LIFETIME ALCOHOL MISUSE PREVALENCE RATES AMONG SEXUAL OFFENDERS CURRENTLY ENROLLED IN OUTPATIENT SEX OFFENDER TREATMENT

by

JAMES P. FOSTER

Presented to the Faculty of the Graduate School of

The University of Texas at Arlington in Partial Fulfillment

of the Requirements

for the Degree of

MASTER OF SCIENCE IN SOCIAL WORK

THE UNIVERSITY OF TEXAS AT ARLINGTON

August 2012

ACKNOWLEDGEMENTS

This thesis is dedicated to my parents for their never ending support and encouragement. Your never ending love through all of my life's ups-and-downs has made my dreams a reality. A special "Thank You" to Kayla Foster who inspired me to resume my academic career. I hope this makes you proud. Thank you to Dr. Alexa Smith-Osborne for chairing my thesis committee and being an outstanding mentor throughout this process. You always demonstrated the utmost patience, while constantly pushing and encouraging me. To my thesis committee, Dr. Norman Cobb and Dr. Vijayan Pillai, thank you for your time and efforts. Thank you also to my Field Instructor and his staff for their support and allowing me access to their clients. This thesis would not have been possible without the support of Shawn Wiser and my co-workers at Supreme Distributing, LLC who allowed me all of the time off I have needed the past four years to pursue my education. Thank you also to Rhonda Weaver for constantly reminding me that I can accomplish whatever I desire. This thesis would not have become a reality if not for a telephone conversation with Dolores Sutter five years ago. Mrs. Sutter encouraged me to return to college and inspired me to pursue my Bachelor's and Master's degrees at a pivotal point in my life.

July 12, 2012

ABSTRACT

LIFETIME ALCOHOL MISUSE PREVALENCE RATES AMONG SEXUAL OFFENDERS CURRENTLY ENROLLED IN OUTPATIENT SEX OFFENDER TREATMENT

James P. Foster, M.S.

The University of Texas at Arlington, 2012

Supervising Professor: Alexa Smith-Osborne

Sex offenders' high prevalence of alcohol misuse augments their risk of reoffending. Identifying sexual offenders' alcohol misuse patterns and history is vital to effective treatment that lowers rates of recidivism. The present study seeks to determine the prevalence of lifetime alcohol misuse among individuals participating in court mandated outpatient sex offender treatment. Participants were administered the *Michigan Alcoholism Screening Test* (MAST). The participants' MAST scores were then separated into categories of, "No Problem (scores 0-5)," "Alcohol Problem (scores 6-8)," and "Alcohol Abuse/Dependence (scores 9+)" to compare with the participants' self-reported alcohol use during their intake assessments. The MAST score ranges were also compared to the number of participants' who were court-ordered to undergo substance abuse assessments and the number of participants who are enrolled in, or completed, substance abuse treatment. Findings in the present study replicated the findings of other studies by demonstrating that 41.1 percent of the participants scored in the "problem drinking"

category on the MAST, with an overall *mean* score of 9.4 for all participants. Limitations and future research recommendations are also presented.

TABLE OF CONTENTS

LIST OF ILLUSTRATIONS

LIST OF TABLES

CHAPTER 1

NATURE OF THE PROBLEM

1.1 Sexual Offenders' Alcohol Misuse and Recidivism

Sex offenders' high prevalence of alcohol misuse augments their risk of reoffending. According to Abbey, Zawacki, Buck, Clinton, and McAuslan, perpetrators who consumed alcohol committed an estimated half of all sexual assaults (2001). A study of college men demonstrated that 54 percent of the perpetrators committing sexual assault involved alcohol consumption by the perpetrator, victim, or both (Zawacki et al., 2003). Studies measuring lifetime alcohol problems among sex offenders revealed that a majority scored in the "problem drinking" category, or worse, on the Michigan Alcoholism Screening Test (MAST) (Langevin & Lang, 1990; Abracen et al., 2006; Looman & Abracen, 2011). Sex offenders with a prior history of alcohol abuse or dependence significantly increase their risk of reoffending, over and above estimates of actuarial instruments (Långström, Sjöstedt, & Grann, 2004; Looman & Abracen, 2011). The Minnesota Department of Corrections reported that 45 percent of the individuals, who reoffended while on probation for a sexual offense, had a history of heavy alcohol consumption or dependence (2000). Alcohol consumption increases the risk of sexual perpetrators reoffending.

1.2 Sex Offender and Substance Abuse Treatments

Identifying sexual offenders' alcohol misuse patterns and histories is vital to effective treatment that lowers rates of recidivism. Substance abuse treatments for sexual offenders significantly decreased the likelihood of reoffending and increased the probability of remaining offense free (Abracen et al, 2006). Due to the high prevalence of alcohol abuse among sexual offenders, Abracen, Looman, and Anderson argued that sex offender treatment providers should receive training in substance abuse treatment (2000). Effective treatment for sexual offenders

that reduces the risk of recidivism should include proper diagnosis of alcohol abuse and dependence.

Sex offender treatment programs should include a component of substance abuse assessment and treatment (Abracen, Looman, & Anderson, 2000). Few sex offender treatment programs offer comprehensive concomitant substance abuse treatment (Peugh & Belenko, 2001). Criminal justice system discernments rely on accurate assessment of substance use disorders to determine sexual offenders' risk of recidivism (Marshall & Serran, 2000). Lowering sexual offenders' future rates of recidivism depends predominantly on treating both sexual deviations and co-occurring alcohol use disorders simultaneously (Langevin & Lang, 1990). Sex offender treatment providers properly trained in administering screening and assessment instruments, such as the MAST, could assess and treat alcohol and substance misuse disorders at the onset of sex offender treatment.

1.3 National Statistics on Sexual Offenses

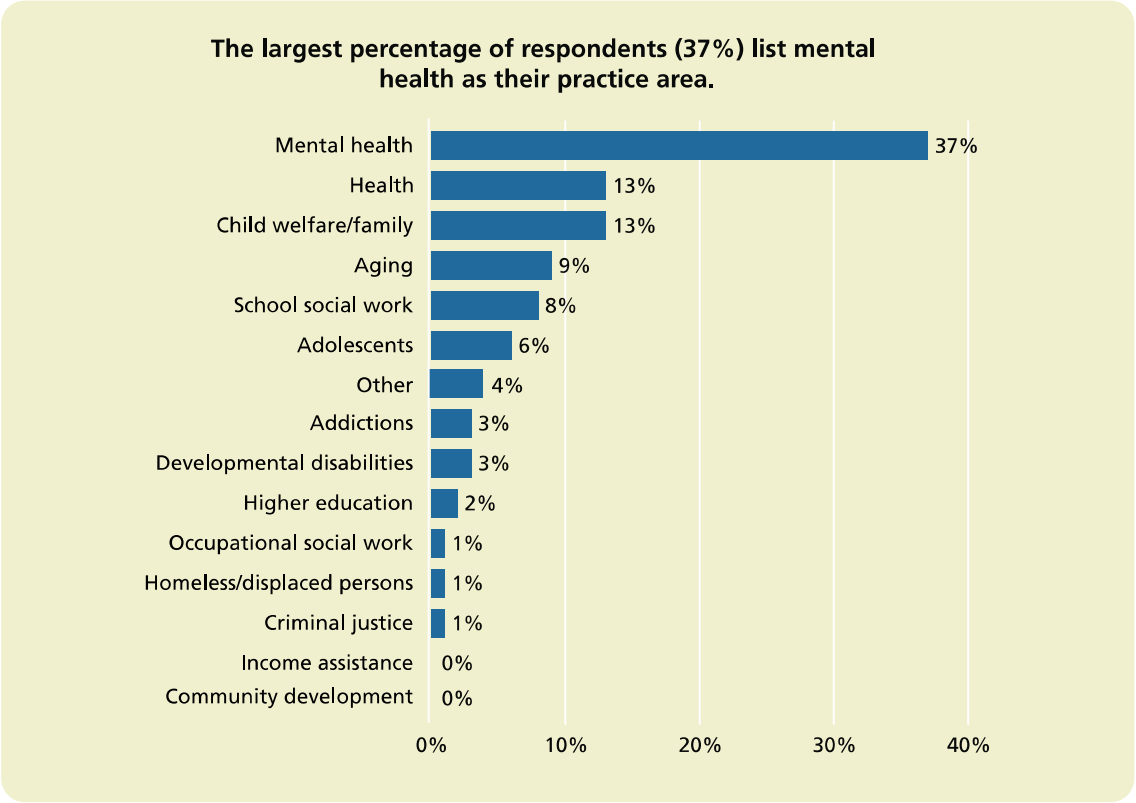
The broad scope of sexual offending includes forcible rape, sexual assault, criminal solicitation of a minor (under 17 years of age), indecency with a child (under 17 years of age), promotion and possession of child pornography, indecent exposure, lewdness, etc. The National Crime Victimization Survey for 2010 estimated that 188,380 individuals over the age of 12 were victims of rape or sexual assault (Truman, 2011). The Federal Bureau of Investigation's *Uniform Crime Report* estimated that 92,716 arrests were made in 2010 for forcible rape and sex offenses (except rape and prostitution) (Federal Bureau of Investigations, 2011). Glaze and Bonczar (2011) reported that approximately 134,000 adults in the United States are currently on parole or probation for a sexual offense. The Office of Justice Programs (2010) estimated that 700,000 registered sex offenders live within communities throughout the United States. Victims and society benefit when the field of social work and the criminal justice system work collaboratively on research, and programs, to decrease sexual offenders' risk of reoffending.

1.4 Impact on the Profession of Social Work

The present study will benefit the profession of social work by providing additional research focused on individuals' with potential alcohol misuse disorders who are engaged in the criminal justice system. According to Wilson (2010), thousands of social workers work with criminal justice populations, often in behavioral health settings. In a national study of licensed social workers conducted for the National Association of Social Workers (NASW), approximately 3 percent of licensed social workers practice in addictions and 1 percent practice in the criminal justice system (Whitaker, Weismiller, & Clark, 2006). Additionally, licensed social workers identified behavioral health and criminal justice as their primary employment sectors (9% & 2%, respectively) (Whitaker, Weismiller, & Clark, 2006). The NASW has no additional data on social workers working with sexual offenders (T. Whitaker, personal communication, April 9, 2012). In Texas, an estimated 20 percent of Licensed Sex Offender Treatment Providers hold an advanced degree in social work (Texas Council on Sex Offender Treatment, 2005). Furthermore, this study will enhance the author's and potentially other social work students' advanced knowledge and skills in working with substance abusing populations. Social work education research has identified a need for increased attention to this practice area (Bina et al., 2008; Jani et al., 2009). The present study will benefit the field of social work by specifically focusing on a population of sex offenders on probation, or parole, by contributing further knowledge to the prevalence rates of alcohol misuse among this population.

Table 1.1 Primary Practice Area (Specialty) of Licensed Social Work

FIGURE 6. PRIMARY PRACTICE AREA (SPECIALTY) OF LICENSED SOCIAL WORK



(Weismiller & Clark, 2006; permission to reprint granted by the NASW, 4/9/12)

CHAPTER 2

LITERATURE REVIEW USING SYSTEMATIC REVIEW METHODS

2.1 Literature Search Term Results

The present study seeks to determine the prevalence of lifetime alcohol misuse among individuals participating in court mandated outpatient sex offender treatment. Numerous searches, using a combination of search terms, were conducted in Criminal Justice Abstracts, PsycINFO, PsycARTICLES, Psychology and Behavioral Sciences Collection, and Social Work Abstracts. Three primary search terms were used - sexual assault, sex offender (SO), and sex offender treatment (SOT) - with the ancillary terms, substance use (SU), substance abuse (SA), alcohol (AX), alcohol abuse (AA), and outpatient (OP). Table 2.1 displays the search term findings.

Table 2.1 Literature Search Term Results by Primary and Ancillary Search Term

Desc.	Single term	w/ AX	w/ AX & OP	w/ AA	w/AA & OP	w/ SU	w/ SU & OP	w/ SA	w/ SA & OP
Sex. Ass.	7,582	724	7	16	4	153	5	280	21
SO	8,778	151	9	48	4	33	6	170	15
SOT	1,713	18	0	8	0	9	2	32	3

Note. Desc. = Description. Sex. Ass. = Sexual Assault. AX = Alcohol. OP = Outpatient. AA = Alcohol Abuse. SU = Substance Use. SA = Substance Abuse.

The reference sections of the selected studies were reviewed for relevant research and additional studies selected from them.

The literature review produced two reviews, five meta-analyses, and two studies proposing models relevant to the present study. The two reviews and five meta-analyses did not utilize conceptual models to investigate the prevalence of substance misuse and substance use among sexual offenders, the effectiveness of sex offender treatment in lowering rates of recidivism, or the effectiveness of sex offender treatment modalities. Conceptual models provide

researchers a guide to follow in their research. The integration and confluence models present explanations related to individuals' consumption of alcohol and the increased risk of sexually aggressive acts. The prevalence of substance misuse and substance use among sexual offenders begins the literature review.

2.2 Substance Misuse Prevalence Rates among Sex Offenders

Kraanen and Emmelkamp (2011) reviewed 42 studies designed to measure substance misuse prevalence rates among sexual offenders. The authors subdivided their research findings into three categories based on research methods employed to gather specific data within each of the independent studies: Retrospective file searches, screening instruments, and semi-structured interviews. The reviews measured the prevalence rates of substance misuse and substance use disorders among sexual offenders, differences among subtypes of sexual offenders with regard to the prevalence of substance abuse, comparisons of the prevalence of substance abuse in sex offenders to the prevalence of substance abuse in other populations, and intoxication at the time of offense.

2.2.1 *Sexual Offenders' Alcohol Misuse Prevalence Rates*

Among all the sexual offenders in the review, approximately 50 percent could be diagnosed with a lifetime substance abuse disorder (Kraanen & Emmelkamp, 2011). Furthermore, one quarter to one half of the sex offenders could be diagnosed with a lifetime alcohol misuse disorder, and an estimated one fifth to one quarter of the sex offenders could be identified with a lifetime drug misuse diagnosis (Kraanen & Emmelkamp, 2011). The researchers found the highest rates of alcohol misuse when assessing with screening instruments (median = 47.5%), followed by semi-structured interviews (median = 38.9%) and retrospective file searches (median = 27.3%). These results could be attributable to screeners' overestimating the prevalence of substance use disorders abuse (Hendriks, 2009, as cited in Krannen & Emmelkamp, 2011, p. 486). When assessing for drug misuse, Krannen and Emmelkamp (2011) revealed that retrospective file searches produced the highest prevalence rates (median =

38.3%), followed by semi-structured interviews (median = 17.5%) and screening instruments (median = 14.2%). The results of drug misuse prevalence rates from semi-structured interviews and screening instruments could have been influenced by respondent bias, whereby the responder is attempting to appear more socially acceptable (Rubin & Babbie, 2011).

2.2.2 *Prevalence Rates by Subtypes of Sexual Offenders*

Comparing the prevalence rates of substance abuse among subtypes of sexual offenders was difficult due to the diversity of the individual studies. Several studies compared substance abuse prevalence rates among rapists and child molesters and found no consistent differences between the two. Future studies concentrating on the prevalence rates of substance abuse among subtypes of sexual offenders may provide clinicians and researchers valuable information useful in developing substance abuse treatment programs specific for these populations.

2.2.3 *Prevalence Rates between Sexual Offenders and Control Groups*

When comparing the substance abuse prevalence rates between sexual offenders and control groups of nonsexual offenders, alcohol abuse was more prevalent among incarcerated sexual offenders in three of the studies reviewed (Kraanen & Emmelkamp, 2011). However, in a study of 1,925 incarcerated male offenders, Motiuk and Porporino (1992) found that sexual offenders have fewer alcohol use disorders compared to other types of offenders. The Motiuk and Porporino study included 103 sexual offenders, significantly fewer than inmates incarcerated for homicide (337), robbery (498), or other (1,044). The total number of sexual offenders in the study, compared to other types of offenders, may have lowered the statistical prevalence rates for alcohol misuse within this population.

2.2.4 *Summary of Substance Misuse Prevalence Rates among Sex Offenders*

Ten studies reported on the number of sexual offenders intoxicated at the time of offense. Sexual offenders' median scores for intoxication on any substance at the time of offense, drinking alcohol at the time of offense, and intoxicated by drugs at the time of offense were, 32.8 percent, 47.9 percent, and 9.1 percent, respectively (Kraanen & Emmelkamp, 2011). These findings

support the idea that alcohol use is proximally associated with sexual aggressive acts, a crucial portion of the integration and confluence models. Sex offender treatment providers should screen and assess sexual offenders for substance use disorders at the onset of criminal sentencing. Future studies focusing on standardized substance abuse treatment protocols, designed specifically to treat sexual offenders who present with a personality disorder or other characteristics (non-compliance, impulsivity, deviance, etc.), may provide crucial research and evidence that can further reduce the recidivism rates of sexual offenders.

2.3 Predictors of Sexual Offender Recidivism

Hanson and Bussière (1996) performed a meta-analysis of 61 studies, representing 87 documents, from six different countries to determine recidivism factors for sexual offenders. Inclusion criteria for the meta-analysis included: An identifiable sample of sexual offenders, a follow-up period, relationship characteristics between offenders and recidivism, recidivism characteristics for sexual offenses, nonsexual violent offenses, any new offenses and sufficient statistical information. Eighty-five percent (52) of the studies sampled adults, ten percent (6) sampled adolescents, and five percent (3) sampled both adults and adolescents. Approximately half of the studies were institutional samples, one quarter of the studies sampled from communities, and another one quarter of the studies sampled both institutions and communities. Nineteen of the studies were exclusively conducted in correctional institutions, eleven from secure mental facilities, and the remainder of the studies from various other sources (private clinics, courts, and a mixture of other sources). Forty-eight percent of the studies included participants in sex offender treatment programs.

2.3.1 *Measures of Recidivism*

The studies included in the Hanson and Bussière (1996) meta-analysis used various measures for recidivism. The most common measures of recidivism rates were reconviction (84%), followed by arrests (54%), self-reports (25%), and parole violations (16%) (Hanson and Bussière (1996). Twenty-seven studies used multivariate measures of recidivism. Furthermore,

the included studies used various sources to obtain recidivism data. The most common source of recidivism data were deduced from national criminal justice records followed by state/provincial records, treatment program records, and self-reports. Approximately 70 percent of the included studies used multiple sources to gather recidivism data.

2.3.2 *Recidivism Statistics*

Thirteen percent of the participants (23,393) committed a new sexual offense (Hanson and Bussière (1996). Rapists (*n* = 1,839) reoffended at a higher rate, 18.9 percent, than child molesters (*n* = 9,603), 12.7 percent (Hanson & Bussière, 1996). The authors argued that characteristics related to sexual deviance (sexual preference for children, prior sexual offense, age, early onset of sexual offending, any prior offenses, and never being married) were the strongest predictors for committing additional sexual offenses. Furthermore, the authors presented evidence that sexual offense recidivism was unrelated to substance abuse, history of sexual abuse as a child, or general psychological problems. Three developmental history variables (negative relationship with mother, juvenile delinquency, and multiple general problems in the family of origin) significantly predicted sexual offense recidivism (Hanson & Bussière, 1996). Sexual preference for children, as measured by phallometric methods, was the greatest single predictor of sexual offender recidivism (Hanson & Bussière, 1996).

2.3.3 *Summary of Predictors of Sex Offender Recidivism*

Participants (*n* = 7,155) in the studies committed new, nonsexual violent offenses at a rate of 12% (Hanson & Bussière, 1996). The studies demonstrated significant differences in nonsexual violent recidivism rates for child molesters (*n* = 1,774, 10%) and rapists (*n* = 782, 22%) (Hanson & Bussière, 1996). General recidivism rates (defined as any new offense) for the studies' participants (n=19,374) were predictably higher, 36 percent, overall (Hanson & Bussière, 1996). General recidivism rates for child molesters' (*n* = 3,363) was 37 percent and rapists' (*n* = 4,017) 46 percent (Hanson & Bussière, 1996). The authors argued that offenders unmotivated for treatment or who did not complete treatment were at the greatest risk of committing new

offenses. The strongest predictor of general recidivism was juvenile delinquency, followed by negative relationship with mother and sexual abuse as a child. The findings in Hanson and Bussière (1996) provided support for mandating sexual offenders attend, and complete, sex offender treatment to reduce their risks of committing new sexual, nonsexual violent, and general offenses.

2.4 Models Depicting Alcohol Use and Sexual Aggression

2.4.1 *Testa's Integration Model*

Testa (2002) proposed a model integrating current research studies (associational, event-based, and experimental) of alcohol consumption and perpetration of sexual assault. The author defined sexual assault as, "a man's attempts, whether successful or not, to coerce, threaten, or force a woman to engage in sexual acts against her will" (p. 1240). Perpetration of sexual assault can be operationalized from a narrow (conviction of sexual assault or other sexual crimes) to a broad perspective (unreported sexual assaults, illegal contact, or coercion, as reported by the victim or perpetrator). Previous studies focused on three categories to determine the relationship between alcohol consumption and perpetration of sexual assault. Associational studies reported distal linkages of alcohol consumption patterns and problems with history of sexual aggression perpetration. Event-based studies analyzed the co-occurrence of alcohol use and sexual aggression with the impact alcohol use has on sexual aggression outcomes within naturally occurring environments. Experimental studies measured the effects of administered alcohol on the intent to engage in sexual aggression or the acceptance of sexual aggression.

2.4.1.1 Alcohol Consumption and Perpetuation of Sexual Assault

Associational studies vary from simple studies examining alcohol consumption levels, behaviors, and dependence among sexual perpetrators and non-perpetrators, to multivariate studies measuring the strength of alcohol use as a predictor of sexual aggression. The intensity of sexual perpetrators alcohol use strongly predicts the severity of sexual aggression. Several studies demonstrated inconsistencies regarding alcohol use or abuse and the perpetration of

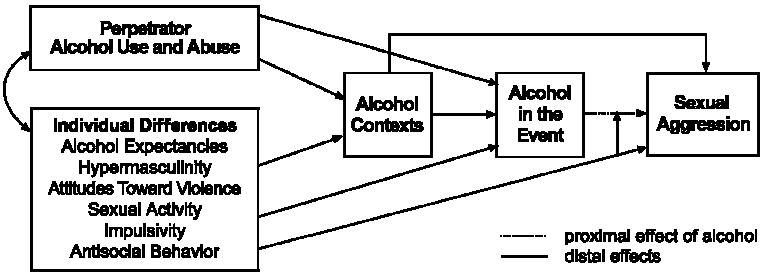
sexual assaults. Sexual deviance, sexual behaviors committed by the minority of the population, an additional variable, may provide valuable insight into the relationship between alcohol consumption and perpetuation of sexual aggression.

Event-based studies measure the proximal effects of alcohol consumption and the perpetration of sexual aggression. The simplest event-studies measure whether perpetrators were under the influence of alcohol when their sexual offense occurred; however, event-studies fail to demonstrate any cause-effect relationship between alcohol consumption and sexual aggression. Event-based studies demonstrated that perpetrators had consumed alcohol in over half of the sexual assaults reported to the police or community samples (Testa, 2002). Perpetrator - alcohol use, as reported by male perpetrators and female victims, was similar for rape (74% perpetrator report, 73% victim report) and attempted rape (67% perpetrator report, 54% victim report) (Testa, 2002). Although alcohol consumption and sexually aggressive acts appear to have a strong association, studies have yet to produce sufficient evidence generating definitive conclusions regarding their relationship.

Experimental studies measure the proximal effects and pharmacological effects of alcohol use and sexual perpetration. These studies posit that alcohol consumption activates beliefs about alcohol and sex, particularly among individuals with strong alcohol expectancies. Alcohol expectancies result in stronger intentions to engage in sexually aggressive behavior when alcohol is consumed, compared to when it is not. Hypermasculinity, a trait associated with sexual aggressive behavior and alcohol consumption, is described as insensitive sexual attitudes toward women combined with a perception that aggression is manly and danger is exciting. Men measuring high in hypermasculinity often demonstrate less empathy for their victims after consuming alcohol. A path model (Figure 2.1) illustrates how alcohol expectancies interact with the contexts and events where alcohol is consumed, which may influence sexually aggressive behaviors.

2.4.1.2 Alcohol Consumption and Sexual Aggression

Testa (2002) proposed the integration model to measure the distal and proximal effects of alcohol consumption and sexual aggression. The integration model includes a third variable, individual differences (alcohol expectancies, hypermasculinity, attitudes towards violence, sexual activity, impulsivity, and antisocial behavior), that interacts dependently with other factors (perpetrators alcohol use/abuse, alcohol contexts, and alcohol in the event) and independently to influence sexually aggressive behaviors. Perpetrator alcohol use and abuse interacts with individual differences and indirectly leads to sexual aggression through the contexts and events in which alcohol is consumed. The context in which alcohol is consumed can lead directly to sexually aggression or indirectly through the event. Alcohol in the event is directly affected by all of the other factors and is a direct, proximal effect on sexual aggression.



(Testa, 2002, p. 1255; Permission to use granted 4/12/12.)

Figure 2.1. Distal and Proximal Effects of Alcohol Consumption on Perpetration of Sexual Aggression

2.4.1.3 Summary of Testa's Integration Model

The integrative model suggests that men who heavily drink alcohol are at greater risk to drink to intoxication and frequent settings (bars, nightclubs, etc.) where alcohol is available, thus increasing their risk of perpetrating sexual aggression. Individual differences may affect the settings and events in which alcohol is consumed before sexual aggression occurs. Also, individual differences may lead directly to sexual aggression, after alcohol is consumed, by some

perpetrators. Ultimately, men measuring high on levels of individual differences, who consume alcohol, may be at greater risk of facilitating sexual aggression. Future research examining the individual characteristics (alcohol expectancies, hypermasculinity, attitudes towards violence, sexual activity, impulsivity, and antisocial behavior) of sexual aggression perpetrators could add an important piece of knowledge explaining how alcohol consumption leads to sexual aggression.

2.4.2. *Confluence Model*

Parkhill and Abbey (2008) conducted a study of 356 college men to examine whether alcohol contributed to the confluence model of sexual assault perpetration. Malamuth's confluence model has been one of the most widely used models to predict men's likelihood of perpetrating sexual assault. (See Malamuth, Sockloskie, Koss, & Tanaka (1991) for additional information on the confluence model.) The confluence model depicts two main pathways in predicting sexual assault perpetration: Impersonal sex and hostile masculinity. Impersonal sex, characterized by emotional detachment in sexual relationships, is believed to originate from adolescent delinquency, associating with delinquent peers, engaging in delinquent behaviors, and early commencement of sexual behaviors. Hostile masculinity concentrates on men's power perspective regarding sexual relationships. Certain men develop higher levels of hostile masculinity through social conditioning (treating women like objects) or witnessing and experiencing abuse as a child. When the impersonal sex and hostile masculinity pathways interact synergistically, men high in these characteristics report higher levels of sexual assault.

2.4.2.1 Interaction of Pathways and Behaviors

The interaction of the impersonal sex and hostile masculinity pathways significantly predicted the number of perpetrated sexual assaults. Independent research team's substantiated these findings through replication and expansion of the confluence model (Parkhill & Abbey, 2008). When included in the confluence model, empathy acted as a buffering agent lowering levels of sexual aggression among men who scored above the median in impersonal sex and hostile masculinity (Parkhill & Abbey, 2008). Empathy, a crucial component of sex offender

treatment, could be the all-important component reducing sexual offenders' risk of committing new sexual offenses.

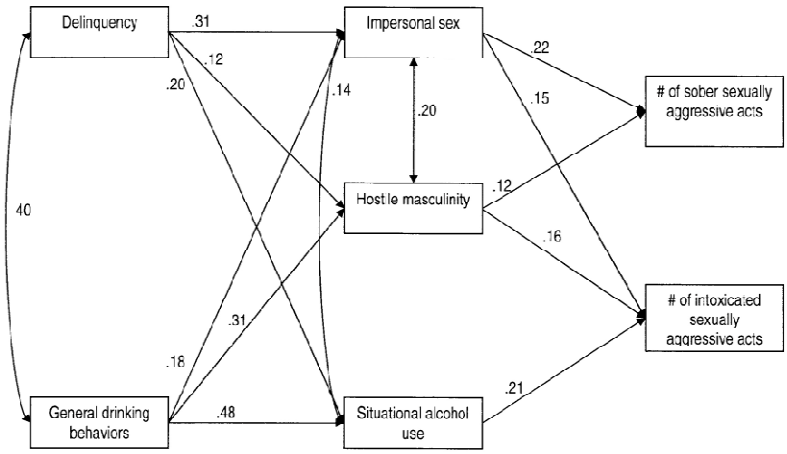
A history of child or adolescent delinquency and excessive drinking behaviors interact with each other and independently with impersonal sex, hostile masculinity, and situational alcohol use, increasing a man's risk of perpetrating sexual assault. Impersonal sex also acts independently with hostile masculinity and situational alcohol use increasing a man's risk of sexually assaulting a victim. Impersonal sex and hostile masculinity interact with the number of sober sexually aggressive acts and the number of intoxicated sexually aggressive acts. Situational alcohol use only interacts with the number of intoxicated sexually aggressive acts.

2.4.2.2 Hypotheses and Findings

Parkhill and Abbey (2008) presented several hypotheses examining how the inclusion of alcohol would affect the confluence model. The first component of their hypothesis measured and examined men's general alcohol consumption beliefs. Men's general alcohol consumption beliefs were then used to predict situational alcohol use in dating and sexual situations and the number of intoxicated sexual assaults at the event level (Parkhill & Abbey, 2008). Measuring sexual aggression, Parkhill and Abbey (2008) examined the number of sexual aggressive acts where alcohol was or was not consumed. Delinquency was hypothesized to positively relate to impersonal sex and hostile masculinity, to predict the frequency of perpetration of sexually aggressive acts both when intoxicated and when sober.

Fifty-eight percent of the study's participants self-reported perpetrating at least one sexually aggressive act (Parkhill & Abbey, 2008). Forty-eight percent perpetrated when sober, 27 percent perpetrated when intoxicated on alcohol, and 25 percent perpetrated when both sober and intoxicated on alcohol (Parkhill & Abbey, 2008). Among the participants perpetrating at least one sexually aggressive act, 47 percent had consumed five or more drinks during the incident (Parkhill & Abbey, 2008). As expected, the study found high levels of adolescent and child delinquency associated with high levels of impersonal sex and hostile masculinity. Impersonal

sex and hostile masculinity were significantly related to the number of intoxicated and sober sexually aggressive acts. Higher levels of impersonal sex and hostile masculinity predicted higher numbers of sexually aggressive acts when intoxicated and sober. General drinking behaviors and beliefs about drinking significantly, positively, related to impersonal sex, hostile masculinity, and situational alcohol use. Furthermore, higher levels of general drinking behaviors and beliefs about drinking resulted in higher levels of impersonal sex, hostile masculinity, and situational alcohol use. Situational alcohol use was significantly associated with the number of intoxicated sexually aggressive acts, whereby the greater the amount of situational alcohol use, the greater the number of sexually aggressive acts perpetrated when intoxicated.



(Parkhill & Abbey, 2008, p.535; Permission to use granted 4/24/12.)

Figure 2.2. Theoretical Model Extending Malamuth et al.'s (1991) Confluence Model with the Addition of an Alcohol Path

2.4.2.3 Summary of the Confluence Model

Parkhill and Abbey (2008) studied alcohol's role as a variable in the confluence model to predict sexually aggressive acts. The authors demonstrated that alcohol beliefs and drinking patterns were a third variable that significantly predicted acts of sexual aggression. Sex offender treatment programs could use the confluence model to develop treatment strategies targeting offenders' beliefs about adolescent delinquency, general alcohol behaviors and beliefs,

impersonal sex, and hostile masculinity. Understanding and treating these critical factors could propel future research and standardize sex offender treatment protocols and ultimately reduce the risks of sexual offenders committing new sexually aggressive acts.

2.5 Effectiveness of Sex Offender Treatments

2.5.1 *Treated Group to Comparison (Drop Out) Group*

Hall (1995) conducted one of the first meta-analysis to measure the effectiveness of sex offender treatment in lowering rates of recidivism. The meta-analysis included 12 studies conducted between 1988 and 1994 comparing rates of recidivism among treated sex offenders and comparison control groups. A significant limitation of Hall's meta-analysis was the use of drop outs as the comparison groups, rather than other forms of treatment, treatment as usual, or untreated groups. Ten studies were of men who committed sexual offenses against children, six studies involved men who committed sexual offense against women, and two studied men who committed "hands off" sexual offenses (exhibitionism, voyeurism, etc.). An equal number of these studies involved outpatient and institutionalized participants. Recidivism was operationalized as an additional sexually aggressive behavior resulting in a new criminal charge, after a period of treatment for those who did and did not complete treatment. Participants who completed sex offender treatment demonstrated recidivism rates of 19 percent compared to 27 percent for the comparison group (Hall, 1995). The use of random assignment to treatment group and comparison conditions did not produce greater mean effect size than less rigorous studies. The mean effect size was greater for studies with follow-up periods longer than five years compared to studies with follow-up periods of less than five years. As expected, treatment effect size was greater in samples having a high base rate of recidivism compared to samples with a low base rate of recidivism. Outpatient studies produced a medium effect size, while institutional studies produced a small effect size. These results may imply that institutionalized participants had characteristics that show lower treatment response (antisocial personality disorder, impulsivity, noncompliance, higher levels of sexual deviance, etc.). Overall, Hall (1995) demonstrated that

sexual offenders who completed treatment had lowered rates of recidivism compared to sexual offenders who dropped out of treatment.

2.5.2 *Analytical Review of Recidivism Rates*

Alexander (1999) conducted an analytical review of 79 studies, with a total 10,988 subjects, measuring recidivism rates by categories of sexual offenders and treatment effectiveness by intervention, location, and within subtypes of categories. The author's definition of recidivism, being rearrested for a new sexual offense, paralleled the one used in Hall's (1995) meta-analysis. Alexander chose this more conservative definition of recidivism to reduce the potential for effective treatment bias (1999). In contrast to Hall (1995), Alexander's comparison groups included both untreated sexual offenders and sexual offenders who dropped out of treatment.

2.5.2.1 Inclusion Criteria

The study included three criteria distinguishing stronger and weaker findings. First, a proposed ceiling for positive treatment outcomes was set at recidivism rates of less than 11 percent. The author argued that the proposed ceiling demonstrated that 90 percent of the sexual offenders remained offense free, an acceptable level to the general public, researchers, and practitioners. Second, at least 100 subjects were needed in each "cell" to establish greater validity to the findings. Third, a 10 percent gap between treated and untreated groups suggested a clear distinction between the groups. Study subjects were separated by the following categories: Juveniles, rapists, child molesters, exhibitionists, and types not specified.

2.5.2.2 Results

Treated subjects across all the categories, except "types not specified," demonstrated overall lower rates of recidivism compared to untreated groups (Alexander, 1999). Relapse prevention interventions, which included cognitive-behavioral techniques, yielded the lowest rates of recidivism across all subjects compared to the other interventions (group/behavioral/other or unspecified) and untreated subjects (Alexander, 1999). Furthermore, relapse prevention

interventions met all three of the above mentioned criteria establishing stronger findings. However, relapse prevention interventions were not specifically defined within the study; therefore the specific treatment techniques used to determine the effectiveness were unclear. Treatment effectiveness was categorized by location: Outpatient, prison, hospital, unspecified or mixed, and untreated. Subjects treated in prisons demonstrated the lowest rates of recidivism, 9.4 percent, though meeting only two of the established criteria, followed by outpatient settings (11.5%) and hospitals (16.6%) (Alexander, 1999).

Treated juvenile rapists (5.8%), child molesters (2.1%), and unspecified (7.5%) all demonstrated recidivism rates below the 11 percent ceiling (Alexander, 1999). These findings provide evidence that treating young sexual offenders decisively reduces their risk of committing a new sexual offense as an adult. Incest perpetrators who received treatment demonstrated recidivism rates of 4 percent compared to 12.5 percent for untreated incest perpetrators (Alexander, 1999). Treated non-incest perpetrators were found to have recidivism rates of 11.7 percent, slightly above the 11 percent ceiling, though significantly lower than the 32 percent recidivism rates of untreated non-incest perpetrators (Alexander, 1999). Child molesters with female victims who received treatment demonstrated recidivism rates of 15.6 percent, marginally below the recidivism rates of 18.2 percent for treated child molesters with male victims (Alexander, 1999). Alarmingly, the rates of recidivism for adult rapists who received treatment were 20.1 percent, compared to 23.7 percent for untreated rapists (Alexander, 1999). These findings demonstrate that rapists may possess additional characteristics (hypermasculinity, attitudes towards violence, impulsivity, etc.) that are associated with lower treatment response.

2.5.2.3 Summary of Recidivism Rates

The Alexander (1999) review provided a thorough analysis demonstrating that treatment for sexual offenders, in general, reduces rates of recidivism. The study found that relapse prevention interventions significantly reduced rates of recidivism for all categories of sexual offenders (juveniles, rapists, child molesters, exhibitionists, and types not specified). Alexander's

review is important because it was one of the largest reviews, to date, that distinguished recidivism rates among categories of sexual offenders by subtype, treatment modality, and location of sex offender treatment. The review also provides valuable knowledge to researchers and practitioners who better understand which type of treatment modality, within different settings, provides the most effective means of lowering sexual recidivism rates for categories and subtypes of sexual offenders.

2.5.3 *Psychosocial Treatment Effectiveness*

Hanson et al. (2002) conducted a meta-analysis of 43 psychosocial treatments for sexual offenders measuring the effectiveness in lowering rates of sexual and general recidivism between treatment and comparison groups. Two eligibility criteria were established for inclusion in the meta-analysis. First, the study had to use the same recidivism criteria for treatment and comparison groups. Second, rates of recidivism had to be reported for approximately the same length of follow-up period. The studies operationalized recidivism as reconviction, rearrest, a parole violation, readmission to an institution, and unofficial community reports. The most common source of recidivism data were national criminal justice records, followed by state/provincial records. A majority of the studies included in the meta-analysis reported both sexual and general recidivism rates.

2.5.3.1 Recidivism Rate Statistics

On average, sexual offense recidivism rates were lower for treatment groups (12.3%) than comparison groups (16.8%) (Hanson et al., 2002). General recidivism rates were lower for treatment groups than comparison groups (27.9% and 39.2%, respectively) (Hanson et al., 2002). The authors replicated the findings of Hall (1995) who demonstrated that sexual offenders who dropped out of treatment had consistently higher sexual recidivism rates. The replicated findings stress the importance that all sexual offenders be mandated to complete sex offender treatment. Sexual offenders refusing treatment were not at higher risk of sexual recidivism compared to those who completed sex offender treatment. These findings may be the result of practitioners

properly screening sexual offenders in most need of sex offender treatment. Institutional and community treatments both reduced rates of sexual recidivism. Offenders who completed sex offender treatment had consistently lowered rates of general recidivism compared to those who refused or dropped out of treatment. Hanson et al. (2002) posited that sex offenders dropping out of treatment pose a greater risk to reoffend due to preexisting characteristics associated with recidivism and factors motivating treatment termination.

2.5.3.2 Effectiveness of Current Treatments

Current treatments (any physical, hormonal, or psychosocial treatment currently offered and cognitive-behavioral treatments since 1980) were equally effective at lowering rates of sexual recidivism (17.3% to 9.9%) and general recidivism (51% to 32%) among adult and adolescent sexual offenders (Hanson et al., 2002). Sex offender treatment currently provided in the community had a stronger effect size on general recidivism, compared to institutionally provided treatment (Hanson et al., 2002). The stronger effect size could be attributable to personal characteristics of incarcerated sex offenders (antisocial personality, noncompliance, hostility towards authority, etc.). The findings in the Hanson et al. (2002) meta-analysis provided evidence that sex offender treatment programs are effective at lowering the rates of sexual and general recidivism for sexual offenders.

2.5.4 *International, Comprehensive Meta-Analysis*

Lösel and Schmucker (2005) conducted, at the time, the most comprehensive meta-analysis of 69 studies with 80 comparisons from documents published in five languages. The study was designed to measure the effectiveness of sex offender treatment in lowering rates of recidivism on an international level. The authors established the following eligibility criteria for potential studies inclusion in the meta-analysis: 1.) sexual offenders must have been convicted of a sexual offense or committed an illegal sexual behavior for which they could have been convicted, and 2.) recidivist behavior had to be the dependent variable in the study. Recidivism was operationalized using broad parameters of incarceration for a new sexual offense, to lapses

in sexual offense behavior. Recidivism rates were primarily extracted from official records, though some self-reports from the sexual offenders were used. The most common forms of recidivism were reconviction, followed by rearrest and new criminal charge (Lösel and Schmucker, 2005). The average follow-up periods of the included studies were longer than five years.

2.5.4.1 Recidivism Rates and Treatment Effect Size

Comparisons of 74 studies demonstrated average recidivism rates of 12 percent for treated sexual offenders and 24 percent for control groups (Lösel and Schmucker, 2005). The authors integrated the individual effect size in the random model to produce an absolute difference. The absolute difference in sexual recidivism rates between treatment and control groups was six percentage points, a 37 percent reduction from the base rate of the control groups (Lösel and Schmucker, 2005). On average, treated sexual offenders' rates of sexual recidivism were 5.2 percentage points lower than untreated offenders, equating to a 44 percent reduction (Lösel and Schmucker, 2005). General recidivism rates for treated sexual offenders were 11.1 percentage points lower than untreated offenders, a 31 percent reduction (Lösel and Schmucker, 2005). Psychological treatment for sexual offenders reduced sexual recidivism by 27 percent compared to untreated groups (Lösel and Schmucker, 2005). The effect size of sexual offenders who voluntarily participated in sex offender treatment was significantly positive, compared to no effect for sexual offenders obligated to participate in treatment or mixed conditions. Lösel and Schmucker (2005) replicated findings that sexual offenders who drop out of treatment demonstrate significantly worse treatment effect (higher rates of recidivism) and doubled their risk of reoffending.

Treatment effect size was greatest for physical treatment (castration), followed by hormonal treatments and psychosocial measures (Lösel and Schmucker, 2005). Of the psychosocial measures, only cognitive-behavioral treatments and classical behavior treatments demonstrated a significant impact on lowering rates of sexual recidivism (Lösel and Schmucker,

2005) . There was no significant effect size between individual and group treatments, randomized trials and other lower design studies, or for the length of follow-up periods.

2.5.4.2 Summary of International, Comprehensive Findings

Lösel and Schmucker (2005) produced an in-depth meta-analysis demonstrating the effectiveness of sex offender treatment by lowering rates of recidivism. However, the study failed to provide any information on the subtypes of sexual offenders. Furthermore, the analyzed studies did not report any additional/adjunct services provided for sexual offenders in need of substance use treatment. Though no reviews or meta-analyses regarding the prevalence of substance abuse were published prior to this study, one large study (Langevin & Lang, 1990) demonstrated the high prevalence of substance misuse among sexual offenders. A critical factor further decreasing recidivism rates for sexual offenders could be accurately treating sexual offenders' substance misuse disorders, which would also provide additional support for the efficacy of sex offender treatment programs.

2.5.5 *Quantitative Review of Treatment Approaches*

Gallagher, Wilson, Hirschfield, Coggeshall, and MacKenzie (1999) performed a quantitative review of sex offender treatment approaches and their effect on lowering rates of sexual recidivism. The goal of the authors was to measure rates of recidivism, post treatment, through an analysis of sex offender treatment modalities (behavioral, cognitive-behavioral, medical, and other psychosocial approaches). The study included 22 documents with 25 separate studies measuring rates of recidivism between treated and comparison groups. Recidivism was operationalized in 18 of the studies as an arrest for a new sexual offense, from official records. An additional six studies operationalized recidivism through a composite measure of self-reports, family-reports, and official records. The majority of the studies included male adult participants in both the treated and comparison groups. The study separated surgical castration from chemical castration with adjunct components to treatment, relapse prevention with cognitive-behavioral treatment from exclusively cognitive-behavioral approaches, and strictly

behavioral treatment from behavioral treatment with adjunct components to narrow the focus on treatment effect.

Overall, treated groups demonstrated lower rates of sexual offense recidivism for treated groups compared to the untreated/comparison groups (Gallagher et al., 1999). Surgical castration demonstrated the most significant positive treatment effect size with regards to rates of sexual recidivism, though only one study from Germany was found measuring the modality's effectiveness (Gallagher et al., 1999). Cognitive-behavioral treatment with a relapse prevention component demonstrated a mean effect size of .43, yet half of the studies were statistically significant(Gallagher et al., 1999). Cognitive-behavioral interventions are widely used among sex treatment programs and designed to teach sexual offenders the needed cognitive meditational skills to reduce their risks of reoffending. Cognitive-behavioral approaches without a relapse prevention component were also statistically significant in terms of reducing rates of sexual recidivism (Gallagher et al., 1999). The designs of the chemical castration with supplemental treatments were weak and their evidence insufficient to determine effectiveness (Gallagher et al., 1999). Neither strictly behavior nor behavioral with adjunct approaches produced significant reductions in rates of sexual recidivism. Overall, treated sex offenders demonstrated lower rates of sexual recidivism compared to untreated/comparison groups (Gallagher et al., 1999). Of the various treatment approaches, cognitive-behavioral treatments demonstrated the most promise in reducing the risk of future sexual offenses committed by treated sexual offenders.

CHAPTER 3

METHODOLOGY

3.1 Research Aims

The present study aimed to determine the prevalence of lifetime alcohol misuse among participants enrolled in outpatient sex offender treatment. Therefore, for the purposes of this study, the definition of sexual offender included individuals' currently on parole or probation that are court ordered to attend and/or complete outpatient sex offender treatment. Three hypotheses are based on four independent variables:

Hypothesis #1: Participants' alcohol misuse will be under-reported at intake as compared to scores on the MAST screenings.

Hypothesis #2: Participants' alcohol misuse will be under-reported at intake as compared to the number of court ordered substance abuse assessments.

Hypothesis #3: The percentage of participants who participated in, or completed, court ordered substance abuse treatment will be less than the percentage of participants who score in the "problem drinking" category as determined by MAST scores.

The knowledge gained from the present study will benefit social workers treating sexual offenders, who present for services with an alcohol misuse disorder, and provide crucial information for social workers employed in the criminal justice system.

3.2 Participants

The present study recruited 78 voluntary, randomly selected males who are court-ordered to complete a sex offender treatment program (SOTP) in Tarrant County, Texas. All individuals in the research study were in the process of completing a self-pay, outpatient sex

offender treatment program. The participants were on probation or parole for a sexual offense or to a pled down charge of Bodily Injury to a Child/Minor, and most were required to complete the program within three years of sentencing. The clientele served by the sex offender treatment provider were predominantly male (97%).

The inclusion criteria for participation in the proposed study were: Currently attending sex offender treatment at the agency, ability to understand and answer the written questions, and the ability to understand and provide a written consent. Participants were not screened for a substance use disorder prior to the onset of the study. The present study was conducted after full approval from the Institutional Review Board (IRB) of The University of Texas at Arlington. The present study complied with ethical treatment of human subjects and recognized the potential harm to participants who are currently on probation or parole. Signed informed consents were obtained from all participants prior to study participation.

3.3 Research Procedures

The research participants were randomly selected and approached about participation in the present study. Participation in the study was strictly voluntary. Licensed and Affiliate Sex Offender Treatment Providers employed at the agency explained the purpose of the study at the beginning of weekly group therapy sessions, prior to the randomly selected individuals being approached about participation in the proposed study. Randomly selected individuals that did not attend their regularly scheduled group therapy sessions were not approached. Individuals who consented to participate in the present study were given the *Michigan Alcoholism Screening Test* (MAST) questionnaire to complete and also a short demographic update questionnaire. The demographic questionnaire ascertained the participant's responses to questions involving court-ordered substance abuse assessment, referral for substance abuse treatment, completion/enrollment in substance abuse treatment, current relationship status, number of lifetime co-habitations (living with a partner) lasting longer than six months, and current employment status (see Appendix C). Finally, a chart analysis was conducted for each

participant to gather the following information: age, ethnicity, current criminal charge, number of arrests, number of months in outpatient sex offender treatment, number of treatment plan goals completed, self-reported alcohol use during intake assessment, court-ordered substance abuse assessment, highest education level attained, and self-reported childhood abuse during intake assessment (see Appendix B).

3.4 Research Instruments

3.4.1 *Michigan Alcoholism Screening Test (MAST)*

The *Michigan Alcoholism Screening Test* (MAST) is a 24 item self-report questionnaire consisting of yes/no responses that measures lifetime alcohol use (Selzer, 1971). Other alcohol screening instruments were considered for the study, but the MAST was chosen due to its extensive use in other studies and has no cost associated for administering and scoring. Each question is scored as one, two, or five, with total scores ranging from 0 to 53. Scores of nine or greater are indicative of the participant having a severe drinking problem at some point in their lifetime. Scores ranging from six to eight are indicative of the individual having some lifetime difficulties with alcohol, including alcohol abuse. Selzer (1971) suggested a cutoff score of five or greater as indicative of an individual having some lifetime problem with alcoholism; however cutoff scores greater than five and greater than eight are commonly used as indicators of alcoholism (Langevin & Lang, 1990). The participants' MAST scores were coded as "no problem (score 0-5)", "alcohol problem (score 6-8)", and "alcohol abuse/dependence (score 9+)" According to Gibbs, the MAST has high face validity, though the instrument may under diagnose individual's unwilling to admit alcohol problems (1983). The MAST has demonstrated high test retest reliability in studies conducted by Zung (1982) and Skinner and Sheu (1982) (As cited in Storgaard, Nielsen, & Gluud, 1994, pp. 498 & 501). Langevin and Lang (1990) demonstrated satisfactory internal consistency as a single factor test for the MAST with an alpha reliability of .89 when administering the MAST to sexual offenders. Conley (2001) argued that the MAST

demonstrates very good internal consistency with an alpha reliability of .86 when administered to individuals charged with multiple drunken driving offenses.

3.4.2 *Demographic Update Questionnaire*

Independent variables around substance misuse and substance misuse treatment were found in the literature review to be under studied, but potential factors in treatment outcomes for this population (Langevin & Lang, 1990; Peugh & Belenko, 2001). Therefore, a supplementary demographic questionnaire was created for this study to obtain data on the independent variables. A demographic update form was also administered to the participants ascertaining specific information that cannot be extracted from the record review. The demographic update gathered the following self-report information regarding: Court ordered substance abuse assessment, court ordered referral for substance abuse treatment, enrollment or completion of substance abuse treatment, current relationship status, total number of lifetime cohabitations lasting longer than six months, and current employment status.

3.4.3 *Chart Analysis and Code Book*

A chart review of the agency's files was conducted on every participant to obtain information on the clients' age, ethnicity, criminal history (number of arrests), current criminal charge, self-reported alcohol use at intake, court-ordered substance abuse assessment, self-reported childhood abuse, highest education level completed, number of months in treatment, and number of treatment goals completed. The chart review included an analysis of each participant's psychosocial assessment at intake regarding alcohol and/or substance use history. Participants' self-reported alcohol use at intake was coded in one of five ways. Participant's denying previous alcohol use or a problem with alcohol, were coded as, "No Alcohol Use or Problem." Participants admitting previous alcohol use, but no problem were coded as, "Alcohol Use – No Problem." Those participants who admitted, during their intake assessment, to having a problem with alcohol at some point in their lifetime or were previously arrested for an alcohol offense (driving while intoxicated, public intoxications, etc.) were coded as, "Alcohol Misuse." The

code, “Substance Misuse,” was used for participants who admitted to a drug/substance problem at some point in their lifetime or admitted being arrested for a drug/substance offense (possession, distribution, etc.). The participants’ case files that did not have the above information were coded as, “Information Missing.” Childhood abuse information was gathered from the participants’ record reviews and coded as denied childhood abuse, physical abuse as a child, sexual abuse as a child, and physical and sexual abuse as a child. The agency does not currently perform a standardized substance abuse assessment during the intake assessment of new clients.

3.5 Data Analysis

The results of the MAST scores were examined to determine the prevalence of alcohol misuse within the participants of the study. Alcohol misuse results were analyzed through self-report assessment and scores on the MAST. Substance abuse assessments were also compared with self-reports at intake assessment, scores on the MAST, and participants self-report of successful completion of substance abuse treatment.

CHAPTER 4

RESULTS

4.1 Participants

The present study consists of 78 male participants, all currently attending court ordered outpatient sex offender treatment in Tarrant County, Texas. One hundred potential participants were selected through a standardized random numbers generator program to approach regarding their participating in the present study. Three potential participants were not in attendance at their weekly group therapy session, one was discharged from treatment, and one became incarcerated during the research period; therefore 95 potential participants were approached about participation in the present study. Seventeen potential participants declined participation. Seventy-eight participants (82%) of those approached agreed to voluntarily participate in the present study. Research for the present study commenced on June 11, 2012, and ceased on June 23, 2012. The study participants ranged from 22 to 71 years of age (mean = 42, *SD* = 11.80) and were primarily Caucasian (*n* = 56, 71.8%), followed by African-Americans (*n* = 18, 23.1%) then Hispanics (*n* = 4, 5.1%).

4.2 Demographic Data

4.2.1 *Chart Review*

The overwhelming majority of the study participants (*n* = 68, 87.2%) are currently on probation/parole for a sexual crime against a child, which includes Solicitation of a Child via the Internet and Possession of Child Pornography (see Table 4.1). The study participants number of arrests ranged from one to six (mean = 1.77, *SD* = 1.22). The number of months the study participants attended outpatient sex offender treatment ranged from 1 to 121 (mean 32.58, *SD* = 27.08). The number of treatment plan goals completed by the study participants ranged from 0 to

29 (mean = 11.97, *SD* = 9.47). Results of the study participants' self-reported alcohol use at intake is displayed in Table 4.2, followed by the results of the court-ordered substance abuse assessments displayed in Table 4.3. The participants' highest education level completed and self-reported childhood abuse results are presented in Tables 4.4 and 4.5.

Table 4.1. Participants' Current Criminal Charge

Current Criminal Charge	Frequency	Percent
Sexual assault of a child/minor	18	23.1
Indecency with a child - fondling	16	20.5
Aggravated sexual assault of a child	13	16.7
Solicitation of a minor via Internet	7	9
Other	6	7.7
Assault bodily injury to a child	5	6.4
Possession of child pornography	5	6.4
Indecency with a child - exposure	4	5.1
Aggravated sexual assault	2	2.6
Failure to register as a sex offender	2	2.6
Totals	78	100

Table 4.2 Participants' Self-Reported Alcohol Use at Intake Assessment

Alcohol Use at Intake	Frequency	Percent
No alcohol use or problem	19	24.4
Alcohol use – no problem	35	44.8
Alcohol misuse	19	24.3
Substance misuse	3	3.9
Information Missing	2	2.6
Total	78	100

Table 4.3. Participants' Court-Ordered Substance Abuse Assessment

Court Ordered Substance Abuse Assessment	Frequency	Percent
No court ordered substance abuse assessment	32	41
Court ordered for substance abuse assessment	38	48.7
Information missing	8	10.3
Total	78	100

Table 4.4. Participants' Highest Grade Level Completed

Description of Grade Level Completed	Frequency	Percent
No high school diploma	11	14.1
High school diploma	22	28.2
Some college	29	37.2
Associate's degree	8	10.3
Bachelor's degree	7	9
Master's degree	1	1.3
Totals	78	100

Table 4.5. Participants' Self-Reported Childhood Abuse

Reported Child Abuse	Frequency	Percent
Denied childhood abuse	54	69.2
Physical abuse as a child	5	6.4
Sexual abuse as a child	15	19.2
Physical & sexual abuse as a child	3	3.8

4.2.2 *Demographic Update*

The study's demographic update questionnaire gathered participants' responses to six questions (see Tables 4.6, 4.7, and 4.8). Fifty participants (64.1%) responded "no" when asked if they were court-ordered to undergo a substance abuse assessment. Sixty-five participants (83.3%) responded "no" when asked if they were referred for substance abuse treatment after the substance abuse assessment. When asked if the participant completed, or was currently enrolled in, substance abuse treatment, 62 participants (79.5%) responded "no". The results of the participants' responses to "current relationship status" are displayed in Table 4.7. The participants' number of lifetime cohabitations ranged from zero to six (mean = 1.92, *SD* = 1.53). The participants' current employment status responses are displayed in Table 4.8.

Table 4.6. Participants' Responses to Demographic Update Questions 1-3

Response	Court-Order S.A. Assessment		Referred for S.A. Treatment		Participated in S.A. Treatment	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
No	50	64.1	65	83.3	62	79.5
Yes	28	35.9	13	16.7	16	20.5
Total	78	100	78	100	78	100

Note. S.A. = Substance Abuse.

Table 4.7. Participants' Self-Reported Current Relationship Status

Relationship Status	**Frequency**	**Percent**
Single	29	37.2
Married	29	37.2
Co-Habitating	6	7.7
Separated	2	2.6
Divorced	12	15.4
Total	78	100

Table 4.8. Participants' Self-Reported Current Employment Status

Employment Status	Frequency	Percent
Unemployed	8	10.3
Employed full-time	55	70.5
Employed part-time	4	5.1
Disabled – unemployed	2	2.6
Disabled – employed	1	1.3
Other	8	10.3
Total	78	100

4.2.3 *Self-Reported Alcohol Use at Intake*

Nineteen study participants (24.4%) self-reported at intake to not consume alcohol. Thirty-five participants (44.8%) self-reported to consume alcohol, but denied having an alcohol problem. Alcohol misuse, determined by self-reported alcohol problem or prior criminal arrest(s) for an alcohol related crime, was reported by 19 participants (24.4%). Three participants (3.9%) were categorized as "substance misuse" for either admitting to a substance use (other than alcohol) problem at some point in their lifetime or a prior arrest(s) for a narcotics charge. Alcohol use at intake could not be determined on two study participants due to missing information in the participants' case files. (See Table 4.2 for the results of the study participants' self-reported alcohol use at intake.)

4.2.4 *MAST Scores*

The MAST scores for the participants ranged from 0 to 46, (mean = 9.44, *SD* = 11.54). Forty-six participants (58.9%) scored within the "no problem" category of zero to five on the MAST screening. Four participants (5.2%) scored in the "alcohol problem" range of six to eight. Twenty-eight participants (35.9%) scored within the "alcohol abuse/dependence" category with a score of nine or greater. Overall, 32 study participants (41%) demonstrated evidence of

Table 4.9. Self-Reported Alcohol Use at Intake and Current Criminal Charge

Current Charge	Self-Reported Alcohol Use at Intake					Total
	No Ax Use/ or Problem	Ax Use/No Problem	Alcohol Misuse	Substance Misuse	Info. Missing	
Sex. assault - child/minor	1 (1.3%)	13 (16.7%)	4 (5%)	0	0	18 (23%)
Agg. sexual assault	2 (2.6%)	0	0	0	0	2 (2.6%)
Agg. sex. assault - child/minor	3 (3.8%)	7 (8.9%)	2 (2.6%)	1 (1.3%)	0	13 (16.6%)
Indecency – exposure	0	4 (5.1%)	0	0	0	4 (5.1%)
Indecency – fondling	4 (5%)	3 (3.8%)	6 (7.7%)	1 (1.3%)	2 (2.6%)	16 (20.5%)
Agg. bodily injury – child	2 (2.6%)	1 (1.3%)	2 (2.6%)	0	0	5 (6.4%)
Solicitation minor	2 (2.6%)	4 (5.1%)	1 (1.3%)	0	0	7 (8.9%)
Failure to register as S.O.	1 (1.3%)	0	1 (1.3%)	0	0	2 (2.6%)
Poss. child pornography	2 (2.6%)	1 (1.3%)	1 (1.3%)	1 (1.3)	0	5 (6.5%)
Other	2 (2.6%)	2 (2.6%)	2 (2.6%)	0	0	6 (7.8%)
Total	19 (24.4%)	35 (44.8%)	19 (24.4%)	3 (3.9%)	2 (2.6%)	78 (100%)

Note. Info. = Information. Ax = Alcohol. Sex. = Sexual. Agg. = Aggravated. S.O. = Sex Offender. Poss. = Possession.

having an alcohol problem at some point in their lifetime as evidenced by scores ranging from six or greater on the MAST screening, compared to 19 participants (24.4%) who were determined to have an alcohol misuse problem at intake. (Table 4.10 presents the results of the MAST scores by score range and Table 4.11 displays the MAST scores ranges by Current Criminal Charge).

Table 4.10. Participants' Categorical *Michigan Alcoholism Screening Test* (MAST) Scores

MAST Score Coding	Frequency	Percent
No problem (score 0-5)	46	58.9
Alcohol problem (score 6-8)	4	5.2
Abuse/dependence (score 9+)	28	35.9
Total	78	100

Table 4.11. Participants' MAST Score ranges and Current Criminal Charge

Current Charge	MAST Score Ranges			Total
	No Problem (0-5)	Ax Problem (6-8)	Ax Abuse/Dep. (9+)	
Sex. assault - child/minor	11 (14.1%)	2 (2.6%)	5 (6.4%)	18 (23.1%)
Agg. sexual assault	1 (1.3%)	0	1 (1.3%)	2 (2.6%)
Agg. sex. assault - child/minor	8 (10.3%)	0	5 (6.4%)	13 (16.7%)
Indecency – exposure	3 (3.8%)	0	1 (1.3%)	4 (5.1%)
Indecency – fondling	5 (6.4%)	0	11 (14.1%)	16 (20.5%)
Agg. bodily injury – child	3 (3.8%)	0	2 (2.6%)	5 (6.4%)
Solicitation minor	5 (6.4%)	0	2 (2.6%)	7 (8.9%)
Failure to register as S.O.	1 (1.3%)	1 (1.3%)	0	2 (2.6%)
Poss. child pornography	3 (3.8%)	1 (1.3%)	1 (1.3%)	5 (6.4%)
Other	6 (7.7%)	0	0	6 (7.7%)
Total	46 (58.9%)	4 (5.2%)	28 (35.9)	78 (100%)

Note. Ax = Alcohol. Dep. = Dependence. Sex. = Sexual. Agg. = Aggravated. S.O. = Sex Offender. Poss. = Possession.

4.2.5 *Summary of Alcohol Use and MAST Scores*

The present study identified each participant's current criminal charge through record reviews. The participants most common criminal charge was Sexual Assault of a Child/Minor (*n* = 18, 23.1%), followed by Indecency with a Child – Fondling (*n* = 16, 20.5%) and Aggravated Sexual Assault of a Child/Minor (*n* = 13, 16.7%). The range of MAST scores by subtype of criminal charge demonstrated that participants charged with Indecency with a Child – Fondling had the greatest number of participants with an alcohol problem (*n* = 11, 14.1%) followed by Sexual Assault of a Child/Minor (*n* = 7, 7.9%) and Aggravated Sexual Assault of a Child/Minor (*n* = 5, 6.4%). Record reviews and MAST scores determined that 11 participants (14.1%) charged with Indecency with a Child – Fondling were determined to have an alcohol/substance use problem at intake and scored with the "alcohol abuse/dependence" category on the MAST

screening. Four participants (5%) charged with Sexual Assault of a Child/Minor were determined to have an alcohol misuse problem at intake, though seven participants (9%) scored within the "alcohol problem" and "alcohol abuse/dependence" categories on the MAST screening. Three participants (3.9%) charged with Aggravated Sexual Assault of a Child/Minor self-reported a alcohol/substance misuse problem at intake; however five participants (6.4%) charged with Aggravated Sexual Assault of a Child/Minor scored within the "alcohol abuse/dependence" category on the MAST screening.

4.2.6 *Results of Hypothesis #1*

The study's first hypothesis stated that the participants' alcohol misuse will be under-reported at intake as compared to scores on the MAST screening. The participants' self-reported alcohol use during their intake assessments produced the following results: No alcohol use or problem (*n* = 19, 24.4%), alcohol use – no problem (*n* = 35, 44.8%), alcohol misuse (*n* = 19, 24.3%), substance misuse (*n* = 3, 3.9%), and information missing (*n* = 2, 2.6%). (See Table 4.9 for participants' self-reported alcohol use at intake.) The MAST score results, displayed in Table 4.12, for all participants were: No problem (scores 0-5) (*n* = 46, 58.9%), alcohol problem (scores 6-8) (*n* = 4, 5.2%), and alcohol abuse/dependence (scores 9+) (*n* = 28, 35.9%). Overall, 32 (41%) of the participants' scores on the MAST screenings were indicative of having a problem with alcohol at some point in their lifetime.

Calculations for Pearson-Chi Square significance values required collapsing of cells for the study participants' self-reported alcohol use at intake and the MAST score ranges. Participants who denied using alcohol and those self-reporting to consume alcohol, but denying an alcohol problem, during their intake assessment, were combined into the category, "No Problem". The participants who admitted to an alcohol problem or prior arrest for an alcohol related crime and those admitting to substance misuse (other than alcohol) or prior arrest for a narcotics related crime, were combined into the category, "Alcohol/Substance Misuse Problem". Scores on the MAST screening were divided into two categories: No Problem (scores 0-5) and

Alcohol Problem (scores 6+). Results of the Pearson Chi-Square analysis demonstrated the significance of the study's first hypothesis (x^2 (1) = 24.25, $p \leq .001$). Overall, 21 study participants (N = 76, 27.6%) were determined to have an alcohol use problem at intake assessment (n = 18, alcohol use problem; n = 3, substance use problem), significantly under-reported compared to the 30 study participants (N = 76, 40.8%) who scored in the alcohol problem range (scores 6 or greater) on the MAST screening. Furthermore, 13 participants out of 76 (17.1%) denied having a problem with alcohol or prior alcohol related arrest during their intake assessment, yet scored within the "Alcohol Problem" range (6+) on the MAST screening.

Table 4.12. Alcohol Use at Intake/MAST Scores Determining Alcohol Problem

MAST Screening	**Alcohol Use at Intake**		**Total**
	No Problem	Ax/Sx Problem	
No Problem (0-5)	42 (55.3%)	3 (3.9%)	45 (59.2%)
Ax Problem (6+)	13 (17.1%)	18 (23.7%)	30 (40.8%)
Total	55 (72.4%)	21 (27.6%)	76 (100%)

Note. Ax = Alcohol. Sx = Substance.

4.2.7 *Results of Hypothesis #2*

The present study's second hypothesis stated that participants' alcohol misuse will be under-reported at intake as compared to the number of court-ordered substance abuse assessments. Fifty-four participants, or 69.2%, denied consuming alcohol or admitted alcohol consumption, but denied an alcohol problem during their intake assessment. Alcohol or substance misuse was admitted during their intake assessment by 22 participants, or 28.2 percent. Two of the study's participants' intake assessments did not contain information regarding alcohol consumption or the information was missing. (See Table 4.9 for participants self-reported alcohol use at intake.) The record reviews of the participants' case files determined that 32 participants (41%) were not court-ordered to undergo a substance abuse assessment, 38 participants (48.7%) were court-ordered to receive a substance abuse assessment, and 8

participants (10.3%) information regarding court-ordered substance abuse assessments were missing. (See Table 4.3 for participants' court-ordered substance abuse results.)

Pearson Chi-Square calculations required the collapsing of cells to determine the significance of the second hypothesis. Participants' alcohol use at intake was coded as, "No Problem," meaning the participant denied alcohol consumption or admitted alcohol use, but denied an alcohol problem, and "Alcohol/Substance Misuse Problem," meaning the participant admitted to an alcohol problem, prior arrest for alcohol related charge, or to a substance (other than alcohol) problem or prior narcotics related arrest. The total number of study participants with information regarding a court-ordered substance abuse assessment was 70. Fifty-one participants, or 72.9%, denied an alcohol problem and 19 participants (26.1%) admitted to an alcohol/substance misuse problem. Thirty-two participants, or 45.7%, were not court ordered to undergo an assessment for substance abuse, while 38 participants (54.3%) were court-ordered to do so. The results of the Pearson Chi-Square calculation (x^2 (1) = 6.39, p < .011) demonstrated the second hypothesis' significance. Nineteen study participants' (N = 78, 26.1%) self-reported an alcohol or substance problem at intake, significantly fewer than the 38 participants (n = 70, 54.3%) who were court-ordered to undergo a substance abuse assessment.

Table 4.13. Self-Reported Alcohol Use at Intake/Court-Ordered Substance Abuse Assessment

Court-Ordered S.A. Assessment	**Self-Reported Ax Use at Intake**		**Total**
	No Problem	Ax/Sx Misuse Problem	
No	28 (40%)	4 (5.7%)	32 (45.7%)
Yes	23 (32.9%)	15 (21.4%)	38 (54.3%)
Total	51 (72.9%)	19 (26.1%)	70 (100%)

Note. Ax = Alcohol. S.A. = Substance Abuse. Sx = Substance.

Table 4.14. Court-Ordered Substance Abuse Assessment by Current Criminal Charge

Current Charge	Court-Order S.A. Assessment		Total
	No	Yes	
Sex. assault - child/minor	7 (10%)	8 (11.4%)	15 (21.4%)
Agg. sexual assault	1 (1.4%)	1 (1/4%)	2 (2.8%)
Agg. sex. assault - child/minor	7 (10%)	6 (8.7%)	13 (18.7%)
Indecency – exposure	3 (4.3%)	1 (1.4%)	4 (5.7%)
Indecency – fondling	5 (7.1%)	8 (11.4%)	13 (18.5%)
Agg. bodily injury – child	3 (4.3%)	2 (2.9%)	5 (7.2%)
Solicitation minor	2 2.9%)	5 (7.1%)	7 (10%)
Failure to register as S.O.	0	1 (1.4%)	1 (1.4%)
Poss. child pornography	0	4 (5.7%)	4 (5.7%)
Other	4 (5.7%)	2 (2.9%)	6 (8.6%)
Total	32 (45.7%)	38 (54.3%)	70 (100%)

Note. S.A. = Substance Abuse. = Dependence. Sex. = Sexual. Agg. = Aggravated. S.O. = Sex Offender. Poss. = Possession.

4.2.8 *Results of Hypothesis #3*

The third hypothesis in the present study stated that the percentage of participants who participated in, or completed, court-ordered substance abuse treatment will be less than the percentage of participants who score in the "problem drinking" category (scores of six or greater) as determined by the participants' MAST score. Sixteen study participants (20.5%) answered "yes" when asked if they completed or were currently enrolled in substance abuse treatment. Thirty-two study participants (41.1%) scored in the "problem drinking" category on the MAST screening. Pearson Chi-Square calculations demonstrated that the percentage of participants who were enrolled in, or completed, substance abuse treatment was significantly less than the

percentage of participants who scored in the “problem drinking” category on the MAST screening (x^2 (1) = 17.97, $p \leq .001$).

Table 4.15. MAST “Problem Drinking” Category by Participation in Substance Abuse Treatment

Participation in Substance Abuse Treatment	MAST “Problem Drinking” (scores 6+)		Total
	No	Yes	
No	44 (56.3%)	18 (23.2%)	62 (79.5%)
Yes	2 (2.6%)	14 (17.9%)	16 (20.5%)
Total	46 (58.9%)	32 (41.1%)	78 (100%)

Table 4.16. Participation in Substance Abuse Treatment by Current Charge

Current Charge	Participated in S.A. Treatment		Total
	No	Yes	
Sex. assault - child/minor	17 (21.9%)	1 (1.3%)	18 (23.2%)
Agg. sexual assault	2 (2.6%)	0	2 (2.6%)
Agg. sex. assault - child/minor	11 (14.1%)	2 (2.6%)	13 (16.7%)
Indecency – exposure	4 (5.1%)	0	4 (5.1%)
Indecency – fondling	7 (8.9%)	9 (11.4%)	16 (20.3%)
Agg. bodily injury – child	4 (5.1%)	1 (1.3%)	5 (6.4%)
Solicitation minor	6 (7.7%)	1 (1.3%)	7 (9%)
Failure to register as S.O.	2 (2.6%)	0	2 (2.6%)
Poss. child pornography	4 (5.1%)	1 (1.3%)	5 (6.4%)
Other	5 (6.4%)	1 (1.3%)	6 (7.7%)
Total	62 (79.5%)	16 (20.5%)	78 (100%)

Note. S.A. = Substance Abuse. = Dependence. Sex. = Sexual. Agg. = Aggravated. S.O. = Sex Offender. Poss. = Possession.

4.2.9 *Overall Findings*

The purpose of the present study was to determine the lifetime alcohol misuse prevalence rates among sexual offenders currently enrolled in outpatient sex offender treatment. Seventy-eight participants (82.1%) voluntarily agreed to participate in the study. Record reviews of the participants' case files determined 19 participants, or 24.4%, self-reported during their intake assessment an alcohol problem or prior alcohol related arrest. Three additional participants, or 3.9%, were determined to have a substance use problem (other than alcohol) through the same process. MAST screenings were administered to all 78 participants and determined that 32 participants (41.1%) have experienced a problem with alcohol at some point in their lifetime.

All three of the present study's hypotheses were proven significant. Hypothesis #1 demonstrated that 13 participants (17.1%) denied having an alcohol problem during their intake assessment, but scored in the "problem drinking" range on the MAST screening. The study's second hypothesis demonstrated self-reported alcohol use was under-reported at intake assessment when compared to the number of court-ordered substance abuse assessments. Fifty-one participants (*N* = 70, 72.9%) denied having an alcohol problem; however, only 28 of the participants (*N* = 70, 45.7%) were not court-mandated to undergo a substance abuse assessment. The third hypothesis argued that the percentage of study participants who were enrolled in, or completed, substance abuse treatment would be less than the percentage of participants who scored in the "problem drinking" range on the MAST screening. Research findings demonstrated that 20.5% of the study participants were enrolled in, or completed, substance abuse treatment, compared to 41.1 percent of the participants who scored in the "problem drinking" category on the MAST screening. These findings present evidence that more individuals who are sentenced within the criminal justice system for sexual offenses should be court-ordered to undergo a substance abuse assessment.

CHAPTER 5

DISCUSSION

5.1 Lifetime Alcohol Prevalence Rates

The present study confirmed that substantial numbers of men currently enrolled in court-ordered outpatient sex offender treatment have at some point in their lifetimes experienced a problem with alcohol. Lifetime alcohol problems were measured using the *Michigan Alcoholism Screening Test* (MAST). The MAST is a 24 item self-report questionnaire that has demonstrated high face validity and high test- retest reliability (Gibbs, 1983; Storgaard, Nielsen, & Guild, 1994). Langevin and Lang (1990) demonstrated satisfactory internal consistency when the MAST was administered to sexual offenders. Overall, the MAST scores in the present study ranged from 0 to 46 (mean = 9.4, *SD* = 11.54). Forty-six participants' (58.9%) scores were within the "no problem" range of zero to five and 32 participants' (41.1%) scores demonstrated some lifetime alcohol problem (scores six or greater). Twenty-eight participants (35.9%) scored in the "alcohol abuse/dependence" category with scores on the MAST of nine or greater.

Lifetime alcohol problems among sex offenders in the present study are similar to results demonstrated in other studies. Langevin and Lang (1990) demonstrated that 240 male sexual offenders (*N* = 461, 52 %) scored a six or greater on the MAST screening (mean = 10.4, *SD* = 12.5). In a study of 115 incarcerated offenders comparing *mean* MAST scores between sexual offenders (*n* = 94) and violent non-sexual offenders (*n* = 21), Abracen et al. (2006) demonstrated sexual offenders experienced greater lifetime alcohol problems (mean = 8.41) than violent non-sexual offenders (mean = 5.5). Abracen, Looman, and Anderson (2000) conducted a preliminary investigation to discover differences between sexual offenders and non-sexual violent offenders in regard to alcohol and drug abuse. Their findings demonstrated that 47 participants (*N* = 106,

44%) scored in the “severe” level of lifetime alcohol problems on the MAST with scores of ten or greater (Abracen, Looman, & Anderson, 2000). The meta-analysis conducted by Kraanen and Emmelkamp (2011) demonstrated that between 16 percent and 80 percent (median = 42.5%) of sexual offenders score five or greater on the MAST and *mean* MAST scores ranged from 5.1 to 26 (median = 9.5). Findings in the present study replicated the findings other studies by demonstrating that 41.1 percent of the participants scored in the “problem drinking” category and an overall *mean* score of 9.4 for all participants.

5.2 Court-Ordered Assessments and Substance Abuse Treatment

Record reviews of the study participants’ case files determined that 38 participants (54.3%) out of 70 were court ordered to undergo an assessment for substance abuse. The present study was unable to determine through official records the number of participants who were court-ordered to participate and complete substance abuse treatment. Therefore, participants self-reported participation in or completion of substance abuse treatment was determined through the study’s demographic update questionnaire (see Appendix C). The participants’ self-reported participation in substance abuse treatment demonstrated that nine participants (11.4%) charged Indecency with a Child – Fondling participated in substance abuse treatment, followed by participants charged with Sexual Assault of a Child/Minor (*n* = 2, 2.6%). The present study determined through MAST scores and participants’ self-reports that 32 participants (41.1%) had some lifetime alcohol problem though only 16 participants (20.5%) were enrolled in or completed substance abuse treatment. These findings demonstrated that approximately half of the participants who scored in the alcohol problem range (scores six or greater) did not attend or completed substance abuse treatment.

The study’s findings suggest that assessment and treatment of substance use disorders among individuals charged and/or convicted of sexual offenses is underutilized. Recognition of this contributing factor, coupled with adequate treatment, may lower sexual offenders’ risk of committing future offenses. Langevin and Lang (1990) argued that clinicians and professional

within the criminal justice system could incorporate substance abuse assessment and treatment into the treatment of sexual offenders. Abracen et al. (2006) demonstrated that sexual offenders who completed a substance abuse treatment program were significantly less likely to recidivate with any new offense and more likely to remain offense free (p.26). Approximately half of the present study's participants who were determined to have some lifetime problem with alcohol, by scores on the MAST screening, self-reported to not participate in or complete substance abuse treatment.

5.3 Sex Offender Recidivism

Research studies have demonstrated mixed results regarding the impact substance abuse has on recidivism rates of sexual offenders. Hanson and Bussière (1996) argued that their meta-analysis results demonstrated that substance abuse was not a significant factor in sexual offense recidivism. However, several smaller studies have argued that substance abuse is a significant factor and predictor of sexual offense and general recidivism (Abracen et al., 2006; Looman & Abracen, 2011; Långström, Sjöstedt, & Grann, 2004). The ultimate goal for treatment of sexual offenders is to reduce their risks of committing any new offenses, sexual and general. All risks factors, including substance abuse, should be assessed by professionals with regards to sexual offenders, taking all precautionary measures that may reduce sexual offenders' recidivism rates.

5.4 Limitations

The present study's findings are presented with acknowledged limitations. First, the study participants were all enrolled in sex offender treatment with the same provider. Broadening the scope of the present research study to include other outpatient sex offender treatment providers may have altered the present study's findings. Second, the present study's participants were limited to individuals whose first language is English. Third, the results of the study participants' record reviews pertaining to alcohol use at intake assessment were not gathered from a standardized substance abuse assessment. Inferences and deductions were made from

the study participants' answers to general questions regarding their alcohol/substance use. Fourth, the MAST screening only measures lifetime alcohol problems and does not differentiate between a past and/or current alcohol use disorders. Furthermore, the MAST fails to measure, or allow for, participants' length of sobriety (if any). Individuals who had a past alcohol problem, but have maintained sobriety for a length of time are not separated from individuals who currently have an alcohol use disorder.

5.5 Future Research

Future research studying alcohol misuse prevalence rates among sexual offenders enrolled in outpatient sex offender treatment should focus on court-ordered substance abuse assessments and treatment, substance abuse treatment protocols and manualized treatments designed specifically for sexual offenders, and combining sex offender treatment with substance abuse treatment. Though the present study demonstrated that the criminal justice system is often mandating substance abuse assessment for sexual offenders, there has not been substantial evidence demonstrating the effectiveness of the substance abuse assessments. Future research could focus on how accurately court-ordered substance abuse assessments are at identifying sexual offenders with a substance use disorder. A second factor in future research could be standardized substance abuse treatment programs designed exclusively for sexual offenders. Substance abuse treatment programs for sexual offenders could focus on factors/characteristics identified in Testa's (2002) Integration Model (hypermasculinity, attitudes towards violence, impulsivity, anti-social behavior, etc.) and Parkhill's and Abbey's (2008) study of alcohol's role in the Confluence Model (impersonal sex, hostile masculinity, general alcohol behaviors and beliefs, empathy, etc.). A third suggestion for future research would be to develop comprehensive concomitant sex offender and substance abuse treatment programs (Peugh & Belenko, 2001). The outpatient sex offender treatment population has several key areas where future research could be explored, most of which could include a component of substance abuse assessment and treatment.

5.6 Conclusion

In light of the previous and current evidence regarding alcohol abuse among sexual offenders, there is more research yet to be conducted. Researchers have continued to provide clinicians and professionals with evidence that alcohol and other substances are distal and proximal factors in sexual offenses. Reducing victims' and societies' future costs of sexual offenders' offenses may depend largely on future research that could start with proper assessment and treatment of sexual offenders with substance use disorders.

APPENDIX A

UNIVERSITY OF TEXAS AT ARLINGTON INSTITUTIONAL REVIEW BOARD APPROVAL

ANNUAL CONTINUING REVIEW:
In order for the research to continue beyond the first year, a Continuing Review must be completed via the online submission system within 30 days preceding the date of expiration indicated above. A reminder notice will be forwarded to the attention of the Principal Investigator (PI) 30 days prior to the expiration date. Continuing review of the protocol serves as a progress report and provides the researcher with an opportunity to make updates to the originally approved protocol. Failure to obtain approval for a continuing review will result in automatic ***expiration of the protocol*** all activities involving human subjects must cease immediately. The research will not be allowed to commence by any protocol personnel until a new protocol has been submitted, reviewed, and approved by the IRB. Per federal regulations and UTA's Federalwide Assurance (FWA), there are no exceptions and no extensions of approval granted by the IRB. The continuation of study procedures after the expiration of a protocol is considered to be an issue of non-compliance and a violation of federal regulations. Such violations could result in termination of external and University funding and/or disciplinary action.

ADVERSE EVENTS:
Please be advised that as the principal investigator, you are required to report local adverse (unanticipated) events to The UT Arlington Office of Research Administration; Regulatory Services within 24 hours of the occurrence or upon acknowledgement of the occurrence.

HUMAN SUBJECTS TRAINING:
All investigators and key personnel identified in the protocol must have documented Human Subjects Protection (HSP) training or CITI Training on file with The UT Arlington Office of Research Administration; Regulatory Services. Completion certificates are valid for 2 years from completion date.

COLLABORATION:
If applicable, approval by the appropriate authority at a collaborating facility is required prior to subject enrollment. If the collaborating facility is *engaged in the research*, an OHRP approved Federalwide Assurance (FWA) may be required for the facility (prior to their participation in research-related activities). To determine whether the collaborating facility is engaged in research, go to: http://www.hhs.gov/ohrp/humansubjects/assurance/engage.htm

CONTACT FOR QUESTIONS:
The UT Arlington Office of Research Administration; Regulatory Services appreciates your continuing commitment to the protection of human research subjects. Should you have questions or require further assistance, please contact Robin Dickey at robind@uta.edu or you may contact the office of Regulatory Services at 817-272-3723.

Sincerely,

Patricia Turpin

Digitally signed by Patricia Turpin
DN: postalCode=76019, o=The University of Texas at Arlington, street=701 South Nedderman Drive, st=TX, l=Arlington, c=US, cn=Patricia Turpin, email=pturpin@uta.edu
Date: 2012.06.11 11:17:01 -05'00'

Patricia Turpin, Ph.D., RN, NEA, BC
Clinical Associate Professor
UT Arlington IRB Chair

APPENDIX B

CODE BOOK

Code Book

Category	Description	Numeric Value
Identification #		123
Age:		40
Gender:		
	Male	0
Ethnicity:		
	Caucasian	1
	African-American	2
	Hispanic	3
	Asian-Pacific Islander	4
	Other	5
Criminal History:		
	Number of Arrests	0-9
Current Charge:		
	Sexual Assault	1
	Sexual Assault of a Child/Minor	2
	Aggravated Sexual Assault	3
	Aggravated Sexual Assault of a Child	4
	Indecency with a Child – Exposure	5
	Indecency with a Child – Fondling	6
	Assault Bodily Injury to a Child	7
	Solicitation of a Minor via Internet	8
	Failure to Register as a Sex Offender	9
	Possession of Child Pornography	10
	Other	11
Alcohol Use Intake Assessment:		
	Denies problem/No Problem	0
	Alcohol Use – No Problem	1
	Alcohol Misuse	2
	Substance Misuse	3
	Information Missing	4
Substance Abuse Referral:		
	No	0
	Yes	1
	Information Missing	2

Category	Description	Numeric Value
MAST Score:		
	No Problem (0-5)	0
	Alcohol problem (6-8)	1
	Alcohol Abuse/Dependence (9+)	2
Childhood Abuse:		
	Denies Abuse	0
	Physical Abuse	1
	Sexual Abuse	2
	Physical & Sexual Abuse	3
Education:		
	No High School Diploma	0
	High School Diploma	1
	Some College	2
	Associate's Degree	3
	Bachelor's Degree	4
	Master's Degree	5
	Ph.D.	6
Time in Treatment:		
	Number of Months	0-121
Number of Treatment Goals Completed:		0-30

APPENDIX C

DEMOGRAPHIC UPDATE

Demographic Update

Were you court ordered to undergo an assessment for substance abuse? yes or no

Were you referred for substance abuse treatment after the assessment? yes or no

Did you complete or are you currently enrolled in substance abuse treatment? yes or no

What is your current relationship status?

single married co-habitating separated divorced widowed

What is the number of lifetime co-habitations (living with a partner) lasting six months or longer?

_____

What is your current employment status?

unemployed employed full-time employed part-time disability other

APPENDIX D

ELSEVIER LICENSE TERMS AND CONDITIONS

ELSEVIER LICENSE
TERMS AND CONDITIONS

Apr 12, 2012

This is a License Agreement between James P Foster ("You") and Elsevier ("Elsevier") provided by Copyright Clearance Center ("CCC"). The license consists of your order details, the terms and conditions provided by Elsevier, and the payment terms and conditions.

All payments must be made in full to CCC. For payment instructions, please see information listed at the bottom of this form.

Supplier	Elsevier Limited The Boulevard,Langford Lane Kidlington,Oxford,OX5 1GB,UK
Registered Company Number	1982084
Customer name	James P Foster
Customer address	3860 Evergreen St. #201 Irving, TX 75061
License number	2886810322315
License date	Apr 12, 2012
Licensed content publisher	Elsevier
Licensed content publication	Clinical Psychology Review
Licensed content title	The impact of men's alcohol consumption on perpetration of sexual aggression
Licensed content author	Maria Testa
Licensed content date	November 2002
Licensed content volume number	22
Licensed content issue number	8
Number of pages	25
Start Page	1239
End Page	1263
Type of Use	reuse in a thesis/dissertation
Portion	figures/tables/illustrations
Number of figures/tables /illustrations	8
Format	both print and electronic
Are you the author of this Elsevier article?	No
Will you be translating?	No

Order reference number	
Title of your thesis/dissertation	Lifetime Alcohol Misuse Prevalence Rates Among Sexual Offenders Currently Enrolled in Outpatient Sex Offender Treatment
Expected completion date	Jul 2012
Estimated size (number of pages)	50
Elsevier VAT number	GB 494 6272 12
Permissions price	0.00 USD
VAT/Local Sales Tax	0.0 USD / 0.0 GBP
Total	0.00 USD
Terms and Conditions	

INTRODUCTION

1. The publisher for this copyrighted material is Elsevier. By clicking "accept" in connection with completing this licensing transaction, you agree that the following terms and conditions apply to this transaction (along with the Billing and Payment terms and conditions established by Copyright Clearance Center, Inc. ("CCC"), at the time that you opened your Rightslink account and that are available at any time at http://myaccount.copyright.com).

GENERAL TERMS

2. Elsevier hereby grants you permission to reproduce the aforementioned material subject to the terms and conditions indicated.

3. Acknowledgement: If any part of the material to be used (for example, figures) has appeared in our publication with credit or acknowledgement to another source, permission must also be sought from that source. If such permission is not obtained then that material may not be included in your publication/copies. Suitable acknowledgement to the source must be made, either as a footnote or in a reference list at the end of your publication, as follows:

"Reprinted from Publication title, Vol /edition number, Author(s), Title of article / title of chapter, Pages No., Copyright (Year), with permission from Elsevier [OR APPLICABLE SOCIETY COPYRIGHT OWNER]." Also Lancet special credit - "Reprinted from The Lancet, Vol. number, Author(s), Title of article, Pages No., Copyright (Year), with permission from Elsevier."

4. Reproduction of this material is confined to the purpose and/or media for which permission is hereby given.

5. Altering/Modifying Material: Not Permitted. However figures and illustrations may be altered/adapted minimally to serve your work. Any other abbreviations, additions, deletions and/or any other alterations shall be made only with prior written authorization of Elsevier Ltd. (Please contact Elsevier at permissions@elsevier.com)

6. If the permission fee for the requested use of our material is waived in this instance, please be advised that your future requests for Elsevier materials may attract a fee.

7. Reservation of Rights: Publisher reserves all rights not specifically granted in the combination of (i) the license details provided by you and accepted in the course of this licensing transaction, (ii) these terms and conditions and (iii) CCC's Billing and Payment terms and conditions.

8. License Contingent Upon Payment: While you may exercise the rights licensed immediately upon issuance of the license at the end of the licensing process for the transaction, provided that you have disclosed complete and accurate details of your proposed use, no license is finally effective unless and until full payment is received from you (either by publisher or by CCC) as provided in CCC's Billing and Payment terms and conditions. If full payment is not received on a timely basis, then any license preliminarily granted shall be deemed automatically revoked and shall be void as if never granted. Further, in the event that you breach any of these terms and conditions or any of CCC's Billing and Payment terms and conditions, the license is automatically revoked and shall be void as if never granted. Use of materials as described in a revoked license, as well as any use of the materials beyond the scope of an unrevoked license, may constitute copyright infringement and publisher reserves the right to take any and all action to protect its copyright in the materials.

9. Warranties: Publisher makes no representations or warranties with respect to the licensed material.

10. Indemnity: You hereby indemnify and agree to hold harmless publisher and CCC, and their respective officers, directors, employees and agents, from and against any and all claims arising out of your use of the licensed material other than as specifically authorized pursuant to this license.

11. No Transfer of License: This license is personal to you and may not be sublicensed, assigned, or transferred by you to any other person without publisher's written permission.

12. No Amendment Except in Writing: This license may not be amended except in a writing signed by both parties (or, in the case of publisher, by CCC on publisher's behalf).

13. Objection to Contrary Terms: Publisher hereby objects to any terms contained in any purchase order, acknowledgment, check endorsement or other writing prepared by you, which terms are inconsistent with these terms and conditions or CCC's Billing and Payment terms and conditions. These terms and conditions, together with CCC's Billing and Payment terms and conditions (which are incorporated herein), comprise the entire agreement between you and publisher (and CCC) concerning this licensing transaction. In the event of any conflict between your obligations established by these terms and conditions and those established by CCC's Billing and Payment terms and conditions, these terms and conditions shall control.

14. Revocation: Elsevier or Copyright Clearance Center may deny the permissions described

in this License at their sole discretion, for any reason or no reason, with a full refund payable to you. Notice of such denial will be made using the contact information provided by you. Failure to receive such notice will not alter or invalidate the denial. In no event will Elsevier or Copyright Clearance Center be responsible or liable for any costs, expenses or damage incurred by you as a result of a denial of your permission request, other than a refund of the amount(s) paid by you to Elsevier and/or Copyright Clearance Center for denied permissions.

LIMITED LICENSE

The following terms and conditions apply only to specific license types:

15. **Translation**: This permission is granted for non-exclusive world **English** rights only unless your license was granted for translation rights. If you licensed translation rights you may only translate this content into the languages you requested. A professional translator must perform all translations and reproduce the content word for word preserving the integrity of the article. If this license is to re-use 1 or 2 figures then permission is granted for non-exclusive world rights in all languages.

16. **Website**: The following terms and conditions apply to electronic reserve and author websites:
Electronic reserve: If licensed material is to be posted to website, the web site is to be password-protected and made available only to bona fide students registered on a relevant course if:
This license was made in connection with a course,
This permission is granted for 1 year only. You may obtain a license for future website posting,
All content posted to the web site must maintain the copyright information line on the bottom of each image,
A hyper-text must be included to the Homepage of the journal from which you are licensing at http://www.sciencedirect.com/science/journal/xxxxx or the Elsevier homepage for books at http://www.elsevier.com , and
Central Storage: This license does not include permission for a scanned version of the material to be stored in a central repository such as that provided by Heron/XanEdu.

17. **Author website** for journals with the following additional clauses:

All content posted to the web site must maintain the copyright information line on the bottom of each image, and
he permission granted is limited to the personal version of your paper. You are not allowed to download and post the published electronic version of your article (whether PDF or HTML, proof or final version), nor may you scan the printed edition to create an electronic version,
A hyper-text must be included to the Homepage of the journal from which you are licensing at http://www.sciencedirect.com/science/journal/xxxxx , As part of our normal production process, you will receive an e-mail notice when your article appears on Elsevier's online service ScienceDirect (www.sciencedirect.com). That e-mail will include the article's Digital Object Identifier (DOI). This number provides the electronic link to the published

article and should be included in the posting of your personal version. We ask that you wait until you receive this e-mail and have the DOI to do any posting.
Central Storage: This license does not include permission for a scanned version of the material to be stored in a central repository such as that provided by Heron/XanEdu.

18. **Author website** for books with the following additional clauses:
Authors are permitted to place a brief summary of their work online only.
A hyper-text must be included to the Elsevier homepage at http://www.elsevier.com

All content posted to the web site must maintain the copyright information line on the bottom of each image
You are not allowed to download and post the published electronic version of your chapter, nor may you scan the printed edition to create an electronic version.
Central Storage: This license does not include permission for a scanned version of the material to be stored in a central repository such as that provided by Heron/XanEdu.

19. **Website** (regular and for author): A hyper-text must be included to the Homepage of the journal from which you are licensing at http://www.sciencedirect.com/science/journal/xxxxx. or for books to the Elsevier homepage at http://www.elsevier.com

20. **Thesis/Dissertation**: If your license is for use in a thesis/dissertation your thesis may be submitted to your institution in either print or electronic form. Should your thesis be published commercially, please reapply for permission. These requirements include permission for the Library and Archives of Canada to supply single copies, on demand, of the complete thesis and include permission for UMI to supply single copies, on demand, of the complete thesis. Should your thesis be published commercially, please reapply for permission.

21. **Other Conditions**:

v1.6

If you would like to pay for this license now, please remit this license along with your payment made payable to "COPYRIGHT CLEARANCE CENTER" otherwise you will be invoiced within 48 hours of the license date. Payment should be in the form of a check or money order referencing your account number and this invoice number RLNK500759577.
Once you receive your invoice for this order, you may pay your invoice by credit card. Please follow instructions provided at that time.

Make Payment To:
Copyright Clearance Center
Dept 001
P.O. Box 843006
Boston, MA 02284-3006

For suggestions or comments regarding this order, contact RightsLink Customer

Support: customercare@copyright.com or +1-877-622-5543 (toll free in the US) or +1-978-646-2777.

Gratis licenses (referencing $0 in the Total field) are free. Please retain this printable license for your reference. No payment is required.

APPENDIX E

THE GUILLFORD PRESS PERMISSION LETTER

jamespfoster@mavs.uta.edu
(Guilford Website User)
04/12/2012 06:00 PM

To permissions@guilford.com, guilford2@formatease.com,
cc
bcc
Subject Coursepack Permissions Request

Below is the result of your feedback form. It was submitted by Guilford Website User (jamespfoster@mavs.uta.edu) on Thursday, April 12, 2012 at 18:00:26

---

name: James P. Foster

inst: University of Texas at Arlington

addl: 3860 Evergreen St. #201

city: Irving

state: Texas

zip: 75061

country: U.S.A.

phone: 972-639-4963

fax: 972-352-5554

PERMISSION GRANTED FOR ONE TIME USE
FEE: N/C
DATE: 4/24/12
THE GUILFORD PRESS
72 SPRING STREET
NEW YORK, N.Y. 10012

GP_title: Journal of Social and Clinical Psychology

author: Parkhill, M. R., & Abbey, A.

chapter: Does alcohol contribute to the confluence model of sexual assault perpetration?

pagenum: 529-554

pubyear: 2008

volume: 27

issue: 6

course_title: Thesis - Research

semester: Spring/Summer 2012

instructor: Dr. Alexa Smith-Osborne

course_inst: University of Texas at Arlington

copies: 1

other: Thesis

comments: I am currently enrolled in the Master of Science in Social Work

REFERENCES

Abbey, A., Zawacki, T., Buck, P. O., Clinton, A. M., & McAuslan, P. (2001). Alcohol and sexual assault. *Alcohol Research & Health, 25*(1), 43-51.

Abracen, J., Looman, J., & Anderson, D. (2000). Alcohol and drug abuse in sexual and nonsexual violent offenders. *Substance Abuse: A Journal of Research and Treatment, 12*(4), 263-274. doi: 10.1177/107906320001200403

Abracen, J., Looman, J., DiFazio, R., Kelly, T., & Stirpe, T. (2006). Patterns of attachment and alcohol abuse in sexual and violent non-sexual offenders. *Journal of Sexual Aggression, 12*(1), 19-30. doi: 10.1080/13552600600722963

Alexander, M. A. (1999). Sexual offender treatment efficacy revisited. *Sexual Abuse: A Journal of Research and Treatment, 11*(2), 101-116. doi: 10.1007/BF02658841

Bina, R., Hall, D., Mollette, A., Smith-Osborne, A., Yum, J., Sowbel, L., & Jani, J. (2008). Substance abuse training and perceived knowledge: Predictors of preparedness to work in substance abuse. *Journal of Social Work Education, 44*(3), 7-20.

Conley, T. B. (2001). Construct validity of the MAST and AUDIT with multiple offender drunk drivers. *Journal of Substance Abuse Treatment, 20*(4), 257-295. doi: 10.1016/S0740-5472(01)00159-3

Federal Bureau of Investigation. (2011). *Crime in the United States*. Retrieved March 25, 2012 from: www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2010/crime-in-the-u.s.-2010/tables/10tbl29.xls

Gallagher, C. A., Wilson, D. B., Hirschfield, P., Coggeshall, M. B., & MacKenzie, D. L. (1999). A quantitative review of the effects of sex offender treatment on sexual reoffending. *Corrections Management Quarterly, 3*(4), 19-29.

Gibbs, L. E. (1983). Validity and reliability of the Michigan Alcoholism Screening Test: A review. *Drug and Alcohol Dependence, 12*(3), 279-285. doi: 10.1016/0376-8716(83)90071-6

Glaze, L. E., Bonczar, T. P. (2011). Probation and parole in the United States, 2010. *Bureau of Justice Statistics, NCJ 236019.* Retrieved March 25, 2012 from: www.bjs.gov/content/pub/pdf/ppus10.pdf

Hall, G. C. N. (1995). Sexual offender recidivism revisited: A meta-analysis of recent treatment studies. *Journal of Consulting and Clinical Psychology, 63*(5), 802-809. doi: 10.1037/0022-006X.63.5.802

Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14*(2), 169-194.

Jani, J., Sowbel, L., Smith-Osborne, A., Yum, J., Mollette, A., Hall, D., & Bina, R. (2009*).* Perceived preparation and knowledge of substance abuse among recent MSW graduates: Advanced standing revisited. *Journal of Social Work Practice in the Addictions, 9,* 381-399*.*

Kraanen, F. L., & Emmelkamp, P. M. G. (2011). Substance misuse and substance use disorders in sex offenders: A review. *Clinical Psychology Review, 31*(3), 478-489.

Langevin, R., &Lang, R. A. (1990). Substance abuse among sex offenders. *Annals of Sex Research, 3*(4), 397-424.

Långström, N., Sjöstedt, G., & Grann, M. (2004). Psychiatric disorders and recidivism in sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 16*(2), 139-150. doi: 10.1177/107906320401600204

Looman, J., & Abracen, J. (2011). Substance abuse among high-risk sexual offenders: Do measures of lifetime history of substance abuse add to the prediction of recidivism over actuarial assessment instruments? *Journal of Interpersonal Violence, 26*(4), 683-700. doi: 10.1177/0886260510365871

Lösel, F., & Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology, 1*(1), 117-146. doi: 10/1007/s11292-004-6466-7

Malamuth, N. M., Sockloskie, R. J., Koss, M. P., & Tanaka, J. S. (1991). Characteristics of aggressors against women: Testing a model using a national sample of college students. *Journal of Consulting and Clinical Psychology, 59*(5), 670-681. doi: 10.1037/0022-006X.59.5.670

Marshall, W. L., & Serran, G. A. (2000). Current issues in the assessment and treatment of sexual offenders. *Clinical Psychology & Psychotherapy, 7*(2), 85-96. doi: 10.1016/j.cpr.2010.11.006

Minnesota Department of Corrections. (2000). *Community-based sex offender program evaluation project: 1999 report to the legislature.* St. Paul, MN: Author.

Motiuk, L., & Porporino, F. (1992). The prevalence, nature and severity of mental health problems among federal male inmates in Canadian penitentiaries (Report No. 24). Ottawa, Canada: Correctional Services Canada.

Office of Justice Programs. (2010). *Sex Offender Management*. Retrieved March 25, 2012 from: www.ojp.usdoj.gov/smart/sexoffendermgmt.htm

Parkhill, M. R., & Abbey, A. (2008). Does alcohol contribute to the confluence model of sexual assault perpetration? *Journal of Social and Clinical Psychology, 27*(6), 529-554.

Peugh, J., & Belenko, S. (2001). Examining the substance use patterns and treatment needs of incarcerated sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 13*(3), 179-195. doi: 10.1177/107906320101300303

Rubin, A., & Babbie, E. R. (2011). *Research Methods for Social Work*. Belmont, CA: Brooks/Cole.

Selzer, M. L. (1971). The Michigan Alcoholism Screening Test (MAST): The quest for a new diagnostic instrument. *Journal of Psychiatry, 127*(12), 89-94.

Storgaard, H., Nielsen, S. D., & Gluud, C. (1994). The validity of the Michigan Alcoholism Screening Test (MAST). *Alcohol and Alcoholism, 29*(5), 493-502.

Testa, M. (2002). The impact of men's alcohol consumption on perpetration of sexual aggression. *Clinical Psychology Review, 22*(8), 1239-1263.

Texas Council on Sex Offender Treatment. (2005). *Licensed sex offender treatment providers, 15*(2005-2006).

Truman, J. L. (2011). Criminal victimization, 2010. *Bureau of Justice Statistics, NCJ 235508*. Retrieved March 25, 2012 from: www.bjs.gov/index.cfm?ty=pbdetail&iid=2224

Whitaker, T., Weismiller, T., & Clark, E. (2006). *Assuring the sufficiency of a frontline workforce: A national study of licensed social workers. Executive summary.* Washington, DC: National Association of Social Workers.

Wilson, M. (2010). *Criminal justice social work in the United States: Adapting to new challenges.* Washington, DC. NASW Center for Workforce Studies.

Zawacki, T., Abbey, A., Buck, P. O., McAuslan, P., & Clinton-Sherrod, A. M. (2003). Perpetrators of alcohol-induced sexual assaults: How do they differ from other sexual assault perpetrators and nonperpetrators. *Aggressive Behavior, 29*(4), 366-380.

BIOGRAPHICAL INFORMATION

James P. Foster earned an Associate of Arts and Associates of Applied Science – Mental Health degrees from Tarrant County College (TCC), Bachelor of Science degree in rehabilitation studies from the University of North Texas (UNT), and candidate for a Master of Science in social work from the University of Texas at Arlington (UTA). Mr. Foster has completed internships at a residential substance abuse treatment center, a psychiatric hospital, and a local sex offender treatment provider. Mr. Foster will apply for licensure as a Licensed Master Social Worker and Licensed Chemical Dependency Counselor, contingent upon graduation. Future plans for Mr. Foster include pursuing a career in substance misuse treatment and becoming an affiliate sex offender treatment provider. Currently, Mr. Foster works for Supreme Distributing, LLC, a growing corporation providing vending machine services throughout Dallas and Fort Worth, managing all of the business' cash and financing activities.