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Normative Data Set for Evaluating Civilly Committed Sexual Offenders Using the Denial and Minimization Scale (DAMS)

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Abstract

The true nature of the roles played by denial and minimization in both sexual offender treatment and recidivism continue to vex researchers and practitioners. Some limited research exists regarding the role that denial might play in certain subgroups of offenders; however, meta-analytic findings suggest that neither construct assists in predicting reoffending. Nonetheless, most clinicians and laypersons strongly believe that, in order to truly rehabilitate themselves, offenders must admit to and take personal responsibility for their offenses. To that end, various practitioners have constructed self-report indices hoping to measure the existence and extent of denial and minimization in sexual offenders. In this brief report, we report psychometrics on the Denial and Minimization Scale (DAMS—Eccles, Stringer, & Marshall, 1997), which was revised to specifically fit a population of adjudicated sexually violent predators. Our intent is to provide normative data on this scale, so that it might be used in civil-commitment settings.

Key Words: sexual offenders, denial, minimization, civil commitment

In 1972, an article addressing denial related to the treatment of male adult sexual offenders was published in the journal *Perspectives in Psychiatric Care* (Hitchens, 1972). Today, the construct of denial has risen to a perceived position of primacy in the treatment and risk management of sexual abusers, as successful completion of treatment is frequently predicated upon the identified abuser admitting guilt and accepting personal responsibility for his/her offending behavior (Association for the Treatment of Sexual Abusers [ATSA], pp. 20 and 50). Most, if not all, contemporary treatment programs for these clients reference issues related to denial and minimization; however, the empirical foundation for focusing on these issues, *vis a vis* their relation to reoffense risk, is weak, tenuous, or nonexistent (Hanson & Morton-Bourgon, 2005; Nunes et al., 2007). Nonetheless, it is still commonly believed that sexual abusers who deny or minimize their offenses have been unsuccessful in treatment and present enhanced risk for sexual recidivism.

The perceived need for sexual abusers to acknowledge personal responsibility for their offending behavior is well established in the literature (Cooper, 2005; Rogers & Dickey,

1991). Definitions of factors comprising the denial construct have been offered (Baldwin & Roys, 1998; Gibbons, de Volder, & Casey, 2003; Schneider & Wright, 2004), and attempts have been made to understand denial as it relates to treatment outcomes (Abracen & Looman, 2004; Barrett, Wilson, & Long, 2003; Lord & Willmot, 2004; Pollock & Hashmall, 1991; Schneider & Wright, 2004). Traditionally, denial and minimization have been characterized as treatment interfering factors (Cullen & Wilson, 2003; Wilson, 2009) that affect treatment responsivity (Andrews & Bonta, 2006) and motivation to change (Barrett et al., 2003). However, we are caused to query what role denial and minimization may actually play in assessing motivation to change.

The responsivity literature clearly indicates that treatment participants must be appropriately motivated to change in order for programmatic elements to "take hold" (Hanson, Bourgon, Helmus, & Hodgson, 2009); however, whether one has to admit guilt or accept personal responsibility for harm done is less clearly associated with ultimate success in treatment. Specifically, the empirical literature has not clearly supported or discarded either denial or minimization as major factors in the prediction of sexual recidivism. In a meta-analysis of 82 recidivism studies, Hanson and Morton-Bourgon (2005) found that interventions targeting denial in treatment had little impact on the incidence of sexual or violent recidivism with this population. Nevertheless, Hanson and Morton-Bourgon report that the lack of support for the impact of treatment effect may be related to the difficulty in assessing the denial construct.

On the other hand, Marshall and associates (Marshall, Marshall, Fernandez, Malcolm, & Moulden, 2008) summarized the factors of refusal and failure to achieve treatment goals as being related to client denial. These authors did not stop at identifying factors specific to the client. They acknowledged that denial on the part of the client influenced some service providers who interpreted client denial as an obstacle to be overcome via treatment. Marshall et al. suggest that therapists' negative responses to denial can lead to adversarial relationships in treatment. They recommend that treatment with clients who deny focus on pre-treatment programming, thereby allowing the client to develop internal motivations to participate in more in-depth therapy. Marshall et al. found that denying clients who participated in and completed preparatory programming for denying clients had a lower incidence of recidivism (as measured by return to custody for any violent, sexual, or general criminal convictions).

To summarize, the relative value-added of considering what most refer to as "denial and minimization" in sexual abuser risk management remains an unanswered question. The Hanson meta-analyses noted above suggest that these constructs are unrelated to risk for reoffending. However, other research (e.g., Nunes et al., 2007) identifies group-specific elements, such as offense type or aspects of victim choice, that may assist us in better understanding circumstances in which these potential treatment targets are more worthy of clinical and risk management attention. It has been our experience that a good deal of the difficulty in establishing the so-called value-added of these constructs has to do with how well or poorly they have been defined. Specifically, it appears that, as a field, we have yet to offer clear operational definitions of what we mean by denial and minimization.

Efforts to codify the denial construct and to establish "best practice" models identifying denial as a primary indicator of treatment success continue. However, advances made in the scientific measure of denial are lacking. Attempts to measure denial are found in the Minnesota Multiphasic Personality Inventory (MMPI—Lanyon & Lutz, 1984; Wasyliw, Grossman, & Haywood, 1994), the Rorschach Ink Blot Method (Grossman, Wasyliw, Benn, & Gyoerkoe, 2002), the 16 Personality Factor Questionnaire (Grossman, Haywood, & Wasyliw, 1992), and other psychometric instruments (Langton et al., 2008; McGrath, Cann, & Konopasky, 1998). However, instruments designed to specifically measure denial amongst sexual abusers are few.

One promising instrument, for example, is the Denial Scale for Male Incest Offenders (DSMIO—see Guthrie, Canada, Lim, & Jennings, 1998). An *EBSCOhost* search for the DSMIO revealed only the original study reporting the development of this instrument. Another, more recently developed assessment tool designed to measure denial in the context of child molester assessment and treatment and which is beginning to see interest in the scientific literature is the Facets of Sexual Offender Denial (FoSOD) by Schneider & Wright (2001; see also Levenson & Macgowan, 2004; Wright & Schneider, 2004). However, both the DSMIO and the FoSOD are subjective, self-report measures. Susceptibility of self-report measures to socially desirable response set is discussed in Anastasi & Urbina (1997, p. 374). The Denial and Minimization Checklist–III (Langton, Barbaree, & McNamee, 2003) introduces confounds for acquiescence. The authors of the Denial and Minimization Checklist–III recommend both a thorough record review and clinical interview with the individual offender in order to contextualize their denial and minimization.

The Denial and Minimization Scale (DAMS)

The Denial and Minimization Scale (DAMS—Eccles, Stringer, & Marshall, 1997; see Appendix 1, reproduced with permission of the authors) was introduced during a poster session at the 1997 annual conference of the Association for the Treatment of Sexual Abusers (ATSA). The DAMS represents yet another psychometric index designed to measure levels of denial and minimization, as endorsed by the sexual offender. The DAMS has been in the public domain since its introduction in 1997; however, despite its early promise, it has received less scientific attention in the literature than even the Denial Scale for Male Incest Offenders. The DAMS was developed to assist in understanding an individual sexual abuser's level of denial and minimization with relation to his offending behavior. However, subsequent to its presentation in 1997, there has been no published research on this instrument.

Eccles et al. (1997) reported that they combined categories of minimization reported by two earlier sources: 1. Barbaree (1991) outlined means to categorize responsibility for offending, the extent to which the offender's behavior impacted the victim(s), and the degree of harm inflicted by the offender upon his victim with the categories of intent to offend. 2. Salter (1988) reported a number of offense-related behaviors. Eccles et al.

reported a belief that such a combination would provide a comprehensive assessment of the denial and minimization construct.

There are two sections to the DAMS, making it something of a hybrid between an objective and subjective measure. The first section consists of 12 items intended to assess the individual's status as a Denier or Admitter. Once the subject completes the first 12 items of the instrument, the clinician performs an objective evaluation of the subject's responses to ascertain whether they are substantively admitting or denying the offenses of which they have been accused, charged, or convicted. Admitting subjects then go on to complete the second section. Those identified as "Deniers" do not complete the remaining 42 questions in section two. Section two of the DAMS was designed to assist in developing a subjective understanding of the individual's level of minimization with respect to his abusive behavior. The DAMS concludes by asking the subject to assign a percentage of blame for his abusive behavior. The individual has the opportunity to select any percentage when identifying self-blame. The subject then identifies the percentage of responsibility he feels his victim holds for the victimization. The DAMS yields a set of 23 subscale scores over five domains, from which it is theoretically possible to evaluate the subject's level of denial and minimization.

Eccles et al. (1997) reported the DAMS as being sensitive to treatment change and having excellent reliability and validity for use with child molesters. They based their conclusions on two unpublished studies. The first study sample reportedly consisted of 20 convicted child molesters on probation/parole. The second study sample was comprised of 29 convicted child molesters. The authors reported a range of possible scores on the DAMS from 40 to 200, with deniers automatically receiving 200 points. Normative data for the produced scores of the samples were not reported by the authors. Instead, they offered numerical score ranges on the Score Summary for interpreting individually produced DAMS scores. These range scores are interpreted as either None or High. Instructions regarding interval scores are absent. The DAMS was clearly designed to quantify a range of the study construct possessed by the individual subject. Application of a dichotomous interpretation of produced scores only serves to confound comparison of individually produced scores to those of the general study population. Without a descriptive statistic of the DAMS data for use in comparative analysis, developed scores are left to the subjective interpretation of the evaluator, thereby marginalizing the usefulness of this instrument as either a scientific or therapeutic tool.

Because no data were reported in Eccles et al.'s original sample regarding distribution of scores on the DAMS subscales, no inferences based on produced scores appeared possible. Therefore, the purpose of this study was to establish baseline data for evaluating scores produced on the DAMS in a population of SVPs. In doing so, others would then have access to a data set to compare their findings when working with this instrument. Several hypotheses were developed for this study. As the method reported by Eccles et al. for interpreting scale scores was somewhat coarse, it was hypothesized that the Minimization Range recommended by the original authors for interpreting the DAMS subscales would not be an accurate representation of the scores generated by an SVP sample on this instrument. It was further hypothesized that recommendations

for interpreting scores produced by the SVP sample used in this study would be significantly different from the method recommended by the original authors.

Method

Subjects

Subjects were 140 male adults adjudicated as SVPs and detained at the Florida Civil Commitment Center (FCCC), a secure treatment facility for sexually violent predators. Inclusion criteria were: a valid profile on the DAMS, age between 21 and 85 years, and the individual was not identified as intellectually disabled. A valid DAMS profile required that the subject be identified as an "Admitter" on the first section of the measure. To facilitate additional analyses (see Table 3), records were further divided into subgroups based upon victim profile at the time of the index offense. Demographic data are reported in Table 1.

Table 1
Demographic Data

	Number of subjects	Percent of sample
Age		
25 or younger	1	.71
26-35	19	13.57
36-49	76	54.29
50-64	41	29.29
65 and older	3	2.14
Race/Ethnicity		
White	98	70
Black	35	25
Hispanic	7	5
Education		
8th grade or less	18	12.86
Some high school	31	22.86
High school graduate	19	13.57
GED	54	38.57
Some College	13	9.29
College graduate	5	3.57
Marital Status		
Single	90	64.75
Married	3	2.16
Divorced	45	32.37
Widower	1	.72

Index victim age group		
5 and younger	21	15.00
6-9	33	23.57
10-12	23	16.43
13-17	34	24.29
18 and older	29	20.71
Index victim's gender		
Female	84	60
Male	56	40
Index victim status		
Stranger	43	30.71
Acquaintance	97	69.29

Procedure

The DAMS has been historically included as one component instrument in a comprehensive treatment-needs-assessment battery used to individualize treatment plans at the Florida Civil Commitment Center. Archival data held at the FCCC were screened for completed DAMS; demographic and DAMS data meeting the inclusion criteria for the study were collected. Once the sample was collected, a statistical analysis of the DAMS subscale scores was conducted to identify aggregate mean and standard deviation values for each subscale of the entire sample. Next, the sample was divided into five subsets based on the recorded age of the identified victim at the time of the index offense. For each of the subsets identified by the demographic data, a statistical analysis of subscale scores was again conducted for each of the 23 subscale scores measured by the DAMS.

Results

Aggregate means and standard deviations computed for each DAMS subscale are reported in Table 2. Means and standard deviations for DAMS subscales for Index Victim Age Groups represented by the sample are presented in Table 3. While the F% scale (see Q53 in Appendix 1) is "Undefined" by the DAMS, means and standard deviations were also reported across sample groups. Consistent with the purpose of this report, these data were not evaluated beyond development of descriptive analysis.

Table 2
Measured Means and Standard Deviations of Sample Aggregate Scores Compared to Subscale Minimization Ranges Reported on the Denial and Minimization Scale

Sub-scale	Subscale Nomenclature	Mean	SD	Mode	DAMS Minimization Range		
					None	to	High
A	***Minimization of Responsibility***						
Ai	Blames victim verses offender	6.49	3.17	4	4	-	20
Aii	Blames external factors	6.78	2.71	4	4	-	20
Aiii	Blames internal factors beyond control	9.20	3.64	8	4	-	20
At	Subscale total	22.55	6.59	24	12	-	60
B	***Minimization of Extent***						
Bi	Minimizes frequency	4.30	2.59	2	2	-	10
Bii	Minimizes force	4.97	2.76	2	2	-	10
Biii	Minimizes intrusiveness	4.99	2.49	2	2	-	10
Bt	Subscale total	14.35	6.06	10	6	-	30
C	***Minimization of Harm***						
Ci	Minimizes long term effects	3.55	1.96	2	2	-	10
Cii	Because not hurt	3.62	2.12	2	2	-	10
Ciii	Because of victim's past	3.12	1.81	2	2	-	10
Ct	Subscale total	10.29	5.12	6	6	-	30
D	***Minimization of Intent***						
Di	Out of love	3.07	1.49	2	2	-	10
Dii	To give pleasure	4.06	1.8	2	2	-	10
Diii	To be a teacher	3.2	1.46	2	2	-	10
Dt	Subscale total	10.47	4.01	6	6	-	30
E	***Minimization of Offense Related Behaviors***						
Ei	Pre-offense planning	6.01	3.01	2	2	-	10
Eii	Pre-offense fantasies	5.33	2.50	-	2	-	10
Eiii	Intra-offense arousal	5.12	2.67	2	2	-	10
Eiv	Post-offense risk	5.3	2.85	2	2	-	10
Ev	Post-offense need to change	3.87	2.22	2	2	-	10
Et	Subscale total	25.66	9.6	26	10	-	50
F%	Other (percent self to blame)	92.25	18.92	100	Undefined		

Table 3
Measured Mean and Standard Deviation Scores
for Denial and Minimization Scale Subscales Based on Victim Age Group

DAMS Subscale	Index Victim Age Group									
	≤ 5 (n=21)		6-9 (n=33)		10-12 (n=23)		13-17 (n=34)		18+ (n=29)	
	M	SD	M	SD	M	SD	M	SD	M	SD
A										
Ai	7.38	3.95	6.36	2.98	6.17	2.96	6.55	3.22	6.17	2.94
Aii	6.14	2.24	6.39	2.53	6.52	2.06	6.94	2.8	7.72	3.37
Aiii	9.14	4.16	9.15	3.75	9.78	2.92	9.08	2.96	9	3.2
At	22.66	6.15	21.9	6.84	22.47	4.62	22.88	6.88	22.89	7.86
B										
Bi	4.76	2.66	4.54	2.75	4.69	3.53	4.23	2.08	3.48	1.92
Bii	5.66	3.23	5.12	2.86	6.04	2.61	4.91	2.64	3.55	1.99
Biii	5.61	2.45	5.54	2.56	4.56	2.62	4.97	2.5	4.27	2.21
Bt	16.04	6	15.21	5.53	15.3	6.83	14.41	6.28	11.31	5
C										
Ci	3.14	1.31	3.87	2.31	3.21	1.7	3.79	2.29	3.44	1.72
Cii	4	2.23	4.06	2.24	3.47	2.27	3.41	2	3.24	1.92
Ciii	3.14	2.03	2.72	1.25	2.82	1.3	3.35	1.8	3.55	2.41
Ct	10.28	5.18	10.66	4.97	9.52	4.96	10.5	5.57	10.24	5.17
D										
Di	3.23	1.48	2.84	1.43	3.13	1.63	3.29	1.5	2.89	1.49
Dii	4.14	1.87	3.96	1.66	4.56	1.85	4.02	1.93	3.75	1.74
Diii	3.09	1.41	3.33	1.65	3.56	1.9	3.08	1.21	2.96	1.11
Dt	10.95	4.24	10.15	3.69	11.21	3.99	10.7	4.56	9.62	3.57
E										
Ei	7.42	3.64	5.42	2.82	5.17	2.79	6.26	2.88	5.96	2.82
Eii	6.23	2.75	5.21	2.91	4.73	2.37	4.79	2.21	5.93	2.06
Eiii	6.28	2.83	4.51	2.68	4.82	2.38	5.23	2.89	5.79	2.48
Eiv	5.52	3.47	5.18	2.73	4.82	2.03	4.67	2.5	6.37	3.27
Ev	3.85	2.32	4.06	2.6	3.65	2.18	3.5	1.63	4.31	2.36
Et	28.04	11.80	24.39	10.66	23.21	7.58	24.47	7.94	28.72	9.28
F%	93.04	21.92	93.6	12.43	92.34	22.74	91.82	15.23	90.55	32.90

Discussion

The results of this report provide a preliminary set of standard scores for use with the study population—civilly committed sexually violent predators—thereby increasing the usefulness of the DAMS in both clinical and research settings. The results show that interpretation of the DAMS is enhanced when using means and standard deviations for assessing a subject's self-reported data. These data allow for a more precise estimate

of offense-related minimization presented by male adult SVPs when using the DAMS. Further, the means and standard deviations identified for this population allow comparisons with other instruments commonly employed in a standard assessment battery with this population.

Several concerns related to the DAMS were revealed in describing the data used in this study. As would be expected, the more specific subscales were prone to more erratic distributions than when aggregate means were developed across the entire sample. This may become more evident as sample size decreases, as was observed in reviewing scores by index victims groups and individual subscale assessments of the aggregate group. These more disparate distributions suggest that the DAMS would benefit from further analysis of the items representing both subgroup and subscale scores.

Another issue of interest is the lack of specific evaluative criteria for the F% scale (Q53 in Appendix 1). Indeed, the F% scale appears to be an afterthought on the DAMS. However, it might be useful as a measure of in-treatment progress. Because the DAMS does not have an aggregate or "total" score, the F% may serve this purpose. Therefore, values of F% on the DAMS warrant further investigation. A summative total score for all the subscales measured by the DAMS could be useful as a measure against which the subscales could be individually judged. Such a score might also supplement the F% score when assessing treatment effects.

Overall, this study accomplished its goal of developing a specific set of descriptive statistics for use when interpreting DAMS results with the male adult SVPs. The hypothesis that the DAMS Minimization Range does not accurately reflect the scores produced by persons identified as SVPs (at least those served by the Florida Civil Commitment Center) was supported. The next logical step would be to compare the results of this investigation with similar sample groups. Alternatively, as other instruments for measuring denial and minimization amongst male adult sexual abusers generally conceptualize the constructs of denial and minimization in a similar manner to the DAMS, it would be useful to compare the results of this study with an equivalent sample using the DISMO or the FoSOD.

The paucity of research related to this instrument limits its value in both clinical and research settings. The results of this report revealed that the DAMS Minimization Range serves as a gross measure of denial and minimization, which, ultimately, supports the usefulness of the DAMS as a measure of these constructs. In the end, however, no strong statements can be currently made regarding the overall usefulness of the DAMS, especially given the ongoing lack of strong, empirically confirmed relationships between denial and minimization and reoffense. In this report, all we have essentially done is identify the potential of the DAMS to assist in better understanding these constructs. Whether or not denial and minimization are useful to consider in sexual abuser treatment and risk management remains an empirical question. Greater scientific interest and inquiry may ultimately assist in better defining their potential use.

There is ongoing debate regarding denial as a risk factor for reoffending. Evidence exists suggesting that denial is a risk factor for subsets of the offending population (e.g., intrafamilial child molesters), but not for others (see Nunes, et al., 2007). Denial is also represented in the literature as a treatment interfering factor recognized by both therapists and clients (Levensen & Macgowan, 2004). Additionally, possibly the most problematic aspect of denial is the idea that some persons in need of treatment are either diverted from involvement or simply refuse to participate in treatment, thereby resulting in those sexual abusers identified as "deniers" being excluded in research related to denial (Schlank, 2009). These are legitimate concerns that would benefit from further study. For example, many questions remain: How are researchers defining the construct of denial? What "accepted" protocols exist for challenging denial? How should the denial construct be evaluated as a treatment interfering factor? Is denial a bipolar construct—that is, "you have it or you don't"—as seen in section one of the DAMS, or should we view it as being better conceptualized on a continuum? If the latter, what could (or should) be done to encourage those abusers identified as "deniers" to meaningfully engage treatment programming? Given current policies, which tend to promote lifelong public identification and increased social ostracism, there is less and less incentive for abusers to admit guilt and accept responsibility for their offensive behavior. The attendant problems this creates for sexual abusers, treatment providers, and the community are clear.

Authors' Notes

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Appendix 1

Note: The language and phrasing in the DAMS are those of the original authors. No grammatical changes were made in order to preserve the integrity of the measure for replication and research purposes.

DAMS

(Eccles, Stringer, & Marshall, 1997)

Instructions:
Everyone who has been accused of sexual abuse has their own special situation. This questionnaire asks for your ideas about the incident(s) which brought you here. On the following pages you will see a number of statements. Read each of these statements carefully. In Section 1 which follows, you will circle either YES, NO or NA (Not Applicable) on the scale depending on your view of your own situation.

Example:
"In plea bargaining, I had to plead guilty to charges I did not commit in order to get a reduced sentence"

Y N NA

In the example, you would: Circle Y if your answer is "Yes", Circle N if your answer is "No', Circle NA if your answer is "Not Applicable". However, only choose 'NA" when the statement really does not apply in your case. Also, when you do answer NA, please write a brief note underneath explaining why (e.g., "I have not yet appeared in court to make a plea").

Section 1 - Part A

The statements in this section refer to whether you believe that you did anything wrong sexually Please answer honestly.

1. The alleged victim in my case liked or benefited from what happened so what I did was not abuse (Answer NA if no sexual contact occurred).	Y	N	NA
2. What I did was certainly abusive because I touched her/him without consent in a deliberately sexual manner.	Y	N	NA
3. What I did was a sexual assault and not a physical assault (answer NA if there was no sexual or physical assault).	Y	N	NA
4. I could not have committed any sexual abuse because (s)he and I had no sexual contact at all.	Y	N	NA
5. When I touched her/his private parts (i.e., breasts, genitals or buttocks) it was either an accident or I did it for a good reason (e.g. checking for health problems). (Answer NA if there was no contact with the private parts).	Y	N	NA
6. The alleged victim(s) misunderstood my affectionate touching as being sexual. (Answer NA if there was no touching whatsoever).	Y	N	NA

7. What I did was sexual abuse even if I thought (s)he was older than (s)he really was. (Answer NA if the alleged victim was an adult).	Y	N	NA
8. What I did was sexual abuse because (s)he did not or could not consent to what happened.	Y	N	NA
9. I did something wrong sexually. The allegations have not been completely made up just to get me.	Y	N	NA
10. I did have sexual contact with her/him, but it should not be a crime because some young persons are able to choose who they wish to have sex with. (Answer NA if the alleged victim was an adult).	Y	N	NA
11. I admit that all of the people who said I offended against them were in fact sexually abused by me. (Answer NA if you have only been considered as offending against one person).	Y	N	NA
12. I have done nothing wrong sexually and people (e.g. the victims family, your ex—wife, the police or others) are just out to get me.	Y	N	NA

Section 1 - Part B

Whether or not you agree with all the allegations, simply put, do you believe that you have committed a sexually abusive act against her/him?

Yes No

Stop here if you have answered N to Part B above. Otherwise please go on to answer Section 2. Feel free to write explanations for your decision on the back of this page. If you are unsure about what to do, please ask the tester.

SECTION 2

The statements in this section give you a chance to answer in more detail the accusations that have been made against you.

CIRCLE THE NUMBER which best describes how well each statement matches your situation.	Not at all accurate	Slightly accurate	Somewhat accurate	Mostly accurate	Extremely accurate
13. I was made so angry that I was really provoked into doing what I did.	1	2	3	4	5
14. At some point before I did it, whether I got an erection or not, I must have been sexually interested in her/him and this motivated me to do what I did.	1	2	3	4	5
15. Being abused as a child, sexually or otherwise, has made me a sexual abuser.	1	2	3	4	5
16. What I did will likely cause her/him a lot or emotional scars.	1	2	3	4	5
17. (S)he was correct in her/his description of what I did and (s)he has not blown anything out of proportion.	1	2	3	4	5
18. I did not plan any part of what took place, not even right	1	2	3	4	5

before I acted. What I did just happened.					
19. Nobody pressured me to do what I did.	1	2	3	4	5
20. (S)he will probably not suffer any bad long term effects because (s)he seemed to like what happened.	1	2	3	4	5
21. While I hope that I will never do this again, it is possible that I might, and so I will need to be careful as a result.	1	2	3	4	5
22. The sexual contact was started by me. I made the sexual advances towards her/him.	1	2	3	4	5
23. What I did may have been wrong but it did not go as far as (s)he said it did.	1	2	3	4	5
24. Whether I had an erection or not, I did not get anything out of it sexually.	1	2	3	4	5
25. When I did it, I had no thoughts at all of the effects on her/him.	1	2	3	4	5
26. (S)he has not exaggerated the number of incidents which took place.	1	2	3	4	5
27. (S)he has had sex before and so will be less harmed by what I did to her/him (Circle 1 if you do not know her/his sexual history at all.)	1	2	3	4	5
28. I have an uncontrollable sex drive which made this happen.	1	2	3	4	5
29. What I did to the victim was an act of force because I used either strength or authority to do it.	1	2	3	4	5
30. What I did was done out of love.	1	2	3	4	5
31. This would not have happened if I had a partner who paid attention to me and gave me enough sex.	1	2	3	4	5
32. I was careful about choosing when and where to do what I did and so on some level I was clearly planning it.	1	2	3	4	5
33. (S)he should have told me to stop. I did it because (s)he never said anything.	1	2	3	4	5
34. What I did to her/him must be very damaging regardless of who (s)he was and what her/his background was like.	1	2	3	4	5
35. I had no thoughts at all for her/his wellbeing. My only concern was my own pleasure.	1	2	3	4	5
36. At no time did I have any sexual fantasies or sexual interest in her/him. It just happened.	1	2	3	4	5
37. What happened was not caused by high levels of my sex hormones.	1	2	3	4	5
38. I learned my lesson and that is enough. I do not have any problems or things about myself related to what happened that I need to change.	1	2	3	4	5
39. All I wanted to do was give her/him some pleasure.	1	2	3	4	5
40. (S)he was not hurt by me and should be fine by now or in the near future.	1	2	3	4	5
41. What I did was not caused by a disease or sickness of any kind.	1	2	3	4	5
42. (S)he is not responsible for what happened.	1	2	3	4	5

43. I never forced her/him to do anything (s)he did not want me to.	1	2	3	4	5
44. (S)he got me so aroused by her/his behavior that I was seduced and couldn't help what happened.	1	2	3	4	5
45. (S)he will probably be affected greatly by what I did for a long time to come.	1	2	3	4	5
46. There were fewer incidents than (s)he said there were. The number has been exaggerated.	1	2	3	4	5
47. I was just trying to be a teacher to her/him.	1	2	3	4	5
48. I will have to work hard for some time to change my problem thinking and behavior to make sure that I never do anything like this again.	1	2	3	4	5
49. When it took place I was being completely selfish.	1	2	3	4	5
50. Neither alcohol nor drugs are to blame for what I did.	1	2	3	4	5
51. I am not at all worried that I will do anything like this again. There is not even the slightest chance that it could.	1	2	3	4	5
52. Whether or not I had an erection, this was clearly a sexual act which was sexually enjoyable to me.	1	2	3	4	5

53. Using percentages indicate below how much of the fault for what happened is yours and how much is hers/his (i.e., if it was about equally your fault and hers/his, you would put 50 in each box). Note: the two numbers must add up to 100 (e.g., 80 - 20, 35 - 65, etc.).

YOU	HER/HIM
%	%

54. If there is anything important that has not been covered in this questionnaire which you think helps to explain what happened, please describe in "Comments" below:

Comments: