulsive scale. Both observed differences were of medium effect ($d = .51$), suggesting that these findings are moderately reliable.

In terms of the Axis I scales, only differences on the Alcohol Dependence and Drug Dependence scales were identified as significant. Base Rate score means of the higher risk group were significantly greater than those of the lower risk group on both of these scales. Furthermore, these differences can be considered reliable, as the effect sizes for comparisons on each scale (Alcohol Dependence $d = .45$ and Drug Dependence $d = .44$) were approaching Cohen's medium classification.

Table 8

Summary of Mean BR Score Differences Between Lower and Higher Risk Sexual Offenders on MCMI-III Axis II Scales

Scales	Lower Risk Sexual Offenders		Higher Risk Sexual Offenders		Mean Difference	<i>t</i>	<i>p</i> ^b	Cohen's <i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>				
1: Schizoid	55.57	31.57	61.14	25.89	-5.57	-1.01 ^a	.316	
2A: Avoidant	56.35	35.46	48.89	37.56	7.46	1.04	.302	
2B: Depressive	46.48	37.57	51.72	40.34	-5.25	-0.69	.494	
3: Dependent	54.71	31.46	53.17	32.52	1.55	0.24	.807	
4: Histrionic	48.89	20.55	52.39	18.45	-3.50	-0.88	.381	
5: Narcissistic	56.31	18.69	60.08	19.15	-3.77	-1.01	.316	
6A: Antisocial	59.08	22.88	69.61	14.88	-10.53	-2.99 ^a	.004**	.51
6B: Sadistic (Aggressive)	42.77	26.52	51.72	22.03	-8.95	-1.91 ^a	.059	
7: Compulsive	61.80	12.87	54.86	14.83	6.94	2.58	.011*	.51
8A: Negativistic (Passive- Aggressive)	48.05	32.58	57.72	25.29	-9.67	-1.76 ^a	.083	
8B: Masochistic (Self-Defeating)	52.80	35.06	48.86	37.15	3.94	0.55	.581	
S: Schizotypal	52.74	33.63	48.86	33.82	3.88	0.58	.565	
C: Borderline	50.04	32.33	60.11	27.32	-10.08	-1.75 ^a	.084	
P: Paranoid	52.10	30.67	54.44	30.01	-2.35	-0.39	.699	

Note. Analyses included $n = 84$ lower risk sexual offenders and $n = 36$ higher risk sexual offenders for all scales. Table values have been rounded. Degrees of freedom for each comparison equaled 118.

^aComparison is based on unequal population variances. ^bTwo-tailed p values are reported.

* $p \leq .05$. ** $p \leq .005$. *** $p \leq .001$.

Table 9

Summary of Mean BR Score Differences Between Lower and Higher Risk Sexual Offenders on MCMI-III Axis I Scales

Scales	Lower Risk Sexual Offenders		Higher Risk Sexual Offenders		Mean Difference	<i>t</i>	<i>p</i> ^b	Cohen's <i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>				
A: Anxiety	53.77	40.00	53.86	38.07	-0.09	-0.11	.991	
H: Somatoform	35.50	32.30	35.19	32.01	0.31	0.05	.962	
N: Bipolar: Manic	51.71	25.99	51.03	28.46	0.69	0.13	.898	
D: Dysthymia	45.04	35.49	48.83	34.94	-3.80	-0.54	.590	
B: Alcohol Dependence	56.73	27.76	68.36	20.70	-11.63	-2.54 ^a	.013*	.45
T: Drug Dependence	56.24	24.79	66.22	17.68	-9.98	-2.50 ^a	.014*	.44
R: Post-Traumatic Stress Disorder	43.19	35.40	47.53	33.63	-4.34	-0.62	.534	
SS: Thought Disorder	44.89	32.04	43.69	30.87	1.20	0.19	.853	
CC: Major Depression	45.10	39.68	47.64	38.39	-2.54	-0.33	.746	
PP: Delusional Disorder	44.13	32.24	47.42	32.76	-3.29	-0.51	.612	

Note. Analyses included $n = 84$ lower risk sexual offenders and $n = 36$ higher risk sexual offenders for all scales. Table values have been rounded. Degrees of freedom for each comparison equaled 118.

^aComparison is based on unequal population variances. ^bTwo-tailed p values are reported.

* $p \leq .05$. ** $p \leq .005$. *** $p \leq .001$.

Multiple Linear Regressions. Due to the inadequate ratio of predictors to cases comprising the lower risk sexual offender group, Logistic Regression techniques were not used in the second methodological approach of this study. Instead, lower risk and higher risk groups were collapsed, and attempts were made to discover which, if any, MCMI-III scales significantly contributed to the prediction of sexual offender Static-99 scores through multiple regression analyses employing the enter method. Separate regression models were run for each set of predictor variables, the Axis II and Axis I scales, with sexual offender Static-99 scores used as the criterion variable in both models. Tables 10 and 12 display the descriptive statistics and predictor contributions for the Axis II and Axis I scales, respectively. Bivariate correlations between each predictor are reported for each model in Tables 11 and 13.

The model utilizing Axis II scales as predictors was significant, $F(14, 105) = 2.11, p = .017$; however, it accounted for just 11.5% (Adjusted R^2) of the variance in sexual offender Static-99 scores ($R = .47; R^2 = .22$). As shown in Table 10, the Antisocial scale was the only statistically significant individual predictor ($t(118) = 2.06, p = .041$), with a bivariate correlation of .26 and partial correlation of .20. As such, it is indicated that an increase on this scale is associated with an increase in Static-99 score, though the importance of this predictor is clouded by its correlations with the other Axis II predictors (See Table 11).

The multiple regression model including Axis I scales as predictors was not found to be significant, $F(10, 109) = 1.19, p = .308$. Nevertheless, as mentioned above, the results and bivariate correlations for this model are provided in Tables 12 and 13.

Table 10

Descriptive Statistics and Predictive Contributions of MCMI-III Axis II Scales Toward Static-99 Score

Predictors	<i>M</i>	<i>SD</i>	Correlations		Standardized	<i>t</i>	<i>p</i>
			Bivariate	Partial	Coefficient β		
1: Schizoid	57.24	29.98	.05	.12	0.24	1.28	.202
2A: Avoidant	54.11	36.11	-.14	-.12	-0.29	-1.23	.223
2B: Depressive	48.05	38.33	.00	.12	0.25	1.21	.229
3: Dependent	54.25	31.65	-.03	-.05	-0.08	-0.49	.623
4: Histrionic	49.94	19.93	.13	.08	0.16	0.83	.411
5: Narcissistic	57.44	18.83	.18	.08	0.11	0.79	.430
6A: Antisocial	62.24	21.30	.26	.20	0.33	2.06	.041*
6B: Sadistic (Aggressive)	45.45	25.50	.11	-.18	-0.31	-1.87	.065
7: Compulsive	59.72	13.80	-.15	-.07	-0.09	-0.71	.480
8A: Negativistic (Passive-Aggressive)	50.95	30.79	.08	.04	0.08	0.39	.700
8B: Masochistic (Self-Defeating)	51.62	35.59	-.07	-.17	-0.35	-1.79	.076
S: Schizotypal	51.58	33.59	-.03	.05	0.10	0.54	.591
C: Borderline	53.06	31.15	.14	.12	0.25	1.19	.237
P: Paranoid	52.80	30.37	.00	-.02	-0.04	-0.23	.821

Note. Criterion variable is sexual offender Static-99 score. Analyses included $n = 120$ sexual offenders. Table values have been rounded.

* $p \leq .05$. ** $p \leq .005$. *** $p \leq .001$.

Table 11

Correlations Among MCMI-III Axis II Scale Predictor Variables Used in Multiple Linear Regression Analysis

Predictors	1	2A	2B	3	4	5	6A	6B	7	8A	8B	S	C	P
1: Schizoid	—													
2A: Avoidant	.76	—												
2B: Depressive	.71	.82	—											
3: Dependent	.58	.70	.80	—										
4: Histrionic	-.75	-.75	-.63	-.49	—									
5: Narcissistic	-.32	-.48	-.43	-.34	.65	—								
6A: Antisocial	.49	.38	.49	.43	-.21	.00	—							
6B: Sadistic (Aggressive)	.57	.46	.61	.48	-.32	.00	.76	—						
7: Compulsive	-.41	-.36	-.43	-.38	.43	.39	-.56	-.45	—					
8A: Negativistic (Passive- Aggressive)	.72	.68	.76	.65	-.49	-.19	.61	.73	-.47	—				
8B: Masochistic (Self-Defeating)	.69	.82	.81	.74	-.54	-.36	.54	.57	-.44	.77	—			
S: Schizotypal	.75	.83	.72	.61	-.65	-.30	.39	.46	-.35	.69	.76	—		
C: Borderline	.70	.66	.78	.70	-.51	-.28	.70	.73	-.58	.82	.78	.66	—	
P: Paranoid	.73	.74	.73	.66	-.50	-.14	.49	.59	-.26	.81	.74	.76	.67	—

Note. Analyses included $n = 120$ sexual offenders. Table values have been rounded. No correlations between different scales exceeded +/- .83.

Table 12

Descriptive Statistics and Prediction Contributions of MCMI-III Axis I Scales Toward Static-99 Score

Predictors	<i>M</i>	<i>SD</i>	Correlations		Standardized	<i>t</i>	<i>p</i>
			Bivariate	Partial	Coefficient β		
A: Anxiety	53.80	39.27	-.02	-.07	-.14	-0.75	.455
H: Somatoform	35.41	32.08	-.02	-.04	-.09	-0.38	.707
N: Bipolar: Manic	51.51	26.64	.04	-.10	-.14	-1.04	.301
D: Dysthymia	46.18	35.22	-.03	-.09	-.19	-0.93	.354
B: Alcohol Dependence	60.22	26.31	.20	.13	.17	1.38	.171
T: Drug Dependence	59.23	23.27	.22	.15	.19	1.57	.119
R: Post-Traumatic Stress Disorder	44.49	34.79	.01	.04	.09	0.40	.691
SS: Thought Disorder	44.53	32.28	.02	.08	.16	0.80	.426
CC: Major Depression	45.86	39.16	-.03	.00	-.01	-0.02	.985
PP: Delusional Disorder	45.12	32.29	.10	.09	.12	0.94	.351

Note. Criterion variable is sexual offender Static-99 score. Analyses included $n = 120$ sexual offenders. Table values have been rounded. No significant contributions were found.

Table 13

Correlations Among MCMI-III Axis I Scale Predictor Variables Used in Multiple Linear Regression Analysis

Predictors	A	H	N	D	B	T	R	SS	CC	PP
A: Anxiety	—									
H: Somatoform	.75	—								
N: Bipolar: Manic	.50	.47	—							
D: Dysthymia	.71	.80	.50	—						
B: Alcohol Dependence	.36	.36	.52	.42	—					
T: Drug Dependence	.37	.37	.43	.35	.60	—				
R: Post-Traumatic Stress Disorder	.85	.78	.54	.79	.45	.44	—			
SS: Thought Disorder	.77	.75	.63	.81	.39	.34	.78	—		
CC: Major Depression	.77	.90	.42	.87	.37	.32	.82	.80	—	
PP: Delusional Disorder	.56	.58	.52	.54	.37	.41	.47	.61	.53	—

Note. Analyses included $n = 120$ sexual offenders. Table values have been rounded. No correlations between different scales exceeded +/- .90.

CHAPTER FIVE

DISCUSSION

This exploratory research was intended to contribute to the limited existing literature using MCMI assessment data from incarcerated sexual offenders. The purpose of this study was to further our understanding of the underlying personality structures and inclinations toward various types of clinical distress that may present among different subgroups of these offenders. Two separate methodological approaches were incorporated. First, inferential statistics compared offenders based on their offense type (child molesters as compared to nonsexual violent offenders), and next, sexual offenders were grouped and compared based on their recidivism tendencies, as measured by the Static-99 (lower risk sexual offenders as compared to higher risk sexual offenders).

It was anticipated that the first methodological approach would replicate outcomes largely consistent with the findings of both the Chantry and Craig (1994b) and the Ahlmeyer et al. (2003) studies. (Please refer to Appendix B for a concise summary of these studies.) That is, it was anticipated that the convicted child molesters would have higher scores than the nonsexual violent offenders on the MCMI Axis II scales Dependent, Schizoid, Avoidant, Depressive, Borderline, Schizotypal, Masochistic (Self-Defeating), and Negativistic (Passive-Aggressive), as well as on the Axis I scales of Dysthymia, Anxiety, Major Depression, Thought Disorder, Post-Traumatic Stress Disorder, and Somatoform. Conversely, it was anticipated that the nonsexual violent offenders would score higher on the MCMI Axis II scales Narcissistic, Histrionic, Antisocial, and Paranoid, as well as the Axis I Drug Dependence scale.

Independent samples t-tests were generally in line with these predictions. Child molesters scored significantly higher on the Axis II scales of Avoidant, Dependent, Schizotypal,

Depressive, Masochistic (Self-Defeating), Schizoid, and Borderline (Cohen's *d* values ranging from .51 to .36), whereas the nonsexual violent offender group scored significantly higher on the Narcissistic, Histrionic and Antisocial scales (Cohen's *d* values ranging from .72 to .31). All of the significant differences between these two groups on the Axis I scales, including Major Depression, Dysthymia, Post-Traumatic Stress Disorder, Somatoform, Thought Disorder, and Anxiety, reflected higher scores by the child molesters (Cohen's *d* values ranging from .67 to .35).

In general, these results appear to be mostly consistent with the findings of similar comparisons completed in the previous literature. For example, as displayed in Table 14, the present study replicates Chantry and Craig's (1994b) findings of significantly higher scores by child molesters on the Avoidant and Borderline scales, although Ahlmeyer et al. (2003) did not. However, this study is consistent with Ahlmeyer et al.'s (2003) findings of higher scores among the child molesters on Masochistic (Self-Defeating), Schizotypal, Somatoform, and Post-Traumatic Stress Disorder, as well as higher scores among the nonsexual offenders on the Histrionic and Antisocial scales, which were not identified by Chantry and Craig (1994b). The only findings observed in these past studies that were not also identified in the present study included significantly greater means by the child molesters on the Negativistic (Passive-Aggressive) scale, reported by Chantry and Craig (1994b); significantly greater means by nonsexual offenders on the Compulsive and Paranoid scales, also found by Chantry and Craig (1994b); and significantly greater means by the nonsexual offenders on the Drug Dependence scales, as reported by Ahlmeyer et al. (2003).

Table 14

Comparison of Present Research Results to Past Studies Using Similar Offender Types

Scales	Significantly Greater Scores by Child Molesters			Significantly Greater Scores by Nonsexual Offenders		
	Chantry and Craig (1994b) ^a	Present Study ^b	Ahlmeyer et al. (2003) ^c	Chantry and Craig (1994b) ^a	Present Study ^b	Ahlmeyer et al. (2003) ^c
1: Schizoid	X	X	X			
2A: Avoidant	X	X				
2B: Depressive		X	X			
3: Dependent	X	X	X			
4: Histrionic					X	X
5: Narcissistic				X	X	X
6A: Antisocial					X	X
6B: Sadistic (Aggressive)						
7: Compulsive				X		
8A: Negativistic (Passive-Aggressive)	X					
8B: Masochistic (Self-Defeating)		X	X			
S: Schizotypal		X	X			
C: Borderline	X	X				
P: Paranoid				X		
A: Anxiety	X	X	X			
H: Somatoform		X	X			
N: Bipolar: Manic						
D: Dysthymia	X	X	X			
B: Alcohol Dependence						
T: Drug Dependence						X
R: Post-Traumatic Stress Disorder		X	X			
SS: Thought Disorder	X	X	X			
CC: Major Depression	X	X	X			
PP: Delusional Disorder						

Note.

^aStudy used original MCMI; nonsexual offenders had violent crimes. ^bStudy used renormed MCMI-III; nonsexual offenders had violent crimes. ^cStudy used MCMI-III, prior to the 2008 renorming; nonsexual offenders had violent or nonviolent crimes.

It should be noted that the present study also recognized and attempted to control for possible covariates that could have affected MCMI scale scores, including age and educational level, as indicated by previous literature (Chantry & Craig, 1994b; Langevin et al., 1988). In particular, prior to conducting the independent samples t-tests, analysis of covariance (ANCOVA) procedures were executed, the results of which are listed in Appendix G. As shown, no significant covariates were found for the Axis I scales. With regard to the Axis II scales, offender age was identified as a significant covariate on the Narcissistic and Negativistic (Passive-Aggressive) scales, and offender educational level was identified as a significant covariate on the Negativistic (Passive-Aggressive) and Paranoid scales; however, out of these three scales (with identified significant covariates), only the Narcissistic scale produced a significant overall between-subjects effect. Congruent with the aforementioned results of a t-test comparison for this scale, results of this particular ANCOVA also identified significantly higher BR scores by the nonsexual violent offenders than by the child molesters on the Narcissistic scale, even when the variability in offender age between groups was controlled.

Logistic regression analyses were also generally consistent with t-test results, providing a slightly different perspective with which to view these groups of offenders. There was an association between increasing BR scores on the Antisocial, Narcissistic, and/or Drug Dependence scales, and decreased likelihood that an offender would be classified as a child molester. Additionally, higher MCMI scores on the Borderline, Schizotypal, Dysthymia, and/or Major Depression scales were associated with a decreased likelihood of classification as a nonsexual violent offender.

By synthesizing the results of this first approach, a general picture begins to emerge regarding the intrinsic factors that distinguish the sexual-offending subtype of child molesters

from that of other offenders who have directly (and violently) infringed upon the rights of others in a nonsexual manner. While neither group produced clinically elevated profile means, child molesters appear more inclined to exhibit a greater variety of maladaptive characterological features, most of which suggest less ego strength and more of an internalizing system of psychological coping mechanisms, as well as an increased disposition toward experiencing a broader array of clinical distress. Although their greatest (subclinical) mean scores for each set of scales occurred on Antisocial and Drug Dependence, perhaps the more telling story of this group is that the greatest number of *individual* clinically elevated scores were on the Avoidant and Anxiety scales, accounting for almost 39% and 50% of the offenders within this sample, respectively.

In contrast, the nonsexual violent offenders seem more aptly described by their externalizing, potentially dominating, features of personality, with little experiential distress serving to taper such qualities. That stated, for each set of scales, the greatest (yet subclinical) mean BR score for this group occurred on the Narcissistic and Drug Dependence scales. Bolstering this observation, these two scales were also identified as those for which the greatest number of individual group members (slightly over 36% and almost 41%, respectively) scored at clinically elevated levels.

Thus, while both of these groups of offenders have demonstrated dangerous/criminal behaviors, it may be the case that differences in the nature of their deviant behaviors (sexual vs. nonsexual) is, to some extent, driven by slightly different internal constructs, including the way in which the individual offender perceives and approaches his world, as well as his sexual proclivities. Whereas the average nonsexual violent offender seems more likely to exhibit egotism and lack empathy for others, the typical child molester may possess a rather negative,

vulnerable sense of self, possibly viewing himself as inadequate, and appearing to be somewhat of a loner—though not necessarily by choice. It is possible that he is insecure and cynical of others, demonstrating an inclination to prematurely act out in his own interests, as a means of protecting himself from potential emotional pain. Importantly however, it should be noted that neither of these mean profiles produced BR scores that reflect clinical elevations, and thus, the results of this testing alone would not support diagnosis of any personality or acute clinical disorder for the average nonsexual violent offender or child molester.

Although the small sample size of the rapist subgroup did not allow for inferential comparisons among the other two offender groups, a few salient observations were drawn from the profiles of these individuals. First, within each set of Axis II and I scales, they tended to have elevated Avoidant and Drug Dependence scales (with approximately 33% and 39% of this sample's offenders producing a BR score of 75 or greater, respectively). Next, similar to the average nonsexual violent offender, the average rapist involved in this study generated his highest means (for each set of scales) on Narcissistic and Alcohol Dependence, though his profile did not reveal any mean BR scores reaching a level of clinical significance. As such, it appears that the typical rapist included in this study may have a history of problems related to his use of alcohol and may exhibit some signs of self-centeredness and arrogance, as well as exploitative behaviors; however, as previously mentioned, the average rapist in this study does not meet the threshold for diagnosis of any of these Axis I or II issues, at least based on his (average) MCMI-III profile.

With regard to the second methodological approach, it was only generally anticipated that greater signs of antisocial, histrionic, and narcissistic personality features would be exhibited by the higher risk group, while more signs of acute distress would be shown by the lower risk

group. Results of this approach provide only partial support of these anticipations. In particular, statistical comparisons of the subclinical profile means produced by each of these groups revealed that the lower risk group scored significantly higher on the Axis II scale Compulsive (Cohen's $d = .51$), while the higher risk group scored significantly greater on the Axis II Antisocial scale and the Axis I scales of Alcohol and Drug Dependence (Cohen's d values ranging from .51 to .44). Multiple regression analyses also indicated that an increase in BR score on the Antisocial scale is associated with an increase in offender Static-99 score.

The finding that an antisocial construct is associated with recidivism is not necessarily surprising, given the work of Hanson and Bussière (1998) and Hanson and Morton-Bourgon (2005), discussed previously. However, these data provide yet another piece of evidence linking recidivism with Antisocial Personality Disorder. It is also it another example of the severity of this disorder with regard to criminal behavior. Additionally, the finding that the lower risk group had higher means on the Compulsive scale may be understood by Millon's (Millon et al., 2009) explanation that this scale tends to measure an inclination to respond to the test questions in a socially desirable manner. Persons who have a high score on this scale tend to be overly perfectionistic and rule observant, and Millon teaches that these individuals may also show signs of internal anger toward others, yet fear social condemnation. Altogether, these results were not necessarily distinctly impressive, but they did provide some relevant information that otherwise may not have been identified.

Limitations of the Present Study

Arguably one of the greatest limitations of the current study is the exclusion of the rapist subgroup from inferential analyses of the first methodological approach. The inadequate sample size of this subgroup, and thus, lack of associated statistical power, precluded accurate and

meaningful comparison and prediction of group membership between this and the other two major subgroups (child molesters and nonsexual violent offenders). As such, although clinically significant differences were identified between the child molester and nonsexual violent offender subgroups, this study is unable to provide a comprehensive picture of the relationship (or lack thereof) between all three major types of offenders.

Another limitation of the present study has to do with the sample sizes of the remaining offender subgroups. In the logistic regression analyses used to predict offender status (child molester or nonsexual violent offender) from the Axis II and Axis I MCMI-III scales, there was a less-than-ideal ratio of child molester cases to predictor variables (7.2:1 ratio in first full model using the Axis II scales, and a 10.1:1 ratio in the second full model using the Axis I scales), which likely contributed to each model's correctly classifying only 45.5% of the child molesters. In addition to (and possibly exacerbated by) this lack of power, it may also be the case that there are common characteristics shared by both the child molesters and nonsexual violent offenders, or an unknown construct specific to the child molesters, which have prevented accurate classification of this group.

While it would have been desirable to have been able to conduct logistic regressions in the second methodological approach of this study, using the lower and higher risk groups as the criterion variables, the sizes of these groups prevented such analyses. Although, multiple regressions analyses were completed by collapsing the data of these two groups (the overall sexual offender sample), only the Axis II model was significant, and within this model, only the Antisocial scale was shown to be predictive. Although this individual predictor makes sense given what has been described about the Static-99, as mentioned in the previous chapter, the

exact meaningfulness of this particular scale is unclear, given the correlations among the predictor variables.

Future Research Directions

Considering the relative dearth of literature examining the personality patterns of sexual offenders using the MCMI assessments (especially the updated and re-normed MCMI-III), it is obvious that we need more empirical studies of these individuals. Future studies may also consider elaborating/extending the second methodological approach of the present study, in terms of incorporating a recidivism risk assessment measure by which to group offender data. While the present study utilized the Static-99, as this was the particular measure employed at the facility through which this study data were collected, succeeding versions of this assessment have been developed, including the Static- 2002 (Hanson & Thornton, 2003), Static-99R, and Static-2002R (Helmus, Thornton, Hanson, & Babchishin, 2012), and other measures, such as the Minnesota Sex Offender Screening Tool-Revised (MnSOST-R; Epperson, Kaul, Huot, Goldman, & Alexander, 2003), the Sexual Violence Risk 20 (SVR-20; Boer, Hart, Kropp, & Webster, 1997) or the Hare Psychopathy Checklist-Revised (PCL-R; Hare, 2003), could also be used in a study to gauge personality and acute clinical differences between those offenders deemed to be at higher and lower recidivism risk levels.

Implications of the Present Research

In accordance with what has been acknowledged in previous research (Ahlmeier et al., 2003; Bard & Knight, 1987; and Chantry & Craig, 1994b), the present study may also prove useful to those responsible for managing/providing supervision or rehabilitation/treatment services to identified sexual offenders. In particular, the present study indicates the potential usefulness of therapies designed to address the Axis I distress that child molesters entering the

prison system may be experiencing. However, for those sexual offenders who are at a higher risk of re-offense, as well as other offenders with significant signs of narcissistic and/or antisocial personality tendencies (or disorders) but little acute distress, it is also suggested that treatment focus more on the consequences of the offender's behavior, rather than the development of empathy for those whom they have offended against.

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FOOTNOTES

Footnotes

¹ While the recently released *DSM-5* does not group diagnoses according to an axial system, the authors of this dissertation chose to retain the terminology, “Axis I” and “Axis II,” to conveniently (and briefly) differentiate between psychiatric disorders of an acute nature and more chronic personality problems.

² According to the diagnostic criteria of the *DSM-IV-TR*, “Transvestic Fetishism” is restricted to heterosexual males (APA, 2000). This specific restriction does not appear in the criteria of the *DSM-5*, but it does report the prevalence of disorder as being extremely rare in females (APA, 2013).

³ Bard and Knight’s (1987) use of the descriptor, “healthy,” refers specifically to their finding that this particular group of offenders showed no clinical elevations on the MCMI (that is, no BR scores over 75); it does not suggest that they are completely absent any signs of pathology, nor is it meant to justify the sexual offending behaviors of those subsumed within this group.

APPENDICES

APPENDIX A

LIST OF OFFENDER CONVICTIONS BY OFFENSE TYPE IN CURRENT STUDY

Offenses Against Children

Aggravated Criminal Sodomy, Child Less Than 14

Aggravated Indecent Liberties With a Child

Aggravated Indecent Liberties With a Child, Greater Than 14 Less Than 16, Sexual Intercourse

Aggravated Indecent Solicitation of a Child

Aggravated Indecent Solicitation of a Child, Less Than 14

Aggravated Indecent Solicitation of a Child, Less Than 14, Sex Act

Attempted Aggravated Criminal Sodomy, Child Less Than 14

Attempted Aggravated Indecent Liberties With a Child

Attempted Criminal Sodomy

Attempted Lewd and Lascivious Behavior

Attempted Rape Child Less Than 14

Indecent Liberties With a Child

Indecent Liberties With a Child, Greater Than 14 Less Than 16, Lewd Fondling or Touching

Indecent Liberties With a Child, Lewd Fondling or Touching

Lewd and Lascivious Behavior, Presence of a Child Less Than 16

Rape, Sexual Intercourse With a Child Under 14 Years of Age

Rape With a Child Under 14 Years of Age

Sexual Exploitation of a Child

Unlawful Sexual Relations

Unlawful Voluntary Sexual Relations

Offenses Against Individuals (Age 16 or Greater)

Aggravated Sexual Battery

Aggravated Sodomy by Force

Aggravated Criminal Sodomy

Attempted Aggravated Criminal Sodomy

Attempted Rape

Criminal Sodomy

Lewd and Lascivious Behavior

Rape

Rape, Victim Overcome by Fear or Force

Non-Sexual Violent Offenses

Aggravated Assault

Aggravated Assault With a Deadly Weapon

Aggravated Battery

Aggravated Battery- Intentional, Bodily Harm

Aggravated Battery- Reckless, Bodily Harm

Aggravated Kidnapping

Aggravated Robbery

Attempted Aggravated Assault of a Law Enforcement Officer

Attempted Aggravated Battery

Attempted Aggravated Robbery

Attempted Battery on a Correctional Officer

Attempted Battery on a Law Enforcement Officer

Attempted First Degree Murder

Attempted Murder in the Second Degree

Attempted Robbery

Assault

Battery Against a Law Enforcement Officer

Child Abuse

Conspiracy to Commit Aggravated Robbery

Conspiracy to Commit Robbery

Domestic Battery

First Degree Murder

Involuntary Manslaughter

Involuntary Manslaughter in Commission of Driving Under Influence

Involuntary Manslaughter While Under the Influence of Alcohol

Murder in the Second Degree

Murder in the Second Degree (Intentional)

Murder in the Second Degree (Reckless)

Robbery

Note. Classification of sexual offenses according to victim age (i.e. sexual offenses against children and sexual offenses against adults) was accomplished by review of official records when the conviction did not indicate such information.

APPENDIX B

TABLE SUMMARY OF RELEVANT FINDINGS BY PREVIOUS MCMI RESEARCH

Table B1

Summary of Relevant Findings by MCMI Studies Specifically Comparing Child Molesters, Rapists, and Nonsexual Offenders

Study	Offender Group Findings		
	Child Molesters	Rapists	Nonsexual Offenders
Chantry and Craig (1994a) ^a	<ul style="list-style-type: none"> • 57%- No CEs; highest scores on Compulsive and Narcissistic • 23%- CEs on Dependent, Passive-Aggressive, Avoidant, Anxiety, Dysthymia, • 20%- CEs on Dependent, Schizoid, Avoidant, Anxiety, Dysthymia 	<ul style="list-style-type: none"> • 58%- No CEs; highest score on Compulsive • 26%- CEs on Narcissistic, Antisocial, Drug Dependence, Bipolar, Alcohol Dependence • 16%- CEs on Avoidant, Dependent, Schizoid, Anxiety, Dysthymia 	<ul style="list-style-type: none"> • 59%- No CEs; highest scores on Dependent, Dysthymia • 41%- No CEs; highest score on Narcissistic
Chantry and Craig (1994b) ^a	<ul style="list-style-type: none"> • Scored highest on Dependent • GMs* than rapists on Passive-Aggressive, Anxiety, Dysthymia • GMs* than nonsexual offenders on Avoidant, Borderline, Dependent, Schizoid, Passive-Aggressive, Anxiety, Dysthymia, Psychotic Depression, Psychotic Thinking 	<ul style="list-style-type: none"> • Scored highest on Dependent, though not clinically elevated • GMs* than child molesters on Narcissistic, Compulsive, Paranoid • GMs* than nonsexual offenders on Avoidant, Passive-Aggressive 	<ul style="list-style-type: none"> • Scored highest on Histrionic, though not clinically elevated • GMs* than child molesters on Narcissistic, Compulsive, Paranoid • No significantly GMs than rapists
Ahlmeyer et al. (2003) ^b	<ul style="list-style-type: none"> • No mean profile CEs; highest Axis II scale scores on Narcissistic followed by Antisocial and Depressive • GMs* than rapists on Dependent, Depressive, Avoidant, Schizotypal, Major Depression, Dysthymia, Somatoform, and Thought Disorder • GMs* than nonsexual offenders on Dependent, Depressive, Schizotypal, Masochistic, Schizoid, Major Depression, Dysthymia, PTSD, Somatoform, Anxiety, Thought Disorder • Group status predicted by Schizoid, Avoidant, Depressive, Dependent, Masochistic, Dysthymia, Major Depression 	<ul style="list-style-type: none"> • No mean profile CEs; highest Axis II scale scores on Narcissistic followed by Antisocial • GMs* than child molesters on Narcissistic • GMs* than nonsexual offenders on Major Depression, Dysthymia, PTSD • Group status predicted by Alcohol Dependence 	<ul style="list-style-type: none"> • No mean profile CEs; highest Axis II scale scores on Narcissistic followed by Antisocial • GMs* than child molesters on Narcissistic, Histrionic, Antisocial, Drug Dependence • GMs * than rapists on Narcissistic, Drug Dependence

Note. An asterisk “*” indicates significance. CE = clinical elevation (BR score above 75). GM = greater mean. PTSD = Post-Traumatic Stress Disorder

^aStudy used original MCMI; nonsexual offenders had violent crimes. ^bStudy used MCMI-III, prior to the 2008 renorming; nonsexual offenders had violent or nonviolent crimes.

APPENDIX C

SOURCES OF OFFENDER INFORMATION

The following list contains the sources referenced during data collection. When available, relevant, and necessary, these sources were accessed for each offender to obtain study information.

- Affidavits
- Commitment Reports
- Complaint/Amended Complaint documents
- District Attorney's Report for Secretary of Corrections
- DOC Classification reports
- Information/Amended Information documents
- Journal Entry of Judgment
- Journal Entry of Probation Revocation
- Journal Entry of Sentence Presentence Investigation (PSI) records
- Mental health evaluation reports completed in reception unit of prison
- National Crime Information Center (NCIC) records
- Parole Revocation Packet
- Police investigation reports
- Probation/Parole Revocation Order
- Sex Offender Treatment Program reports, including Multidisciplinary Treatment Team reports and Discharge Summary
- State Bureau of Investigation records

APPENDIX D

DESCRIPTIONS OF MCMI-III SCALES

Modifying Indices

Disclosure Index (Scale X): Indicates whether the respondent approached items in a self-revealing manner, or in a way that was less than forthcoming.

Desirability Index (Scale Y): Assesses how much results were influenced by the respondent's tendency to present themselves as socially appealing, righteous, or emotionally healthy, with a greater likelihood of concealed difficulties the higher one's score.

Debasement Index (Scale X): Assesses how much results were influenced by the respondent's tendency to present themselves in a self-deprecating and emotionally and personally troubling manner than might objectively be the case, with a greater likelihood of exaggeration/distortion the higher one's score.

Random Response Indicators

Invalidity (Scale V): Designed to help identify random responding, this scale is composed of items that are extremely unlikely to be endorsed as True based on their content.

Inconsistency (Scale W): Designed to help identify random responding, this scale is composed of item pairs that, based on their content, are contradictory and thus, should result in a response pattern that is reflective of this.

Clinical Personality Patterns

Schizoid (Scale 1): Elevations indicate an inability to experience and express a full emotional range, including pleasure and despair, and instead, suggest a tendency toward apathy, impassivity, and lack of social engagement with minimal need/desire for connection with others.

Avoidant (Scale 2A): Elevations are indicative of those who do not experience much self- or other-generated positive reinforcement, and approach the world in a guarded and vigilant manner, expecting to encounter pain and preparing to withdrawal for self-protection. They view themselves as unappealing, inadequate, and alienated, and are temperamentally tormented by their longing for connection with others, but actively distance themselves from interpersonal relationships for fear of being humiliated and rejected.

Depressive (Scale 2B): Elevations are indicative of characterological depression, in which life experiences have helped shape a sense of significant loss. Hope and joy are lost, and pain is experienced as permanent. Individuals with such a character style see themselves as worthless; possess a pessimistic outlook;

appear disconsolate; and have impoverished defense mechanisms to help them cope.

Dependent
(Scale 3): Elevations indicate a need for nurturance, security, and guidance from others, as such individuals see themselves as inept and lack the initiative and autonomy for fulfillment of their own needs. They are interpersonally passive, naïve, and they heed to the desires of others so as to keep their support.

Histrionic
(Scale 4): Elevations are indicative of those who demonstrate an insatiable need for the attention and affection of others, as well as the avoidance of disapproval, all of which may be achieved through manipulation. They possess a gregarious sense of self and express themselves in a dramatic manner, but despite their confident appearance, they fear true autonomy and thus, are constantly seeking the acceptance of others.

Narcissistic
(Scale 5): Elevations indicate egotism, in which pleasure is derived from focus on the self. Individuals with this characterological style have learned to overestimate their own worth, viewing themselves as admirable and displaying confidence and superiority that they assume others will acknowledge, but that may not actually be based on real accomplishment. These individuals present as arrogant and are interpersonally exploitive, lacking empathy and using others to best serve themselves.

Antisocial
(Scale 6A): Elevations are indicative of those who protect themselves from the pain they expect others to inflict by committing exploitative or illegal acts for their own advantage. Such individuals view other people's motives cynically; they are temperamentally callous, and if they perceive having been wronged, they desire revenge and reparation. Given their untrusting view of others, these individuals rationalize their impulsive and irresponsible behavior as warranted.

Sadistic
(Aggressive;
Scale 6B): Elevations are indicative of those who are hostile and aggressive and who related to others in an abrasive manner, such that they derive pleasure and gratification from inflicting pain on, and violating the rights of others. They may adopt socially approved positions that serve to hide their malevolent inclinations; however, they can be identified by their controlling and contentious behavior.

Compulsive
(Scale 7): Elevations indicate an orientation characterized by ambivalence, in which one experiences feelings of anger toward others, as well as fear of social condemnation. Prudence and perfectionism, including high expectations they place on themselves and others, result from their attempts at controlling their underlying feelings of opposition; however, on occasion such feelings push past their restraints and are exposed. Additionally, their need for perfection can obstruct their ability to make decisions and complete their work. Such individuals relate to others in a respectful

manner and view themselves as conscientious, but they are unusually observant of rules, regulations, and convention; fearful of making mistakes/ being misjudged; and cognitively rigid and constricted.

Negativistic
(Passive-
Aggressive;
Scale 8A): Elevations indicate internal conflict between following one's own desires and the rewards that can be obtained from others, exhibiting a contradictory interpersonal style that wavers between respect/obedience and insolence/aggressive resistance. Individuals with such a personality structure experience constant disappointments; see themselves as discontented, misunderstood, and unappreciated; and express resentment of others. Additionally, they demonstrate unpredictable patterns of rage or obstinance mixed with periods of guilt or embarrassment.

Masochistic
(Self-Defeating;
Scale 8B): Elevations are indicative of those who permit (or even encourage) their own exploitation or maltreatment by others. They are self-debasing and view themselves as deserving of shame. It is possible that such individuals feel comforted by the pain and suffering they experience, as they repeatedly focus on their past wrongs and expect disappointment in their futures.

Severe Personality Pathology

Schizotypal
(Scale S): Elevations indicate a preference for isolation and privacy from others, cognitive dysregulation, eccentricity of expression, and a view of oneself

as being estranged. Depersonalizing, derealizing, and dissociative experiences can occur, and thought processes are tangential, circumstantial, and autistic in nature. These individuals exhibit significant dysfunction in their ability to pick up on other's thoughts and feelings, and they often appear absorbed in their own thoughts, which may consist of magical and odd beliefs. They may present as either anxiously distraught and suspicious or apathetic with and lacking in affect.

Borderline
(Scale C): Elevations indicate affective dysregulation, particularly, mood lability and instability that can include fluctuations between euthymia, apathy, sadness, anger, anxiety, and/or elation. Sense of self is wavering and uncertain, and cognitive and emotional conflict regarding self and others is exhibited by their expressions of love, rage, and guilt. Fearing abandonment, these individuals strongly desire the attention and affection of others; however, they relate to others in contradictory and manipulative ways that can often result in rejection. Importantly, recurrent thoughts of self-harm are common among this population.

Paranoid
(Scale P): Elevations are indicative of those who are vigilantly guarded, mistrustful, and defensive toward others who are expected to be critical, deceptive, and have hidden agendas. They are actively opposed to outside influences/controls, fearing loss of their autonomy and self-determination, and such individuals are noted for their inflexible thoughts and

unchallengeable feelings. These individuals exhibit abrasiveness and irritability, and they are unforgiving and hold grudges.

Clinical Syndromes

Anxiety
(Scale A): Elevations can indicate a phobic reaction or general unease, apprehension, and worry. Tension, restlessness, hypervigilance, and/or physical/somatic discomfort may be expressed, and individuals with anxiety may also exhibit problems with decision-making.

Somatoform
(Scale H): Elevations indicate a physical expression of psychological problems, which can include drowsiness, non-specific pain and other attention seeking somatic complaints, and preoccupation with illness.

Bipolar: Manic
(Scale N): Elevations are indicative of those who experience periods of extreme elation, which may include an expansive sense of self regard, indiscriminant enthusiasm, irritability, mood lability, distractibility, flight of ideas, pressured speech, overactivity, impulsive behavior, and decreased need for sleep. Symptoms of psychosis may also be present and are indicated by very high scores.

Dysthymia
(Scale D): Elevated scores indicate chronic discontentment or feelings of guilt, little sense of regard for oneself, and a lack of motivation, that persist over years, but that does not keep them from functioning on a daily basis.

Individuals who experience dysthymia often make self-debasing comments or statements about their perceived uselessness, and they can exhibit tearfulness and withdrawal socially during times in which they are particularly sad. They may also experience changes in their appetite, fatigue, difficulty concentrating, loss of interest, pessimism/hopelessness, and suicidal ideation.

Alcohol Dependence (Scale B): Elevations indicate a history of problems with alcohol use, possibly including unsuccessful quit attempts. Significant unease within family and work contexts may be a result of such problems.

Drug Dependence (Scale T): Elevations indicate a history of problems with drug use, difficulty refraining from such use, and an inability to deal with the consequences associated with such use.

Post-Traumatic Stress Disorder (Scale R): Elevations indicate that one has been exposed to a traumatic, life-threatening event resulting in feelings of fear and helplessness. These feelings are reactivated through memories and nightmares of the trauma, and persistent anxious arousal can lead to avoidance of associated imagery or reminders of the event.

Severe Clinical Syndromes

Thought Disorder (Scale SS): Elevations are usually indicative of those with schizophrenia or other psychotic disorders. These individuals frequently seem confused and disoriented, and may exhibit inappropriate affect and behavior that is disorganized or regressive. They can experience hallucinations and delusional or bizarre thinking, and their thought processes may be fragmented.

Major Depression (Scale CC): Elevations are usually indicative of periods of incapacitating depression, affecting one's ability to function normally and often involving a sense of dread and hopelessness, as well as suicidal ideation. Psychomotor agitation or retardation, changes in appetite and weight, fatigue, problems with sleep, and difficulty concentrating may be present. Additionally, ruminative feelings of fear, guilt, and worthlessness are common.

Delusional Disorder (Scale PP): Elevations are indicative of acute paranoia and delusional thinking with grandiose, jealous, or persecutory themes. Individuals with this disorder are typically hostile to, and suspiciousness of, other people, and they may be hypersensitivity to possible disloyalty.

Note. These descriptions of MCMI-III scales are based on the *Fourth Edition Manual* by Millon et al. (2009).

APPENDIX E

MCCI-III PROFILE PAGE EXAMPLE

MILLON CLINICAL MULTIAXIAL INVENTORY - III								
CONFIDENTIAL INFORMATION FOR PROFESSIONAL USE ONLY								
						Valid Profile		
PERSONALITY CODE:		5 ** - * 6B 1.8A + 4.7 3 6A 2A " 8B 2B ' ' // - ** - * //						
SYNDROME CODE:		- ** - * // - ** - * //						
DEMOGRAPHIC CODE:		25/CI/M/41/B/D/12/-/-/-----/-----/						
CATEGORY		SCORE		PROFILE OF BR SCORES				DIAGNOSTIC SCALES
		RAW	BR	0	60	75	85	
MODIFYING INDICES	X	88	56					DISCLOSURE
	Y	18	84					DESIRABILITY
	Z	1	34					DEBASEMENT
CLINICAL PERSONALITY PATTERNS	1	6	61					SCHIZOID
	2A	3	36					AVOIDANT
	2B	0	0					DEPRESSIVE
	3	4	40					DEPENDENT
	4	19	56					HISTRIONIC
	5	22	96					NARCISSISTIC
	6A	5	38					ANTISOCIAL
	6B	9	70					SADISTIC
	7	18	55					COMPULSIVE
	8A	8	60					NEGATIVISTIC
8B	1	20					MASOCHISTIC	
SEVERE PERSONALITY PATHOLOGY	S	2	40					SCHIZOTYPAL
	C	3	30					BORDERLINE
	P	11	69					PARANOID
CLINICAL SYNDROMES	A	1	20					ANXIETY
	H	0	0					SOMATOFORM
	N	6	62					BIPOLAR: MANIC
	D	0	0					DYSTHYMIA
	B	1	15					ALCOHOL DEPENDENCE
	T	4	60					DRUG DEPENDENCE
	R	0	0					POST-TRAUMATIC STRESS
SEVERE CLINICAL SYNDROMES	SS	0	0					THOUGHT DISORDER
	CC	0	0					MAJOR DEPRESSION
	PP	8	71					DELUSIONAL DISORDER

Figure E1. Example of a generic MCCI-III profile prior to the 2008 norming updates.

APPENDIX F

VISUAL DISPLAYS OF MEAN MCFI-III SCORES PRODUCED BY MIXED SEXUAL OFFENDERS AND SEXUAL OFFENDERS OF UNKNOWN SUBTYPE

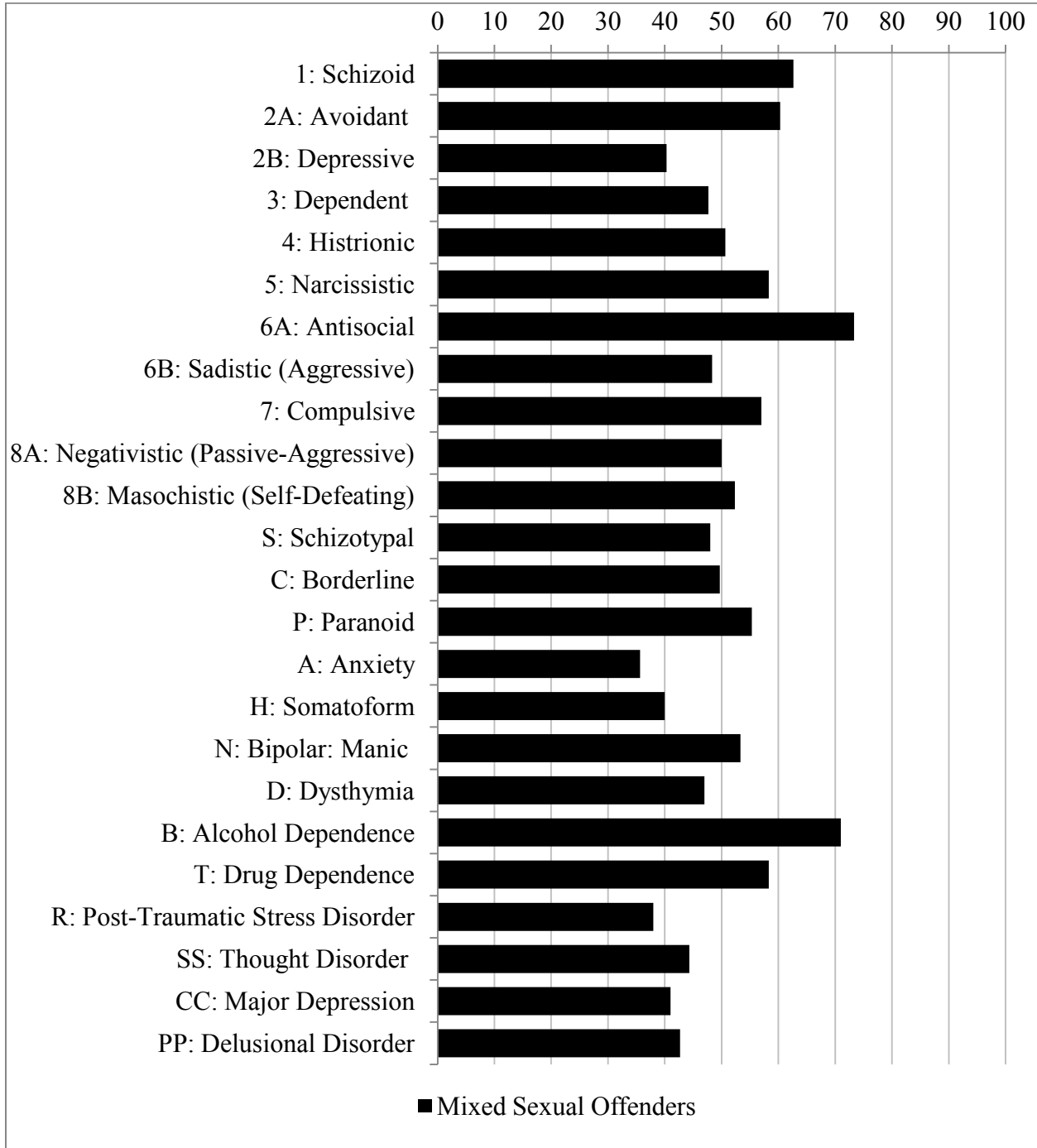


Figure F1. Mean MCFI-III BR scores by mixed sexual offenders ($n = 3$) on the Clinical Personality Patterns, Severe Personality Pathology, Clinical Syndromes, and the Severe Clinical Syndromes scales.

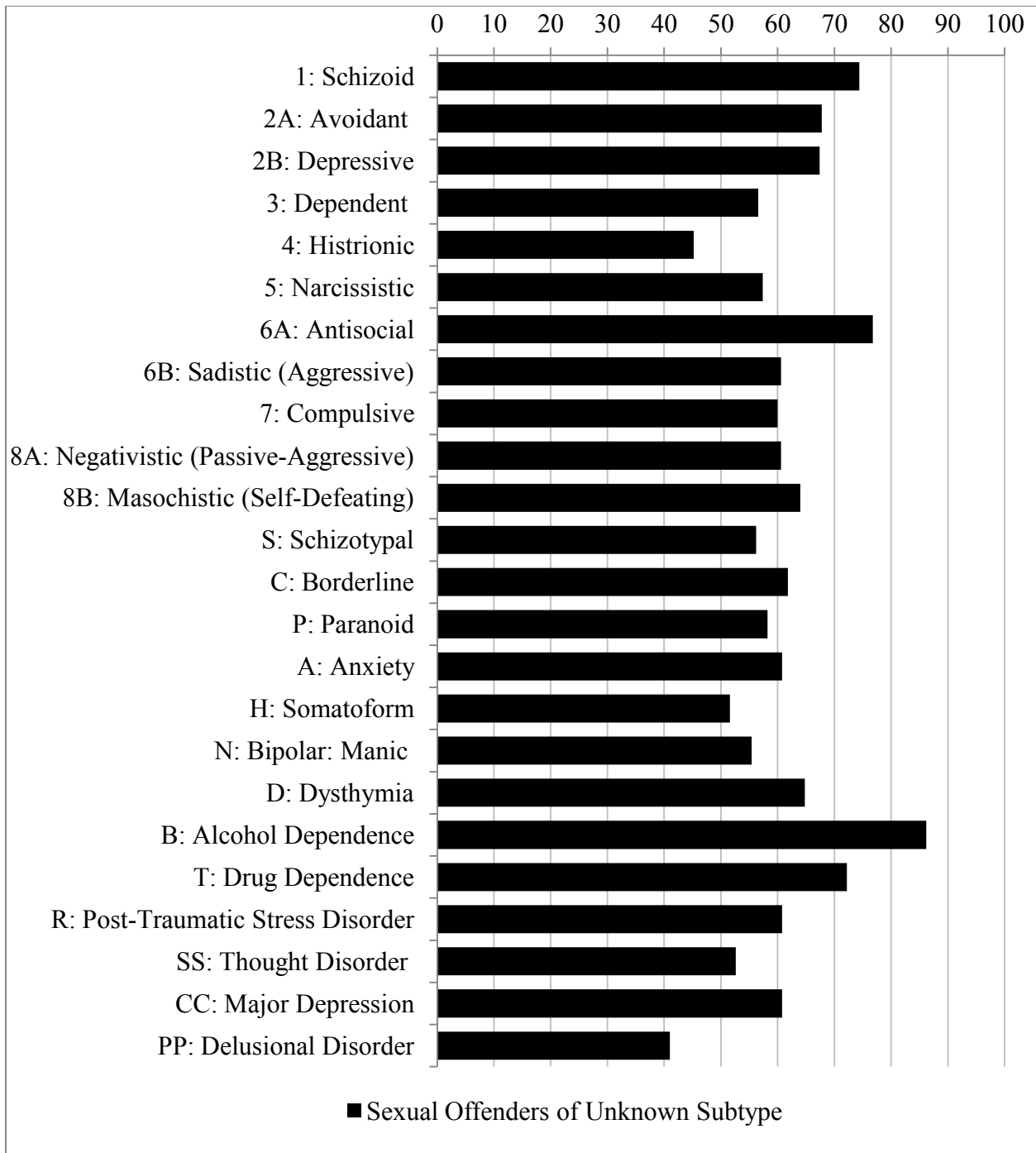


Figure F2. Mean MCMI-III BR scores by sexual offenders of unknown subtype ($n = 5$) on the Clinical Personality Patterns, Severe Personality Pathology, Clinical Syndromes, and the Severe Clinical Syndromes scales.

APPENDIX G

TABLES OF ANALYSIS OF COVARIANCE RESULTS

Table G1

Analysis of Covariance: Significant Differences Between Nonsexual Violent Offenders and Child Molesters on Axis II Scales

Scales	Covariate-Age			Covariate- Education			Overall Between-Subjects Effects		
	<i>F</i>	<i>p</i>	Partial Eta ²	<i>F</i>	<i>p</i>	Partial Eta ²	<i>F</i>	<i>p</i>	Partial Eta ²
1: Schizoid ^{a,c}	0.42	.518	.001	—	—	—	9.05	.003**	.030
5: Narcissistic ^b	12.98	.000***	.044	1.62	.205	.006	33.38	.000***	.106
6A: Antisocial ^{a,c}	—	—	—	—	—	—	4.32	.038*	.015
6B: Sadistic (Aggressive) ^{a,c}	—	—	—	—	—	—	1.63	.203	.006
8A: Negativistic (Passive-Aggressive) ^b	5.18	.024*	.018	3.90	.049*	.014	2.83	.093	.010
8B: Masochistic (Self-Defeating) ^b	0.76	.384	.003	0.04	.845	.000	9.33	.002**	.032
S: Schizotypal ^b	0.49	.486	.002	1.04	.308	.004	14.31	.000***	.048
C: Borderline ^{a,c}	1.75	.187	.006	—	—	—	9.25	.003**	.031
P: Paranoid ^b	2.17	.142	.008	5.35	.021*	.019	1.56	.231	.005

Note. A separate ANCOVA model was run for each scale. Table values have been rounded. Scales 2A (Avoidant), 2B (Depressive), 3 (Dependent), 4 (Histrionic), and 7 (Compulsive) did not pass Levene's Test for homogeneity of variance and thus, are not included in table.

^aAnalyses included $n = 191$ nonsexual violent offenders and $n = 101$ child molesters. ^bAnalyses included $n = 186$ nonsexual violent offenders and $n = 101$ child molesters. ^cAt least one of the listed covariates was excluded from the respective model due to a lack of linearity between the offender groups; thus, missing covariate data is indicated by a dash (—).

* $p \leq .05$. ** $p \leq .005$. *** $p \leq .001$.

Table G2

Analysis of Covariance: Significant Differences Between Nonsexual Violent Offenders and Child Molesters on Axis I Scales

Scales	Covariate-Age			Covariate- Education			Overall Between-Subjects Effects		
	<i>F</i>	<i>p</i>	Partial Eta ²	<i>F</i>	<i>p</i>	Partial Eta ²	<i>F</i>	<i>p</i>	Partial Eta ²
A: Anxiety ^{a,c}	1.98	.160	.007	—	—	—	8.61	.004**	.029
N: Bipolar: Manic ^{b,c}	—	—	—	0.00	.948	.000	3.09	.080	.011
D: Dysthymia ^b	0.14	.705	.001	0.08	.779	.000	23.70	.000***	.077
B: Alcohol Dependence ^{a,c}	0.01	.914	.000	—	—	—	0.42	.516	.001
T: Drug Dependence ^{a,c,d}	—	—	—	—	—	—	3.48	.063	.012
R: Post-Traumatic Stress Disorder ^{a,c}	0.32	.571	.001	—	—	—	15.89	.000***	.052
SS: Thought Disorder ^b	0.83	.364	.003	1.18	.279	.004	9.99	.002**	.034
PP: Delusional Disorder ^{a,c}	—	—	—	—	—	—	0.67	.415	.002

Note. A separate ANCOVA model was run for each scale. Table values have been rounded. Scales H (Somatoform), CC (Major Depression) did not pass Levene's Test for homogeneity of variance and thus, are not included in table.

^aAnalyses included $n = 191$ nonsexual violent offenders and $n = 101$ child molesters. ^bAnalyses included $n = 186$ nonsexual violent offenders and $n = 101$ child molesters. ^cAt least one of the listed covariates was excluded from the respective model due to a lack of linearity between the offender groups; thus, missing covariate data is indicated by a dash (—). ^dThe education covariate was excluded in this model due to a lack of linearity between groups and not meeting the assumption of homogeneity of regression slopes.

* $p \leq .05$. ** $p \leq .005$. *** $p \leq .001$.

Table G3

Adjusted Mean Differences of Significant ANCOVA Axis II Scale Comparisons

Scale	Nonsexual Violent Offenders		Child Molesters		Adjusted Mean Difference
	Mean	Adjusted Mean	Mean	Adjusted Mean	
1: Schizoid ^a	47.28	47.28	57.24	57.24	-9.96
5: Narcissistic ^b	69.03	68.97	56.08	56.51	12.46
6A: Antisocial ^a	66.79	66.79	61.95	61.95	4.84
8B: Masochistic (Self-Defeating) ^b	37.17	37.47	49.78	49.78	-12.31
S: Schizotypal ^b	36.10	36.32	51.41	51.48	-15.16
C: Borderline ^a	42.53	42.53	53.12	53.12	-10.59

Note. Table values have been rounded.

^aAnalyses included $n = 191$ nonsexual violent offenders and $n = 101$ child molesters.

^bAnalyses included $n = 186$ nonsexual violent offenders and $n = 101$ child molesters.

Table G4

Adjusted Mean Differences of Significant ANCOVA Axis I Scale Comparisons

Scale	Nonsexual Violent Offenders		Child Molesters		Adjusted Mean Difference
	Mean	Adjusted Mean	Mean	Adjusted Mean	
A: Anxiety ^a	40.88	40.88	53.77	53.77	-12.89
D: Dysthymia ^b	26.94	27.09	46.16	46.16	-19.07
R: Post-Traumatic Stress Disorder ^a	30.23	30.23	45.38	45.38	-15.15
SS: Thought Disorder ^b	32.13	32.40	44.05	44.05	-11.65

Note. Table values have been rounded.

^aAnalyses included $n = 191$ nonsexual violent offenders and $n = 101$ child molesters.

^bAnalyses included $n = 186$ nonsexual violent offenders and $n = 101$ child molesters.