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Clinical Implications of Wearing a Scarlet Letter: Sex Offender Public Policy

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Clinical Implications of Wearing a Scarlet Letter: Sex Offender Public Policy

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Abstract

This dissertation outlines a mixed methods research approach to evaluate the clinical implications of sex offender public policies. Background information is given regarding current public policy on sex offender civil commitment and community notification and registration, the development of public policy and the current ramifications of the Sex Offender Registration Act (SORNA), the etiology and construction of the definition of sex offenders, and a review of sex offender interventions and their impact on therapeutic outcomes. This study examines the therapeutic and anti-therapeutic effects of SORNA using a therapeutic jurisprudence framework. A discussion of the correlation between mental health symptoms and negative experiences associated with being placed on the sex offender registry is provided. Results from quantitative analyses showed a clinically significant correlation between self-rated negative experiences associated with being on the registry and mental health pathology. Results from qualitative analyses showed the common themes reported by subjects in regard to SORNA, including hopelessness, fear or worry about losing their jobs or housing, and being "branded" for life. Overall, the results suggest that there is a perceived causal relationship between reported negative experiences and SORNA policy.

Keywords: sex offenders, registry, mental health, depression, anxiety, negative experiences

A Scarlet Letter for Sex Offenders: Clinical Implications of Public Policy

Chapter 1

Review of Literature

Sex offenders are placed on public registries and their neighbors are notified of their presence in communities. This is, obviously, a highly stressful event with varying levels of consequences. The stress and emotional consequences of being placed on the registry might actually precipitate a decrease in mental health for the sex offender and raise the probability of engaging in sexual offenses. The following study outlines the development of sex offender public policy, as well as the available research on sex offender etiology, treatment, and risks for reoffending. This study explores the therapeutic and anti-therapeutic aspects of SORNA on registered offenders and links outcomes to the current literature on risks associated with recidivism. This is done through a thorough review of the literature regarding the etiology of the sex offender, recommended treatments for sex offenders, risk assessment and recidivism, and policy changes as attempts to manage sex offenders. Additionally, a discussion of the heinous cases that have initiated the transformation and implementation of sex offender public policy is provided. For the purpose of this project, a sex offender will be defined using four categories: pedophiles (victims under 17), rapists (victims over 18), mixed (victims of both age groups), and non-touch offenders (e.g., voyeurs, exhibitionist, etc.).

There is an overwhelming amount of conflicting research with regard to the etiology of the sex offender. To add to the lack of consistency in both understanding and treating sex offenders, each theory provides its own recommended therapy. This paper includes a discussion of the conflicting research available for the treatment of sex offenders, as well as a discussion of the different conceptualizations of sex offender etiology. A review of research on the

development of risk assessment and the potential impact on public policy is also discussed. This discussion focuses on the transformation of public policy in an attempt to manage sex offenders. The discussion of risk assessment and its potential impact on public policy will elucidate the failure of policy makers to incorporate research findings into the development of public policy.

The theoretical framework used to view the relationship between SORNA and the objective experiences of the sex offender is a therapeutic jurisprudence model. Therapeutic jurisprudence is a term that refers to an "emphasis on increasing therapeutic effects and decreasing of anti-therapeutic consequences of the law" (Brigden, 2004, p. 362). Through this framework the investigator will attempt to quantify registered sex offenders' subjective experiences of being placed on the registry and explore the relationship between those experiences and mental health functioning. From this perspective the investigator will explore possible positive and negative therapeutic effects of the SORNA laws as well as the anti-therapeutic effects of being placed on the registry.

Sex offender registries have been used to notify the public of sex offenders residing or working in the local vicinity. Despite the initial intent of these registries, since their implementation in the early 1990s, researchers have begun to focus on their unintended consequences. Tewksbury (2005) identified these as "collateral consequences" and included the areas of job loss, social stigmatization, difficulty finding housing, and harassment (p. 79). In order to assess the clinical impact of these collateral consequences associated with the Sex Offender Registration Notification Act (SORNA), data was collected to quantify both the positive and negative experiences of sex offenders related to this policy. In an attempt to quantify the degree of the impact of SORNA on sex offenders' mental health, data was collected on the overall mental health functioning of the participants.

This study utilizes a mixed methods approach, including qualitative and quantitative methodologies. This mixed methodology was used to explore the following research questions: (a) Does a relationship exist between offenders' degree of negative experiences of being on the registry and their level of psychiatric symptomatology?; and (b) What are offenders' thoughts in regard to the relationship between being on the registry and their psychiatric symptoms? These questions developed out of the context of the current body of literature on offender legislation, misperceptions regarding sex offender registration, risk assessment, and etiology and intervention development.

The History and Transformation of Public Policy

Chaffin (2008) once stated with regard to the application of research to public policy on sex offenders:

> The good news is that the facts, by which I mean scientific data, are considerably more robust and lend themselves to firmer conclusions. The bad news is that the facts have hardly mattered at all in the public policy arena. (p. 111)

This quote reflects the frustration of researchers in the field who believe that the current public policy (i.e., SORNA) was neither empirically informed in its conception nor efficaciously implemented to reduce sex offender recidivism (Sandler, Freeman, & Socia, 2008). In order to understand the gap between the intent of public policy and the empirical literature on sex offender risk, treatment, and recidivism, it is important to discuss the cases that have impacted public policy throughout the years.

In his discussion of the shift of public policy, Jonathan Simon (1998) discusses what he calls "Managing the Monstrous: Sex Offenders the New Penology" (p. 452). Simon discusses the transformation of public policy toward criminals and reports that during the 1960s and 1970s

there was a focus on a rehabilitation model using correctional facilities to rehabilitate inmates. However, during the 1980s, a change in policy took place and swung the pendulum away from a rehabilitation model toward a retribution model, which did not seek to transform criminal behavior, but, rather, to prevent future crimes via risk predictions (Simon, 1998). Risk prediction, assessment, and management will be discussed at length in a later section; however, it is important to highlight the impact of risk assessment on the transformation of public policy. Simon refers to the new penology as *populist punitiveness* because the policies are driven by the public's demand for retribution and vengeance against those whom they perceive as evil. After a string of highly publicized sexual murders the new penology is now aimed at incapacitation through civil commitment (i.e., placing the individual in a psychiatric facility, Simon, 1998).

The idea of incapacitation of sex offenders through civil commitment is not a new idea and was used from the 1930s through the 1950s for criminals labeled as "sexual psychopaths" (Lafond & Winick, 1998). The goal of civil commitment for sexual psychopaths was to protect society by treating individuals who, at this point in time, were viewed as having an underlying mental disorder (Vess, 2009). However, Lafond and Winick argue that the ideology that informed these laws was the government's need to preserve morality, and that those laws were meant to target homosexual behavior, which was believed to be linked to pedophilia at that time. Due to the underlying ideology behind these social policies, these laws fell out of favor during the 1970s. However, a string of highly publicized acts of sexual murder in the late 1980s and early 1990s brought back the sexual psychopaths laws, which are now referred to as sexual predator acts (Lafond & Winick, 1998; Vess, 2009). In response to these heinous crimes (which are discussed in the next section), society began to identify two alternatives for sex offenders: (a) community notification and (b) incapacitation through civil commitment. These two methods

have shaped the current public policy with regard to sex offenders. A detailed discussion of the impact of civil commitment on convicted sex offenders will be discussed in the conceptual framework portion of this paper.

Community Notification

As of 1986, five states already had what is now known as sex offender registration laws. These laws were largely used to provide police with sex offender information (e.g., the address of sex offenders) in case new crimes were committed (Garfinkle, 2003) and did not include a community notification component. The introduction of community notification laws came in response to various heinous crimes. The first of these crimes occurred in 1989 and involved a man named Westley Dodd who abducted two young brothers and murdered both of them after raping one (Garfinkle, 2003). One month later, Dodd molested and killed another young boy. Dodd went on to state "if released [he] would rape and kill again, and enjoy it" (Garfinkle, 2003, p. 165). In response, the state of Washington had its first legal hanging since 1965 and executed Dodd. Another crime occurred in May of 1989 and involved Earl Shriner, a man with a 24-year history of violent sexual assaults. Shriner had been in and out of institutions since the age of 15. Shriner abducted a 7-year old boy who was riding a bicycle. He raped, strangled, and sexually mutilated the boy (i.e., Shriner cut off the boy's penis). The boy, who was later found wandering in the woods, in shock, and covered in blood, survived the attack (Vess, 2009). The community was enraged to discover that Shriner had just been released from prison for abducting and sexually assaulting two teenage girls. It was reported that while in prison Shriner "bragged about his sadistic fantasies" and prison officials tried to have him legally committed after his prison term due to his perceived level of risk. A psychological evaluation found Shriner could not be committed because he did not suffer from a "mental disorder that rendered him an immediate

and substantial danger to others" (Vess, 2009, p. 265). In response, this apparent oversight in policy, the state of Washington implemented the Community Protection Act, which allowed the state to indefinitely civilly commit sex offenders who posed a significant risk (Vess, 2009).

In another influential case in 1994, Jesse Timmendequas abducted, raped, and murdered 7-year-old Megan Kanka in a house located in a New Jersey suburb; his house was across the street from where Megan lived. Timmendequas was a released sex offender who had been convicted twice of sexual crimes against children (Garfinkle, 2003). He lived with two other sex offenders who also participated in the sexual assault and murder of Megan Kanka. Megan Kanka's parents were outraged that three sex offenders lived in a house nearby and that they were not notified of the sex offenders' presence. Megan's mother had stated that, had she known these sex offenders were in the neighborhood, she would have been able to protect her daughter from playing nearby (La Fond & Winick, 1998). In response to the public's outrage, New Jersey implemented Megan's Law a year later. This is a community registration and notification law that required states to notify the public of sex offenders living in the community.

Before Megan's Law was enacted, there already existed the 1994 federal Jacob Wettlering Crimes Against Children Act, which permitted states to give law enforcement the discretion to provide sex offender information to the community (Garfinkle, 2003). Megan's Law amended the Jacob Wettlering Act to mandate that states inform their citizens of sex offender information or states would be ineligible to receive their "share of the $100 million dollar federal crime prevention funds" (Garfinkle, 2003, p.166). In 1996, congress added the Pam Lyncher Sexual Offender Tracking and Identification Act, which allowed the FBI to create a national database of sex offender registration information (Tewksbury & Lees, 2007).

Megan's Law has sparked controversy for a variety of reasons, but one main criticism is that its rules are vague. For example, Megan's Law mandates that states provide notification to a community, but there is no specific standard for how communities are to be notified nor is there a standard for how to impose the law on juveniles convicted of sex crimes (Garfinkle, 2003, Chaffin, 2008). While a complete description of SORNA's impact on juvenile sex offenders is beyond the scope of this paper, a brief discussion is provided in the Misperceptions of Sex Offenders section below.

The latest addition to SORNA is the Adam Walsh Act from 2006 (Caldwell, Ziemke, & Vitacco, 2008). The Adam Walsh Child Protection and Safety Act amends Megan's Law by including juveniles ages 14 and up who have been convicted of a crime equal severity or greater than aggravated sexual assault (Caldwell et al., 2008). Furthermore, the Adam Walsh Act attempts to address some of the vagueness of Megan's Law by establishing a tiered system, which then determines the length of time the offender must stay on the registry (Caldwell et al., 2008). Tier 1 includes all misdemeanor sex crimes for offenders who serve less than a one-year sentence. Tier 2 is for the majority of felony sexual abuse and exploitation crimes (Caldwell et al., 2008). Tier 3 is reserved for "forcible felony sex crimes, as well as sexual contact crimes that involve victims under the age of twelve" (Caldwell et al., 2008, p. 90). The minimum duration on the registry is 10 years for Tier 1. Tier 2 offenders must stay on the registry for 25 years and Tier 3 offenders have a lifetime sentence on the registry. By definition, what qualifies a juvenile to make the registry also places the juvenile in the Tier 3 category, which is a life sentence on the registry and can be imposed on those as young as fourteen (Caldwell et al., 2008). According to Caldwell and colleagues (2008), upon the full implementation of SORNA, there will be an estimated 70% of the 15,000 juveniles arrested for sexual offenses annually added to the registry.

Civil Commitment

Civil commitment for sex offenders represents new terminology describing an old concept. The ideology behind it has moved away from rehabilitation to incapacitation. After the heinous murder of a Washington boy in 1989 by a recently released sex offender with a long standing history of sexually assaulting children, the state of Washington implemented the Community Protection Act of 1990. The state began to commit offenders who it found to be at risk for re-offense. Eventually, the idea of indefinitely keeping someone in a psychiatric ward after serving a prison sentence was deemed unconstitutional. Winick (1998) discusses the development of civil commitment after serving a prison sentence and the concerns it raises. In the 1992 case, Foucha v. Louisiana, the Supreme Court ruled that states could not civilly commit a person on dangerousness alone; moreover, the Supreme Court ruled that a diagnosis of antisocial personality disorder, although a mental health diagnosis, did not qualify as reason enough to civilly commit a person to a psychiatric ward (Winick, 1998). The Supreme Court at that time ruled that to commit a person to a psychiatric ward without a mental illness diagnosis was also unconstitutional. However, Winick (1998) argues that the Court's ruling was vague and did not define what constituted a mental illness. La Fonda and Winick (1998) argued that the "sexual predator laws represent an aggressive use of the state's power of civil commitment to prevent harm" (p. 11). This left the door wide open for the next case of civil commitment in the 1997 case Kansas v. Hendricks.

Hendricks was a sex offender who was challenging the constitutionality of Kansas's Sexually Violent Predator Act (Winick, 1998). The defendant was found guilty for a "number of serious sex crimes" and served his prison sentence (p. 12). After serving his time, Kansas sought to have him civilly committed. At the trial, Hendricks reported that he agreed with the state's

diagnosis of pedophilia and that he continued to have sexual desires for children. Furthermore, Hendricks indicated that, if under stress in the future, he may be unable to suppress his urge to reoffend. Initially, the court felt that Hendricks met the then standard of "mental abnormality," so he could therefore be committed (Winick, 1998). La Fond and Winick (1998) point out that it makes little sense to say Hendricks was "a moral agent responsible for his conduct," which implies he is capable to stand trial and to serve a sentence (p. 12), only to state at the end of his sentence that he is "suddenly not a moral agent responsible for his conduct" and can thus be civilly committed (La Fond & Winick, 1998, p. 12).

Later the Kansas Supreme Court ruled that mental abnormality was not a sufficient criteria to commit. The U.S. Supreme Court took this as an opportunity to expand on the Foucha decision and overturned the Kansas Supreme Court's decision. The U.S. Supreme Court ruled that states could legally, civilly commit a sex offender if they have "proof of dangerousness with the proof of some additional factor, such as 'mental illness' or 'mental abnormality" (Winick, 1998, p. 516). Justice Thomas went on to state that sexual predator laws "serve to limit involuntary civil confinement to those who suffer from volitional impairment rendering them dangerous beyond their control" (Winick, 1998, p. 517). Because Hendricks himself had reported he would not be able to control his urges under stress and because he had a diagnosis of pedophilia, he met the standard for civil commitment. Winick criticized the ruling because, under Foucha, antisocial personality disorder was not a disorder that impacts control of behavior; however, for Hendricks, pedophilia is considered to be a disorder that does impact the control of behavior. Under this philosophy, Winick argued that any disorder that "renders an individual unable to control his or her dangerous conduct" could be cause for civil commitment (p. 519). Winick goes on to postulate what implications this may have for any criminal, such as a

domestic violence offender or drug dealer, who for example, may have the diagnosis of impulsive personality disorder. Under this philosophy then, these offenders too could and should be civilly committed.

Implications of Sex Offender Legislation

Financial Implications of SORNA

When discussing the importance of implementing treatment to any population one must consider the consequences associated with the treatment/intervention including financial implications. Federal funds are provided to states as incentives to implement the SORNA policies, but the states risk losing those funds if they are found to be non-compliant with the SORNA standards. Although a large percentage of the population agrees with the current sex offender registration and notification acts, current resources indicate that it would make more fiscal sense for a state to not implement SORNA and lose the grant, when compared to the costs of implementing SORNA's standards (Justice Policy Institute, 2009). A state must comply with SORNA standards or risk losing 10% of the state's allocated Bryne Grant money (Caldwell et al., 2008). For example, the estimate to implement SORNA for the state of New Hampshire in 2009 was $2,134,219, whereas the money received from the Bryne Grant in 2006 was $1,192,435 dollars (Justice Policy Institute, 2009). If the state opted not to implement SORNA, they would lose roughly10% of the Bryne Grant or $119,244.

It is important to note the estimates of the cost of civilly committing sex offenders, as these costs indicate that this route is not financially sustainable. With regard to the cost of maintaining these laws, Cohen and Jeglic (2007) report it costs $350 dollars per day "per sex offender, resulting in a cost of millions of dollars over the course of a year when staff and support costs are included as factors" (p. 373). Furthermore, Tewksbury (2010) indicated the

initial start up of a SORNA program can cost around $550,000 and implementation can cost $3.9 million in a fiscal year.

As mentioned previously, the focus of public policy has been on incapacitation, notification, and registration, which means policy has shifted away from the treatment aspect of the sex offender problem. Studies have examined alternative treatments and their potential costs. Donato and Shanahan (2001) discussed the costs of intensive sex offender treatment programs (SOTP) and found them to be extremely cost effective.

There have been various investigations into the effectiveness of treatment programs versus the current model of dealing with sex offenders. Tewksbury's (2010) review of sex offender literature and treatment found that the provision of treatment to sex offenders is cost effective. He also found that there is a low recidivism rate of 10.9%, compared to 19.2% of non-treated sex offenders. Prenky and Burgess (1990) stated that the overriding goal with regard to sex offenders is the reduction of victimization rates, as well as the reduction of costs incurred by victimization. They also state that if rehabilitation of offenders can be shown to reduce the likelihood of repeat offenses, then it is imperative that we overcome our resistance to treating child molesters - not for the sake of the offenders, but for the sake of the victims (p. 116). Donato and Shanahan (2001) conducted a review of Prenky and Burgess (1990) and found that their statements still ring true a decade later. These studies provide results that call out policy makers who would rather pay more to civilly commit sex offenders rather than have more effective treatment provided to sex offenders, in terms of costs and recidivism rates.

Community Registration and Sex Offenders

When sex offenders are forced to register in their communities the consequences make it likely they may then be alienated or shamed publically. Public registries limit social support

creating feelings of shame as well as isolation from the fabric of society. This could lower mental health functioning of those who register and increase the chances of offending sexually. Levenson and Cotter (2005) discuss the residential restrictions for sex offenders due to public policy. At the time of Levenson and Cotter's article, there were 14 states which enacted "buffer zones," which require sex offenders to live a specified distance from schools, playgrounds, etc. (p. 168). The least restrictive distance was 500 ft in Illinois; the most common distance was between 1,000 and 2,000 ft. The rationale behind these laws is that sex offenders who are more likely to recidivate are more likely to seek residences closer to places where children are easily accessible (Levenson & Cotter, 2005). However, Levenson and Cotter point out that a number of studies have found that recidivists did not live any closer to day care centers and schools than non-recidivists. In fact, research indicates that sex offenders who recidivate are more likely to do so in another neighborhood rather than their own (Levenson & Cotter, 2005). These studies provide good examples of how the current public policies in place do not use available research to support their methods and that some, as in the case of buffer zones, are in fact contrary to what the research shows.

Beyond this issue of empirical evidence not supporting the basis for residential restriction, there are also other practical implications to consider. Schools, day cares, and parks may overlap, leaving limited areas for sex offenders to live. Levenson and Cotter (2005) report that in some urban areas, sex offenders are forced to live in clusters in high crime areas, as these are the only geographical options for them based on the current laws. Additionally, the ramifications of not being able to find suitable housing could lead to homelessness and a transient lifestyle, which is counterintuitive to the tracking and supervision system meant to prevent recidivism (Levenson & Cotter 2005). Further, Levenson and Cotter (2005) indicate that

these statutes may increase risk "by aggravating the stressors (e.g., isolation, disempowerment, shame, depression, anxiety, lack of social supports) that can trigger some sex offenders to relapse" (p. 169). As is clear from these examples, these laws may increase the risk of re-offending rather than decreasing the risk of re-offending.

Sex offender community notification laws can have a variety of other effects. Zevitz and Farkas (2000) indicated that notification laws can help communities feel empowered to protect themselves; however, at the same time, they can also "invade the privacy of the offender" (p. 376). Zevitz and Farkas (2000) go on to argue that the anti-therapeutic effects of community notification (e.g., an offender may not be able to live with support friends or family members because of the proximity to a school or park or may not be able to gain employment) can ultimately lead to the offender feeling stigmatized by and ostracized from the community. In rare instances, sex offenders have been the victims of vigilantism—although only 1% of reported cases include physical or property damage (Zevitz & Farkas, 2000). Zevitz and Farkas examined the implications of community notification on level three (high risk) sex offenders and found that the offenders often had perceived stress due to strained interpersonal relationships.

As stated above, Tewksbury and Lees (2007) provide a discussion of the collateral consequences of sex offender registration. They pointed out that the social consequences mentioned above (e.g., poor relationships, employment difficulties, and diminished self worth) can make community reintegration more difficult. Research on the collateral implications of being convicted of a felony leads to similar consequences; however, Tewksbury and Lees reported that the social ramifications of being labeled a sex offender are greater. Levenson and Tewksbury (2009) also researched the implications for family members of registered sex offenders and found that housing restrictions due to buffer zones limit the availability of housing

in a metropolitan area, which leaves areas that have limited public transportation, employment, and access to mental health services. In fact, certain states do not allow offenders to live within 2,500 feet of a church, school, or park, which is a considerable distance from the aforementioned services. According to Levenson and Tewksbury (2009), "family members often reported persistent feelings of hopelessness, depression, and frustration as they adjusted to life with a registered sex offender" (p. 57). Additionally, family members reported they were ostracized for choosing to stay with the sex offender and often reported higher levels of stress. Levenson and Cotter (2005) examined sex offenders' perceptions of the registry in regard to its possible positive and negative effects and found that although some positive experiences were noted, one third of offenders reported job loss, housing problems, and harassment. Further, sex offenders reported that they did not think communities were safer because of the registry and about half of the internet listings were reported by the offenders as having incorrect information.

Misperceptions and Common Sex Offender Myths

Despite the evidence of the negative and anti-therapeutic effects of sex offender public policy, the majority of the population supports these laws. The answer to this conundrum may lie in Simon's (1998) article about the new penology, which states that the public is more concerned with vengeance than rehabilitation. In order to implement this type of public policy, policy makers rely on dehumanizing the sex offender. Simon argues that this can be seen in the names used to refer to sex offenders in sex offender legislation. For example, "predator" is a word often used to describe the person charged with a sexual offense (p. 456). Garfinkle (2003) agrees with this point of view and indicated that sex offender legislation (e.g., Megan's Law) is fueled by rhetoric and emotions rather than using empirical research and logic. Garfinkle (2003) goes on to state there are three techniques that policy makers of SORNA have used to have such laws

passed. First, is the powerful use of narratives (Garfinkle, 2003), namely the use of the heinous crimes that inspired law-makers to enact community registration (i.e., Megan's Law, Jacob Wettlering Act, Adam Walsh Act) and civil commitment (Hendricks v. Kansas). These stories are powerful, and humanize the victims and their stories. In addition, politicians often attempt to personalize these stories and use arguments such as, "Imagine if this were your child" or "If you care about children, then pass this bill." By setting up the arguments in this way, any argument about the constitutionality of the legislation was to argue on behalf of sex offenders and against protecting children, which Garfinkle (2003) indicated would be political suicide.

The second technique used by policy makers, according to Garfinkle (2003), is the use of unsupported or vague statistical claims. For example, Texas Representative Jackson-Lee reported that there were 50,000 cases of child abuse and neglect. However, Garfinkle (2003) argued that congresswoman Jackson-Lee did not point out that "most of these cases were not the kinds of abuse that Megan Kanka had suffered, nor would they result in a sex offense conviction that would require community notification under Megan's Law" (p.170). Another important statistic that Garfinkle (2003) felt politicians ignored was that only 3% of sexual abuse and 6% of child murders have been committed by strangers (which is in theory what community notification is targeting, unknown strangers).

The third technique to create legislation coincides with Simon's (1998) point, which argued that sex offender legislation involves dehumanizing the sex offender (Garfinkle, 2003). For example, Garfinkle (2003) indicated that the origin of the term *predator*, which is used throughout sex offender public policy, means "animals who must hunt prey in order to survive" (p. 170). This term "becomes metaphorically inseparable from the legal category specially

created for Megan's Laws" (p. 170). These three techniques are powerful tools and laws have often been passed with little debate due to a combination of the above three techniques.

Kernsmith, Comartin, Craun, and Kernsmith (2009) discuss the myths that are the basis of current public policy. They point out that sex offender registration laws are based on the premise that by raising public awareness about the location of sex offenders, the public can be protected from them. However, many argue that the registries only provide a sense of false security because it is based on the premise that sex offenders are strangers to their victims, which research has shown is the case only in small minority of offenses (Kernsmith et al., 2009). For example, Kernsmith et al. discuss the Bureau of Justice Statistics (BJS), which in 2000 reported 34% of child sexual abuse cases were perpetrated by family members and 59% were perpetrated by acquaintances. With regard to these numbers it is important to note that the BJS receives information from police reports; therefore, if the crime is not reported to the police then it is not included in the statistics.

While shaming and ostracizing are affects associated with offending, an intent of the sex offender registry is to use these affects to deter future sex offenders. Despite this intent, there has not been a statistical decrease in sex offending as a result of the community notification laws (Kernsmith et al., 2009). There have been reports, however, of unintentional anti-therapeutic effects of notification, including, social and financial constraints, which contribute to recidivism (Kernsmith et al., 2009). Based on this data, the registry laws are not deterring further offenses as intended, but may in fact be having the opposite effect.

Another common misperception of sex offenders is that, if released, they are more likely than other types of offenders to recidivate (Sandler et al., 2008). However, according to the BJS, only 5.3% of sex offenders released in 1994 were rearrested for sex related offenses up to three

years after release; this is compared to 73.8% for property offenders and 66.7% for drug offenders (Sandler et al., 2008). Tewksbury (2010) stated that sex offenders have on average a recidivism rate between 10% and 15% up to five years after release. Again, the sex offenders who received treatment had a recidivism rate of 10.9% versus the 19.2% for sex offenders who did not receive treatment. The only type of offenders who had lower recidivism rates were those who were originally arrested for homicide, kidnapping, and stalking (Tewksbury, 2010). Sandler et al. indicate that these myths are fueled by the media's disproportionate reports of sexually related offenses in a manner that makes the public fear sex crimes more than crimes related to murder, robbery, or assault. Furthermore, the media tends to sensationalize sex crimes, but underreport sex offender rehabilitation, which perpetuates society's hatred of sex offenders and the misperception that sex offenders cannot be treated (Sandler et al., 2008).

Sandler et al. (2008) discuss the ideology behind SORNA and indicate that these laws were based on the premise that public awareness decreases recidivism, will deter future sex crimes, and aid law enforcement in investigating new crimes. However, Sandler et al. reported that little empirical research has been conducted to measure the efficacy of SORNA. The research that has been conducted has found that SORNA has not led to a significant decrease in sexual recidivism. Sandler et al. conducted research in New York using SORNA standards and compared the recidivism rates of sex offenders who were released under SORNA standards to sex offenders released before the implementation of sex offender registration laws. The authors found no statistical difference in recidivism among sex offenders under SORNA and those who were not under the SORNA standards. Despite these results, SORNA maintains strong public support.

Another key argument fueling sex offender registration is the idea that public awareness

promotes safety. Kernsmith and colleagues (2009) conducted a study in Michigan to explore the utilization of the sex offender registry. In this instance, the authors found a positive correlation between those who were informed of a sex offender in the area and higher fears for children and themselves. Of those participants in Kernsmith's study, only 37% used the registry. Kernsmith et al. found that, of the 63% participants who did not view the registry, 41% had no interest, 17.9% felt safe, and 12.4% felt no need to look because they did not have children. Based on these results, the registry did not promote feelings of safety for those who utilized it.

The above studies examined the rational for the legislation versus the impact (e.g., Is it used? Does it help?, Is it effective?). Sandler et al. (2008) compared the SORNA laws to the colloquialism that a watched pot never boils; that is, based on SORNA, it is hoped that a watched offender never reoffends. Research has shown that this is not the case for sex offenders. If watching all possible offenders does not work then the pertinent question logically follows: How do we measure the likelihood of reoffending?

Risk Assessment with Sex Offenders

Hanson's (1998) *What do we know about sex offender risk assessment?,* discusses the static and dynamic risk factors associated with recidivism. Hanson (1998) defines static variables as fixed variables (e.g., prior offenses, childhood maladjustment), which often "indicate deviant developmental trajectories and, as such, mark long-term propensities to engage in criminal behavior" (p. 51). Hanson points out that, although static risk factors are helpful in predicting long-term risk, they are not factors that can be measured in terms of treatment effectiveness. Treatment cannot change static factors, as one cannot change his or her past. Changeable factors are referred to as dynamic risk factors (Hanson, 1998). Dynamic factors are mutable and are most useful in predicting recidivism (Hanson, 1998). A change in dynamic factors can indicate

an increase or a decrease in recidivism; for example, sobriety is a dynamic factor that can lead to an increased risk of recidivism if compromised (Hanson, 1998). Hanson divides the dynamic factors into two groups: stable and acute dynamic factors. A stable dynamic factor "has the potential of changing but typically endure for long periods of time (e.g., sexual preferences or alcoholism)" (p. 51). Acute dynamic risk factors are dynamic factors which are susceptible to change constantly, such as sexual arousal or drunkenness (Hanson, 1998).

Hanson (1998) indicates that there are three types of risk assessment: a *guided clinical approach* (i.e., use clinical judgment to predict risk), a *pure actuarial approach* (e.g., only use empirically validated tools and add predicting factors and the appropriate weighted factors into a regression formula), or an *adjusted actuarial approach* (i.e., using clinical judgment to alter the assessment). He argues that that clinical judgment is not as accurate as actuarial assessment. Those who use actuarial measures feel that adjusting those measures alters the accuracy of the measure (Hanson, 1998). However, it is important to make sure the actuarial tool being used is the best tool for the person whose risk is being assessed, and, in that respect, the adjusted actuarial approach could prove helpful (Hanson, 1998). For example, if an offender makes threats to reoffend, these threats should be taken into consideration in the risk assessment.

Hanson and Thornton (2000) compared three actuarial scales commonly used in risk assessment: the Rapid Risk Assessment for Sex Offense Recidivism (RRASOR), the Structured Anchored Clinical Judgment (SACJ), and the Static-99 (an integration of the RRASOR and SACJ). The Static-99 measures long-term risk potential by assessing sexual deviance, access to victims, the strength of their "habit," antisocial features, and age (young being a higher risk) (Hanson & Thornton, 2000). The authors found the Static-99 showed moderate predictive accuracy for predicting sexual and violent recidivism. However, after careful examination,

Hanson and Thornton indicated that the Static-99 can be improved by adding measures of dynamic factors. Beech, Friendship, Erikson, and Hanson (2002) reported that utilizing the static factors described above in conjunction with the Static-99 (with dynamic risk factors included) is a more effective way to predict recidivism.

Hanson (1998) discusses the implications of civilly committing sex offenders using only static risk factors. Since risk assessment is required for civil commitment, Hanson (1998) argues that current risk assessment tools (e.g., Static-99) are adequate for predicting risk, but are not helpful in measuring treatment effectiveness. This is a problem because our tools for incarcerating people are more refined than our tools for deciding who should be set free, or more importantly, who benefits from treatment (Hanson, 1998). In general, to provide a strong risk assessment, Hanson argues that the assessor must be familiar with factors associated with high risk, figure out how the offender in question compares to those factors, and determine the chance that the offender will commit a sexual or violent crime over the course of time. Hanson points out the first two parts are fairly easy, given the extensive research in the field; it is the third question that poses the challenge. Hanson reported that sex offenders recidivate at a much lower rate than is estimated by current predictive techniques. For example, Hanson found only 10–15% of sex offenders recidivated with a new sex crime over a 5-year follow up. Hanson points out that public policy is often based on the misconception that all sex offenders reoffend, and by creating "blanket policies" that use valuable resources to keep offenders locked up who "would have stopped offending with minimal intervention" (p. 67). .

Risk Factors

Hanson and Harris (2000) discuss the importance of dynamic risk factors and indicate that dynamic risk factors (especially acute dynamic risk factors) are more likely to be tracked by

supervision officers. They interviewed supervisors of sex offenders who reoffended and supervisors of sex offenders who did not reoffend to assess what factors were linked to recidivism. They found reoffenders were more likely than non-reoffenders to have distorted/deviant schemas that support their offending. Furthermore, Hanson and Harris (2000) indicated reoffenders were more likely to "have poorer social supports, attitudes tolerant of sexual assault, antisocial lifestyles, poor self-management strategies, and difficulties cooperating with supervision" (p. 6). Hanson and Bussiere (1998) found offenders in the following categories, including unemployment, single status, youth, criminal lifestyle, a history of victimizing strangers, a history of sexually offending at a young age, diverse victims (i.e., different ages and sex), and a history of attacking male victims to be at the highest risk for reoffense. Prenky, Knight, Lee, and Cerce (1995) linked impulsivity to higher rates of reoffending. Hanson and Harris identified unemployment, substance abuse, negative affect/mood, anger, lack of positive relationships, and distorted attitudes as associated with reoffenders. This is important to note given that public policies, such as SORNA and civil commitment statutes, have been noted to negatively impact these same domains. The important message here is that the anti-therapeutic effects of SORNA are similar to the predictors of relapse in dynamic risk assessment.

As mentioned previously, static and dynamic (both stable and acute) factors must be assessed in predicting risk levels. Thornton (2002) discussed the factors most commonly associated with high risk offenders and breaks them up into four domains of dynamic factors. These domains included sexual interests (i.e., specifically referring to the direction and strength of sexual interests), distorted attitudes (i.e., beliefs about offending that justify the crimes), socioaffective functioning (i.e., negative affect like anger, depression, and anxiety), and self-

management (i.e., the ability to problem solve). Offenders who had strong deviant sexual interests, distorted beliefs, high amounts of negative affect, and low self-management skills are the offenders at the highest risk to recidivate (Hanson & Bussiere, 1998; Thornton, 2002). Of the four domains discussed above, Thornton found distorted attitudes, socioaffective dysfunction, and poor self-management were the strongest predictors of recidivism. As stated above, research has reported that these domains are negatively impacted by sex offender public policies, thus leading to the conclusion that these policies may in fact lead to increase recidivism rates.

In order to be effective with risk assessment and prediction, both stable and acute dynamic risk factors must be assessed and reliance on a single evaluation of static factors must be avoided (Andrews, Bonta, & Wormith, 2006). As mentioned previously, current public policy involves a single risk assessment that places the offender at a certain level of risk. Based on this theory, the current risk assessment model is not providing accurate predictions. It is important that accurate risk levels are determined as this impacts treatment decisions with regard to offenders. Andrews et al. found that treatment based on a general or specific responsivity model (i.e., responding to the offenders based on where they are at in treatment) has demonstrated that offenders show better gains in treatment if it is targeted to their specific risk level. However, offenders are often unable to change the risk level that was determined from their initial evaluation. For example, an offender who was placed on level three may not be able to negotiate their risk level down to level two. This works in the other direction as well so that low risk offenders who have lost their job, home, or social support may become a higher risk than when originally evaluated, but their actual level of risk may not change. For these reasons, clinicians working with sex offenders must continually reassess the risk level of these offenders throughout treatment to modify treatment targets (Andrews et al., 2006). For example, a low risk offender

who loses his job may need to shift the focus of treatment to the offender's specific need at that time (again responding to the sex offender's specific need).

Etiology and Treatment Development

The early treatment of sex offenders during the 1950s and 1960s was dominated by the behaviorist approach (Kirsch & Becker, 2005). The rationale for this approach was based on the assumption that sex offenders were offending because of their deviant sexual preferences and "the conditioned association of sexual arousal with [these] deviant sexual fantasies" (Kirsch & Becker, 2005, p. 209). Although aspects of the behavioral approach are still being used today, conceptualization of the etiology of sex offending became more interpersonal during the 1980s (Kirsch & Becker, 2005). In response to this movement toward an interpersonal approach, therapists began incorporating social skills training and self-esteem building exercises into treatment. The rationale underlying the interpersonal approach was that sex offenders lacked the social skills necessary to form appropriate adult relationships (Kirsch & Becker, 2005).

Another addition to the sex offender treatment model is the incorporation of a relapse prevention (RP) component. The RP model was originally developed based on the addictive behaviors of alcoholics and substance abusers (Kirsch & Becker, 2005). The RP model was incorporated into the sex offender treatment model based on the similarities found between its original population and sexual offending behaviors. As such, the RP model assumes that sex offenders follow the same types of paths toward relapse as addicts. The model also assumes that these behaviors can be prevented through the use of cognitive-behavioral approaches (Kirsch & Becker, 2005). Currently, several treatment programs incorporate a "multicomponent cognitive-behavioral therapy (CBT) that is either built upon or incorporates a relapse prevention framework" (Kirsch & Becker, p. 210).

Laurie Guidry (personal communication, 2009) stated that, when treating sex offenders with mental illness, a key component to treatment lies in the risk–need responsivity (RNR) model. Rather than treating the sex offender population as a homogeneous one, the RNR model recognizes that there are different risks and criminogenic needs, which result in an idiographic treatment model. This model relies on assessment to provide the clinician with the risks and needs of the offender. This is similar to the assessment model proposed by Andrews et al. (2006), which highlighted the importance of targeting the treatments needs to specific risk levels. For example, a risk may be that the offender has substance abuse addiction, in which case the dynamic need would be to reduce substance abuse dependence (Andrews et al. 2006). In other words, treat what the offender needs, whether it be anger management, substance abuse treatment, or education regarding coping and problem solving skills. Each offender will have different needs and just as one would not send a patient who did not have alcohol abuse problems to a 12-step program, the RNS model does not provide a sex offender who possesses charismatic and antisocial features with social skills training.

Implications of Psychological Profiles for Treatment

When attempting to understand the heterogenous sex offender population, researchers have attempted to make homogenous subgroups based on the type of crime, the type of victim, or both (Harris, Smallbone, Dennison, & Knight, 2009). There are adults who sexually assault adult females (rapists) and adults who sexually assault children (child molesters). The child molester subgroup can be divided into two groups: those who have familial relations with the victim (incest) and those who are strangers. Research has demonstrated that rapists tend to have a psychological profile similar to violent, non-sexual offenders, in that they often commit several types of crimes and have antisocial features (Harris et al., 2009). In addition, rapists tend to have

an extensive criminal history, including a wide range of crimes. Extra-familial child molesters tend to specialize in one type of crime (sexual offending) and therefore have higher victim rates and a longer pattern of sexual offending. Incest offenders typically resemble non-offenders, in that they tend to be employed, married, and have efficient social skills (Harris et al., 2009). A major limitation to the categorization of sex offenders is that there is a large amount of offenses with heterogeneous victim groups (i.e., rapists who sexually offend on children and child molesters who rape adult women). Therefore, differences in typology can only be made if the child molester is a true child molester, not a mixed offender. Overall, offenders are challenging to categorize and this categorization may not be useful with regard to treatment. Harris et al. concurred with Andrews and Bonta's (2003) *need principle* (the risk, responsivity, and need framework), in that treating the offenders' generic criminogenic needs (e.g., substance abuse dependency) is more pertinent than treating the specialized sexual deviancy given the heterogeneity of the population.

Conceptual Framework

Therapeutic Jurisprudence

Therapeutic jurisprudence is a framework in which there is an "emphasis on increasing therapeutic effects and decreasing of anti-therapeutic consequences of the law" (Brigden, 2004, p. 362). This psycho-legal approach is essential to the current construction of sex offender treatment because of the increasing role that the criminal justice system plays in the treatment of sex offenders. Policy makers are moving toward harsher and longer punitive sentences for sex offenders, including civil commitment after time served (e.g., Kansas v. Hendricks), because of the popular misperception that sex offenders are more likely to re-offend, less likely to be amendable to treatment and are thus more dangerous. Based on the common notion that

offenders can never be rehabilitated, laws requiring registration have been enacted. Brigden argues that these laws are "confrontational and do not provide incentives for sex offenders to engage in treatment in the community or demonstrate a pro-social lifestyle for deregistration" (p. 355). There is no empirical evidence indicating that this legislation is an effective means to reduce recidivism (Brigden, 2004).

Given that most sex offender treatment occurs in the context of incarceration, the concept of "therapeutic jurisprudence" attends specifically to the therapeutic consequences of legal policies (Brigden, 2004). The current role of treatment programs has expanded with time and now includes therapy and risk assessment. Because of the increasing role of the legal system in treatment, treatment facilities are asked to look at multiple factors in order to attempt to predict future recidivism.

Winick (1998) provides an analysis of both the therapeutic and anti-therapeutic effects of sex offender public policy. In his analysis, Winick states,

> In facilities to which they are committed, they are held like 'dogs in a pen,' offered little in the way of treatment and virtually no promise of eventual release. Those who are released into the community, either after the expiration of their prison sentences or civil commitment, are required to register with the police, and the community is notified of their identity as discharged offenders. They are thereby subjected to a perpetual form of shaming that ensures their continued social ostracism. (p. 505)

In this statement, Winick points out both the direct and indirect effects of the law. The author argues that given the criteria set by the Supreme Court in Kansas v. Hendricks, society is labeling sex offenders as sexual predators, as well as labeling them as mentally ill individuals. Moreover, Winick argues that labeling a sex offender as chronically mentally ill—and thereby

helpless against his illness—is anti-therapeutic because it can be used by the offender to justify the behavior. This can have negative consequences on treatment outcomes as these distorted attitudes are a contributor to recidivism. Winick continues, stating that civilly committing sex offenders also stigmatizes those who are civilly committed for other serious mental illnesses (even though 90% of those who are mentally ill are not violent), in addition to using up space meant for those with other serious mental illnesses. To elucidate the cost of civilly committing sex offenders, Winick indicated that the state of California spends an estimated $107,000 a year per patient to civilly commit and treat a sex offender and currently has 11,000 sex offenders in prison who would qualify for sex offender civil commitment.

Some of the therapeutic effects of these policies for the community may occur because community members may feel a sense of control and empowerment from these policies (Winick, 1998). In addition, law enforcement and prosecutors may feel a sense of relief because they are able to offer the community visible assistance (Winick, 1998). Conversely, there are negative effects on the community as well, as some people become more frightened and anxious when they are aware of sex offenders taking up residence near them; this may result in people experiencing so much fear that they leave their homes (Winick, 1998). Winick points out that a therapeutic effect of these policies on the offender may include helping the offender understand the impact of his or her crime on the victim (e.g., develop victim empathy). By requiring the offender to register, it may provide the offender with a sense of relief rather than distress caused by repressing negative feelings.

Other negative effects on a registered offender can include social isolation from neighbors, unemployment, and difficulty finding adequate housing. Winick (1998) points out that the basic framework of the justice system is to punish offenders, to provide them with time

to reflect on their behavior, and to instill the possibility of forgiveness that may motivate them to achieve rehabilitation. However, this basic frame is not applied to sex offenders, who are publicly labeled for 10 years to life and are told that their crimes are unforgivable. As a society, we are showing them we do not care about them, but are expecting them to care about us and our rules (Winick, 1998). Due to the negative ramifications of both civil commitment and community notification and registration, Winick, argues that both types of laws are anti-therapeutic and need restructuring.

Sex Offender Treatment

The sex offender population is heterogeneous and ranges from child molesters, teen molesters, rapists (e.g., adult victims), non-touch offenders (e.g., voyeurs), to incest offenders. These offenders differ in victim selection and they differ in preferred treatment. For example, social skills training may be useful to child molesters, but it may be less useful for incest offenders. A study by Langevin, Wright, and Handy (1988) found that incest offenders were more likely to be married than any other type of sex offender and thus preferred marriage counseling to other types of therapy.

The RP model assumes that all sex offenders follow a calculated and a predictive path to relapse. Similar to the idea of an alcoholic whose first sign of relapse begins when he or she drives by the bar, a sign of relapse for a sex offender may be purposely driving by an elementary school. However, Kirsch and Becker (2005) point out that not all sex offenders follow the same paths toward relapse. Therefore, clinicians have been utilizing multicomponent CBT approaches to compensate for the heterogeneity in the sex offender treatment groups.

Kirsch and Becker (2005) state that sex offender treatment was often aimed at specific "treatment targets with a correlational basis" (p. 211). The correlations mentioned above have

linked high risk of offending with deviant fantasies, poor social skills, low victim empathy levels, and victim selection. However, it is important to note that reliable markers of risk do not necessarily equate with causes of risk, which is the assumption that underlies targeting risk factors to prevent the offense (Kirsch & Becker, 2005). For example, an offender may learn better social skills through a specific treatment approach, but that is not necessarily a strong predictor of future recidivism. Again, this may be in part because of the heterogeneity of the population, which is not considered in current treatment development. However, according to Andrews and colleagues (2006), the RNR model has emerged as an efficient approach to treating such a diverse and heterogeneous population.

Barriers and predictors of treatment completion. There has been a trend in recent years toward group psychotherapy with incarcerated offenders. Although the group approach can be productive, Morgan and Flora (2002) indicate not enough outcome data have been reported to compare them with the data on individual therapy. Furthermore, only 16% of mental health departments in state correctional facilities are conducting research on the efficacy of group therapy (Morgan & Flora, 2002). According to the authors, the key component to successful group therapy is group member selection. Selection of group members is essential because if an offender is selected for a group, but then the offender drops out, he or she is at an increased risk of recidivating (Morgan & Flora, 2002). Researchers have found correlations between offender dropouts and recidivism in general. Greer, Becker, Gray, and Krauss (2001) found that common variables associated with dropout and recidivism include: (a) “the amount of pressure the subject was under to participate in treatment,” (b) “the diagnosis of antisocial personality disorder,” and (c) “lack of discrimination in the choice of sexual victim or paraphilic act” (p. 303). All of these variables correlate with both recidivism rates and treatment dropout rates.

Although it is useful to know the similarities between treatment dropouts and offenders who recidivate, it is equally important to know the common factors among those members who complete therapy. Greer et al. (2001) found that most therapies being used were a form of CBT, but that CBT requires a community college level of education to complete effectively. CBT often relies on a psychoeducational component that uses homework to facilitate therapy. In general, Greer at al. found that inmates who completed therapy had a higher level of education than those who did not complete therapy. This implies that incarcerated inmates with lower levels of completed education are at a disadvantage with regard to CBT-oriented programs.

Another predictor of treatment completion was whether or not the offender had been a victim of sexual abuse. The treatment program studied by Greer et al. (2001) discussed past victimizations and how members who had a history of abuse may not have been able to listen to these types of stories. Members who did not have a history of crime before being incarcerated were more likely to complete treatment. Greer et al., Morgan and Flora (2002), Kirsch and Becker (2005), and Scalora, and Garbin (2003) found that inmates with a long criminal history, antisocial personality disorder, and poor impulse control were all at an increased risk of treatment failure and eventual recidivism.

From Treatment to a Scarlet Letter

In response to the implementation of sex offender legislation in the 1990s, Tewksbury (2005) researched the *collateral consequences* of sex offender registration legislation. The rationale for sex offender legislation is that community notification of registered sex offenders will prevent the recidivism of those registered sex offenders. This type of law is based on flawed logic that assumes that sex offenders are strangers and that they all operate in a homogenous fashion. Such a law implies that if the public knows where sex offenders are, then the offenders

will not recidivate. Tewksbury continues to argue that sex offender legislation creates the type of environmental stressors that RP therapists would argue actually lead to relapse. These secondary implications of sex offender legislation include stressors of job loss, lack of housing, and social stigmatization (Tewksbury, 2005).

Current Study

The complexity of sex offender risk assessment, implementation of idiographic treatment, and the impact of sex offender registration legislation on treatment outcomes are all essential components that justify more research in the sex offender field. Today, therapists are asked to "provide information to legal decision makers with regard to options, prognosis, and predictions of recidivism related to sex offenders" (Scalora & Garbin 2003, p. 309). Therefore, future research questions should address either of these questions: (a) Does a particular therapy (i.e., CBT, psychodynamic, behavioral, integrative) work best for a specific type of incarcerated sex offender (i.e., pedophile, rapist, non-touch)? or (b) Is there a correlation between sex offender registration laws and sex offender recidivism? Although these are important future research questions, it is also essential to continue to study the effects (both therapeutic and anti-therapeutic) of the current treatment of sex offenders. Research has pointed out that the main focus when working with sex offenders tends to be on assessing them for their risk potential, while little is said in regard to their overall mental health. Research on mental health issues, such as substance abuse, bipolar disorder, anxiety, and depression have been studied in the context of risk assessment factors. After establishing a relationship between negative experiences associated with being on the sex offender registry and mental health functioning, it would be of interest to examine whether being on the registry, in fact, *causes* an increase in mental health pathology (i.e., symptoms of depression, anxiety, somatization etc.) Therefore, the purpose of the

following study is to gather information on the relationship between the perceived impact of SORNA on mental health functioning, as reported by the sex offender.

Statement of the Problem

Throughout the research, there is a recurring theme of the need for a successful treatment for sex offenders due to the heinous nature of their crimes (Brooks-Gordon, Bilby, & Wells, 2006). The emotional response provoked by these crimes has led to the development of a public policy based on populist punitiveness (Simon, 1998). The literature on sex offender research continues to indicate that empirical data have not influenced the development or the implementation of public policy in regard to sex offender management (Chaffin, 2008). In addition to research by Sandler et al. (2008), which indicates that registration laws seem ineffective in regard to lowering recidivism, research also indicates such policies are likely to have unintended anti-therapeutic effects on the sex offender (Kernsmith et al., 2009; Winick, 1998).

Research indicates that dynamic factors, such as poor social support, deviant attitudes/beliefs, antisocial behavior, poor self-management, substance abuse, and unemployment, are associated with recidivism (Beech et al., 2002; Hanson, 1998; Hanson & Bussiere, 1998; Hanson & Harris, 2000; Hanson & Thornton, 2000; Thornton, 2002). Furthermore, Dempster and Hart (2002) indicate that sex offender recidivists "showed increased anger and subjective distress just prior to recidivating" (p. 123). Tewksbury (2005) collected data on the collateral consequences of being on the sex offender registry from the sex offenders' perspectives and stated "sex offenders are punished through their sentences, through the shaming process of registration, and through the reactions and responses of community members aware of registrants' status as sex offenders" (p. 79). Given the possible therapeutic and anti-therapeutic

effects of sex offender public policy (e.g., SORNA and civil commitment), it is essential to explore possible clinical implications (e.g., depression, anxiety, anger, paranoia, antisocial features, negative mood, poor interpersonal relationships, and substance abuse) of these sex offender public policies.

Another important aspect of this study is to keep in mind the findings in the context of the financial implications of current sex offender public policies. Brooks-Gordon et al. (2006) discuss the financial aspect of sexual offending: "The human and financial cost of sexual offending to victims and the social and health services is high, as is the public investing in policing, prosecuting, and incarcerating offenders" (p. 444). Greer et al. (2001) conducted a cost benefit analysis and found that if sexual recidivism was reduced by only 25%, society would save $4.3 million per year. This is why sex offender treatment is not only morally responsible, but fiscally responsible as well. Therefore, the stakeholders for this research project include offenders who are receiving treatment, therapists offering treatment and tailoring treatment goals, sex offender field supervisors, along with correctional, social, and victim services.

As discussed previously, due to the emotional response triggered by the nature of sexual offenses, public policy has begun to institute legislation aimed at protecting the public through invasive procedures, such as registration and community notification of convicted sex offenders. Tewksbury (2005) suggests that there may be anti-therapeutic/collateral consequences associated with being on the registry, therefore the following study explores perceived anti-therapeutic effects of being placed on the registry.

Research Questions

The purpose of this paper was to explore the relationship between the effects of SORNA on the overall mental health functioning of the offender, as measured by response from a brief

self-report symptom inventory and a registry experiences questionnaire completed by the offender. Specifically, this study documented the relationship between subjective negative experiences, such as feelings of shame and social stigmatization, and overall mental health functioning, from the viewpoint of the registered sex offender. This study explored the following: (a) whether subjects who report higher levels of negative experiences associated with being on the registry are also likely to report higher levels of mental health pathology and (b) whether positive experiences associated with being on the registry are related to the absence of psychiatric symptoms. The questionnaire used for this study provided the subject with an opportunity to rate his experience of the registry as either positive or negative. In addition, the questionnaire also provided the subject with an opportunity to comment on his overall perception of the usefulness of the registry. Further, subjects were given the opportunity to answer open-ended questions about the experience of being on the sex offender registry and its impact on their mental health. When a significant relationship was found between offenders' negative subjective experiences of SORNA and mental health symptoms, post hoc analyses was conducted to explore whether differences were to be noted between age and duration in years on the registry. The results of this study indicated that, though public policy is attempting to protect the public from individuals reoffending, it is also leading to subjective negative experiences that may be related to mental health functioning. Since a significant relationship was found between negative experiences of SORNA and mental health symptoms, the responses to the open-ended questions provided identification of a perceived causal link. That is, the investigator examined whether the majority offenders who participated in the study attributed their negative experiences to placement on the registry?

Chapter 2

Method

This study utilized a mixed methods approach, including qualitative and quantitative methodologies, to explore the following research questions: (a) Does a relationship exist between offenders' degree of subjective negative experiences of being on the registry and their reported level of psychiatric symptomatology? and (b) What are offenders' perceptions of the relationship between being on the registry and their psychiatric symptoms? The negative experiences reported on the adapted Tewksbury (2005) instrument will be compared to the psychiatric symptoms rating, as measured by the Brief Symptom Inventory 18 (BSI 18). The adapted Tewksbury instrument will be referred to as the Registry Experiences Questionnaire (REQ).

Participants

At the time of this study, there were 2,114 register sex offenders on the New Hampshire sex offender registry**.** The total sample size required for a statistical power of .80 and an alpha of .05 is 196 completed surveys (Howell, 2008). In order to compensate for the estimated low response rate for this population, 415 questionnaires were sent (more than twice the amount needed). Further, women were excluded from this study as the there were only 30 female registered sex offenders in New Hampshire. After collecting data for 7 months, 44 (n=44) useable questionnaires were received. Due to financial constraints (cost for postage and materials) the investigator was unable to send additional questionnaires. Participants consisted of a random self selected group of men from the New Hampshire sex offender registry. It is important to note that there were 439 participants initially randomly selected (i.e., using a an excel random number selection, a number between 1 and 2,114 was provided and the investigator sent a questionnaire to the corresponding sex offender on the list), but 24 were

eliminated (7 were female, 6 were homeless, 5 were non-compliant with no address listed, and 2 were no longer on the list by the time the questionnaire would have been sent out).

Procedures

The researcher obtained approval from the Institutional Review Board (IRB) and consent forms and questionnaires were sent to registered sex offenders. To see a copy of the consent form, see Appendix A. The researcher mailed out 415 paper copies of the questionnaire to registered sex offenders in New Hampshire. Names and addresses of participants were obtained from the New Hampshire online sex offender registry.

Each questionnaire sent to participants included the informed consent form, the REQ, the BSI 18, and a cover letter explaining the purpose of the study. The REQ form asked respondents to rate the degree to which sex offender public policy has impacted a given symptom in various domains. This questionnaire differed from the original questionnaire used by Tewksbury (2005) in that several of the items from the original questionnaire were removed to facilitate additional questions aligned with this study. Additional items asked subjects to complete open-ended questions regarding the perceived impact of SORNA on their mental health issues. The open-ended questions were designed to explore what life has been like for the offender since being placed on the registry. The questions, 13-17 in the REQ, focus on the offender's perceptions of the registry and its effects on his mental health functioning. A qualitative approach was used to analyze the responses to the open-ended responses on the REQ questions. Specifically, a content analysis method (Flick, 2006), focusing on frequency of recurring themes was used. The BSI 18 was given to assess psychological distress. Quantitative analyses were used to analyze the items on the REQ (excluding the open-ended questions) and the items on the BSI 18.

Instruments

Registry Experiences Questionnaire (REQ). The REQ included questions used in Tewksbury's (2005) instrument, as well as additional questions designed by the author to assess the perceived impact of SORNA on the mental health of the subject, for a total of 12 items. Tewksbury's (2005) original instrument may be found in Appendix B. As stated above, several of the original items from Tewksbury's (2005) questionnaire have been removed as they do not apply to the current study. The excluded items were designed to assess the offender's perception regarding the accuracy of the registry. Tewksbury was interested in whether or not knowledge of the accuracy of the information on the registry would encourage offenders to attempt to change it. For this study questions were substituted that were designed to assess the impact of SORNA on dynamic risk factors associated with mental health functioning. Tewksbury's original instrument was modified in order to focus more on perception of usefulness of the registry rather than on the accuracy of the registry. The original instrument was modified to ensure that all wording is at an eighth grade reading level. The adapted instrument, including the addition of five open-ended questions, can be found in Appendix C. Overall, the purpose of this adapted instrument was to explore offender perceptions of the impact of sex offender registration and notification on several domains of functioning, as well as to provide a measure of the subject's overall perception of the registry.

REQ Composite Score. The REQ is a measure of negative experiences related to being on the sex offender registry. Specifically, the composite score of the REQ was calculated in order to obtain a measure for a given subject's negative experiences. A high score on this measure indicates that the subject reported a high amount of negative experiences associated with being on the sex offender registry, whereas a low score indicates that the subject was

reporting a low amount of negative experiences associated with being on the sex offender registry. The highest possible composite score is 107, which indicated that the subject endorsed every item on the REQ as a negative experience. The lowest possible composite score is 9, which indicates that the subject did not endorse any negative experiences associated with being on the sex offender registry. Questions 2 through 12 make up the REQ composite score. All questions on the composite scale are scored using a Likert scale. Some scores are taken directly from the number indicated by the subject in his or her response, whereas others are reversed scored. For example, question 2 asked the subject how often he or she is recognized in public as a registered sex offender. For this question, more frequent occurrences of recognition are assigned a higher number (i.e., "never" is assigned a value of 0 and "daily" is assigned the highest value of 7). For questions 3, 6, 7, 8, and 10, the Likert value selected by the subject will reflect the same overall value of the item. For example, on question 3 ("I feel ashamed that I am on the sex offender registry"), if the subject circles a "10" indicating maximum agreement, then ten points will be added into the composite score. However, for questions 4, 5, and 9, the directionality of the Likert scale was reversed. That is, if the subject circles a "10" on question 4 ("I understand why people want there to be a sex offender registry"), thus indicating that he or she "fully agrees" with the statement, then the score was reversed and the value of the item added to the composite score would be 1. Lastly, item 12 asked the subject to check all negative scenarios that have happened to him or her as a result of being on the registry. For each negative scenario that the subject endorses, a value of 1 point will be added to the overall composite score.

The primary focus of this study was on the correlation between perceived negative experiences associated with being on the registry and mental health functioning. Open-ended questions were included as a means to explore the possible causal relationship between the

perception of anti-therapeutic and therapeutic effects of registration and notification on the current mental health functioning of the offender. Without the open-ended questions, no causal relationship between negative experiences associated with being on the registry and mental health functioning could be made. While the sample size was small and the qualitative data was largely anecdotal, the analysis of the responses to the open-ended questions may have provided preliminary exploratory data regarding a possible causal link between negative experiences and mental health functioning. The findings may establish a causal link, which may or may not be generalizable to the majority of the population due to the small sample size. Nonetheless, determining this preliminary link is important, as it will allow for the creation of a foundation and possible direction for further research in this area. The open-ended questions can be found on the last page of the REQ in Appendix C. In addition, the content analysis method will be used to identify emerging themes from the open-ended questions in order to capture the subjects' perception of the impact of the registry on his overall functioning.

BSI 18. The packet also included the BSI 18, a brief self-report screening measure of overall psychological symptoms. The BSI 18 is an 18-item self-report inventory used by the behavioral health community to screen for psychological distress and psychiatric disorders. Specifically, the BSI 18 provides individuals with 18 symptoms and asks the participant to rate his or her level of distress in the past week with each symptom. The screen uses a 5-point Likert scale, with 0 indicating *not at all* and 4 indicating *extremely* (Boothroyd, 2001, p. 4). The measure is designed to assess for three symptom domains, including depression, anxiety, and somatization. In addition, this measure includes a Global Severity Index which is based on all 18 items. The BSI 18 was chosen because it can be completed in four minutes and only requires a sixth grade reading level. The BSI 18 provides gender-specific and age-specific community

population normative tables from which the examiner can derive a T-score for each subject. The internal consistency of the four domains of the BSI was as follows: the Depression had an alpha of .84, the Somatization had an alpha of .74, the Anxiety had an alpha .79, and the General Symptom Index had an alpha of .89. The BSI construct validity corresponds with the Symptom Checklist 90 revised (SCL-90-R), with the Somatization having an r of .91, the Anxiety having a r of .96, the Depression having an r of .96, and the GSI having an r of .96 (Boothroyd, 2001).

Data Analyses

Quantitative analysis. To assess the relationship between negative experiences and psychiatric symptoms, a Pearson's product correlation (r) was obtained utilizing the BSI 18 and REQ composite scores as variables. The General Symptom Index represents the overall mental health functioning of the subject and will be the primary focus of the analysis. The BSI 18 also provides 4 composite scores. A Pearson's r was obtained to examine the relationship between the REQ composite score and the remaining three domains of the BSI 18 (Anxiety, Depression, and Somatization). In order to ensure that the items on the REQ have internal consistency and are thus representative of a unitary construct, an inter-item correlation was performed to obtain Cronbach's alpha. If items from the REQ "hang together" and internal consistency is high (i.e., 0.6 or above) it will be assumed that the items on the REQ are representative of a unitary construct. If internal consistency is high, then the total score on the REQ can be correlated with each domain in the BSI (i.e., General Index, Anxiety Index, Depression Index, and Somatization Index). If Cronbach's alpha indicates internal consistency is low (thus indicating that the items on the REQ are not representative of a unitary construct), then each item on the REQ can be individually correlated to the BSI 18 domains using a Pearson's product correlation. This will allow the investigator to determine if specific items are linked to domains in the BSI 18. The

investigator will then be looking to see if specific questions from the REQ correlate with specific types of mental health symptoms as measured by the BSI 18.

Qualitative analysis. The qualitative portion of this project is aimed at establishing a preliminary causal link between negative experiences and poor mental health, which cannot be obtained from the quantitative research analysis portion of this design. In order to assess the participants' perceptions of the relationship between psychiatric symptomatology and negative experiences resulting from being on the registry, the investigator will use content analysis to analyze the responses to the open-ended questions on the REQ. Content analysis is most often used as a supplementary method and although it can be applied in a more complex manner, it is mostly used in "comparison of simple percentages" (Robson, 2002, p. 359). This is done by categorizing answers and counting the frequency of emerging themes from the subjects' responses. This section will explain each step of the content analysis model, as well as how each step relates to this specific study.

The first step in conducting a content analysis according to the United States General Accounting Office (GAO, 1996) includes deciding whether content analysis is appropriate for this project. Flick (2006) supports using content analysis when analyzing written text. The US GAO (1996) indicated that content analysis is useful when investigators need to sift through large amounts of data including answers to open-ended questions on questionnaires. This project is using open-ended questions to establish a preliminary link between the implementation of the registry and mental health functioning, thus making content analysis an appropriate means for analyzing the data.

The second step of this model required the investigator to define the variables and categories. The investigator created three categories including therapeutic aspects of being on the

registry (i.e., positive category), anti-therapeutic aspects of being on the registry (i.e., negative category), and suggestions on policy modification. These categories were based on the content of the open-ended questions. The investigator created the open-ended questions based on themes from the literature on sex offenders. Specifically, questions 17 and 18 were derived from research conducted by Levenson and Cotter (2005), who studied experiences and concerns from the viewpoint of the registered sex offender. Therefore, the first category will include suggestions pertaining to public policy from the view point of the sex offender. Questions 14, 15, and 16 are based on research done by Winick (1998) and Tewksbury (2005), who discussed both therapeutic and anti-therapeutic aspects to sex offender registration. Therefore, the second variable will look at the therapeutic and anti-therapeutic aspects of sex offender registration (categories two and three).

Step three of the content analysis requires the investigator to select the material for analysis and examine how the data are being collected. Of note, the information obtained for this project is from open-ended questions on a questionnaire and not from an interview which could allow for more clarification of specific issues. In regard to the sampling strategy, Robson (2002) indicated that it is often necessary to "reduce your task to manageable dimensions by sampling from the population of interest" (p. 353). Further, when one investigator attempts to code large amounts of data, Robson recommends using a computer software program to assist in the process, because without it, the process can be "extremely laborious and time consuming" (p. 357). Due to financial restrictions, the investigator did not have access to such programs. Therefore, the investigator selected and analyzed 14 participants' answers from the larger sample using this method (n=14). The investigator decided against using a median split when choosing the REQ questionnaires to utilize for the content analysis. Specifically, if the investigator had

used a median split (i.e., seven questionnaires with elevated REQ scores and seven questionnaires with low REQ scores) it would not have been representative of the overall sample. Thus, the sample of 14 subjects were randomly selected from the pool of 44 (n=44).

For step four of the content analysis, the investigator defined the recording units. A recording unit is defined as a theme. A theme is defined as an idea, which can be expressed in a sentence or in a paragraph. Once defined during review, each theme is placed into a pre-existing category. For the purpose of this project, the investigator attempted to determine what the subjects' experiences of the registry have been like and if the subjects believe there is a causal relationship between their mental health and the sex offender registry. The themes were identified while analyzing the responses to the open-ended questions.

The next step (step five) of the process involved developing the analysis plan. According to the GAO (1998), the analysis plan can focus on the presence of variables within the data (i.e., category frequency within the open-ended responses). The investigator of this project counted the frequency of positive versus negative themes in the subjects' responses. The frequency count was used to establish the preliminary causal link between the registry and mental health functioning of offenders, which is discussed further in step seven.

Step six of the content analysis required the investigator to code the text. Each code represents the category in which the identified theme falls. This allows the investigator to look at the data and count the frequency of each code. The investigator for this project typed out each written response to the open-ended questions and used different colors to highlight the different codes found in the responses. It is important to note that though this process was repeated several times to maximize reliability, the principal investigator conducted all of the coding, making coder bias a possibility.

In step seven of this model, the investigator analyzed the themes obtained during the coding process. This involved calculating a frequency count for each code in each category. The investigator counted each theme and provided a percentage in regard to how often the theme was represented in the sample. The themes were useful in providing anecdotal data about each registered individual's story. The investigator was unable to use this data in the form of a chi squared analysis as the subjects often had aspects of both positive and negative thoughts about the registry in each theme, thus making a chi square analysis inappropriate/impossible. However, the investigator conducted a binomial statistic test to examine whether participants felt the registry was either negatively (possible .50 outcome) or positively (possible .50 outcome) impacting their mental health.

Chapter 3

Results

Descriptive Statistics

The sample ($N = 44$) consisted of predominantly white males ($n = 41$) with a mean age of 50 ($M = 50.22$, $SD = 11.82$). The average duration of time spent on the registry by the subjects (N=44) was 9.5 years or 114.91 months (M=114.91, SD= 76.555). See Figure 1 for the age distribution for the sample.

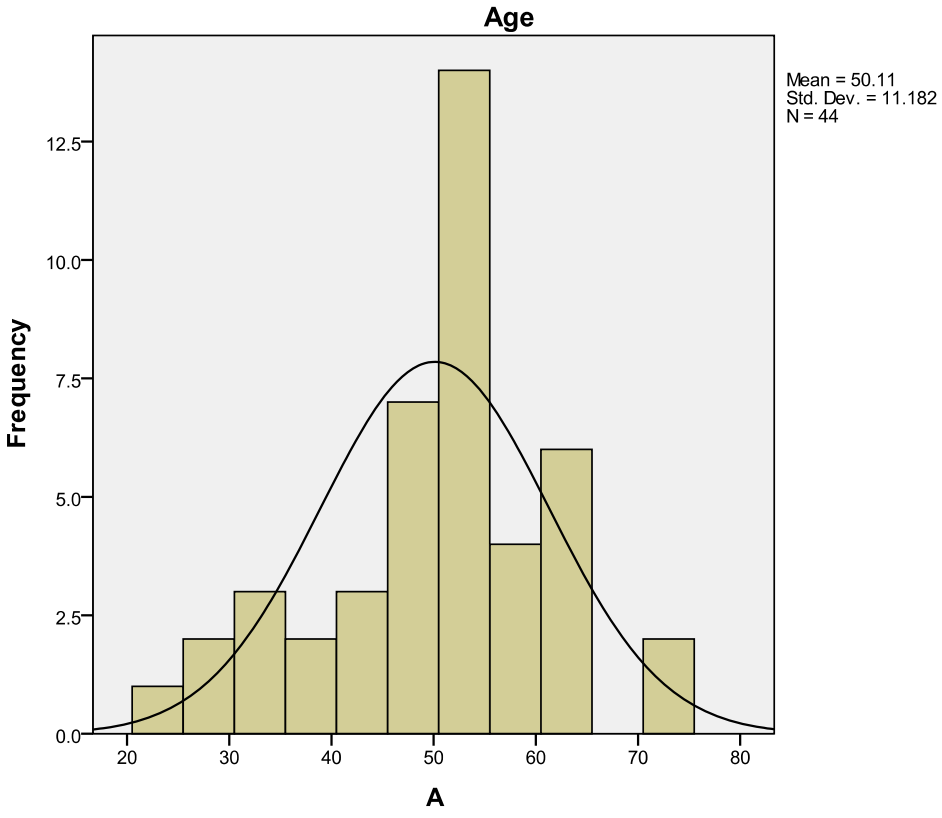

Figure 1. Age distribution for the sample.

Quantitative Analysis of Negative Experiences and Mental Health

REQ and BSI 18. The primary purpose of this study is to explore the relationship between negative experiences associated with SORNA and overall mental health of the subjects as measured by the BSI 18. For this sample, the REQ had a Cronbach's alpha of .809 suggesting good internal consistency. A Pearson correlation was conducted, which showed that the Total REQ score is positively and moderately correlated with the GSI at the .05 level of significance (r= .50, p <.001, n = 42). When compared, those whose REQ scores were clinically significant (above 67) reported greater distress on the BSI than those whose REQ scores were in the normal range or below 48 (t = -3.739, p = .001).

REQ and time on the registry. After establishing a relationship between negative experiences and reported mental health symptoms, the investigator examined whether a possible relationship existed between length of time spent on the registry and severity of one's mental health symptoms. The results of this comparison showed that there was no significant correlation between duration on the registry and GSI scores (r = .057, p = .716). Figure 2 provides the frequency distribution for the total Negative Experience Quotient.

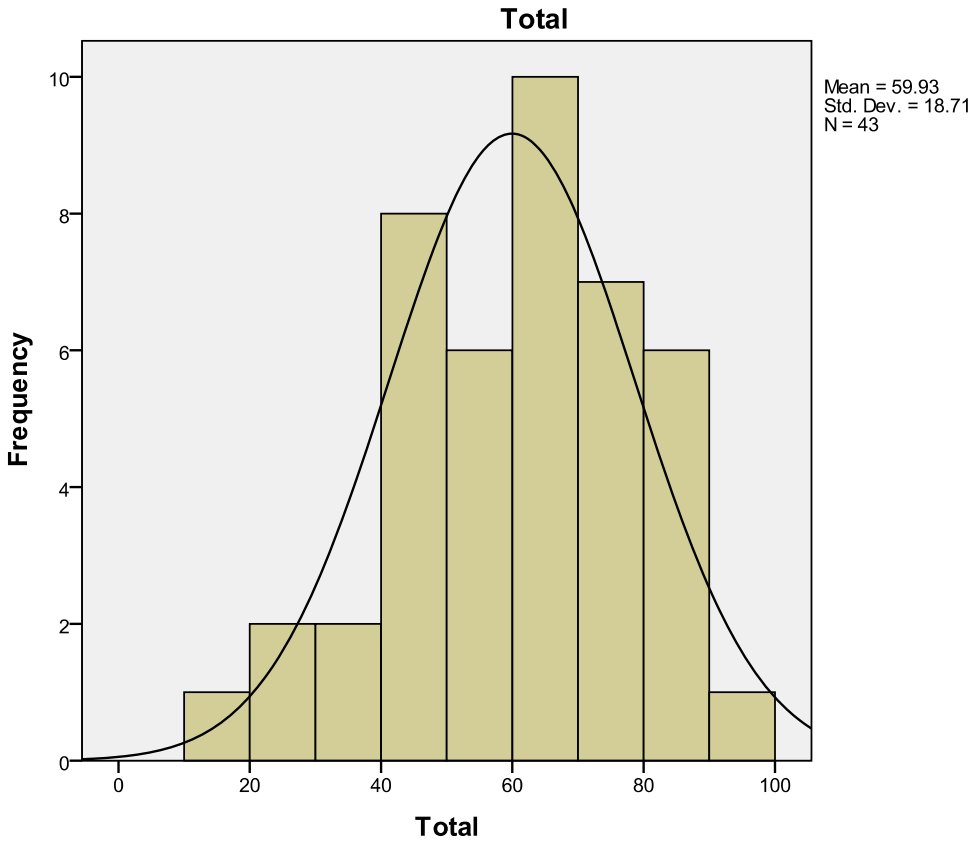

Figure 2. Frequency distribution for the total Negative Experience Quotient

Qualitative Analysis

A content analysis of a small sample (n = 14) was conducted to explore frequencies of reoccurring themes in the responses to the open-ended questions on the REQ. Three categories were identified prior to analyzing the sub-themes. The pre-identified themes/categories used for the qualitative analysis included negative themes, positive experiences associated with being on the registry, and policy implications and recommendations. The subthemes of these three areas are discussed in more detail below.

Negative themes. Of the 14 questionnaires selected, the most recurrent theme was the theme related to negative impacts of the registry on mental health. Subthemes in this area

included increased level of stress since being placed on the registry (*n* = 5), thoughts of suicide since being placed on the registry (*n* = 4), and thoughts of hopelessness (*n* = 4). All of these subthemes were placed under the major theme of hopeless/stressed (n=13). Table 1 illustrates the frequency of each reported theme with regard to being placed on the sex offender registry.

Table 1.

Qualitative Content Analysis of Negative Themes

Theme	Number of Cases	Percentage
Theme 1 Hopeless/stressed	13	92%
Theme 2 Fear/worry	10	71%
Theme 3 Job loss	8	57%
Theme 4 Branded/shame	5	35%
Theme 5 Victim of vigilantism	4	28%
Theme 6 No support	3	21%
Theme 7 No housing	3	21%
Theme 8 Impact on family	2	14%

Note. Themes derived from a content analysis of questions 13, 14, 15, and 17 from the REQ.

Positive experiences associated with being on the registry. Based on questions 13, 14, 15, and 17, there were 48 reported negative experiences, which fell into 8 different reoccurring themes. Those same open-ended questions produced 11 reported positive experiences associated with being on the registry, which fell into four different themes. The most frequent positive theme was that the registry could be a resourceful tool for parents (n = 5). Other themes indicated that being placed on the registry helped the person realize that what he did was wrong (n = 2) and that being placed on the registry led to an increase in strong support from his social support system (n = 2). The last theme indicated that the registry prevents recidivism by keeping the

subject away from situations which could lead to relapse (n = 2). Table 2 illustrates the frequency of these four themes.

Table 2.

Qualitative Content Analysis of Positive Themes

Theme	Number of Cases	Percentage
Theme 1 Registry is resourceful	5	35%
Theme 2 Realization of wrongs	2	14%
Theme 3 Strong support	2	14%
Theme 4 Prevents re-offending	2	14%

Note. Themes derived from a content analysis of questions 13, 14, 15, and 17 from the Questionnaire.

Table 3 illustrates the participants' responses to question 15 from the REQ (i.e., "Do you feel being placed on the registry has impacted your mental health? If so, how?"). Again, the Positive and Negative themes were derived from the content analysis. Utilizing this data, a binomial statistical test was conducted (n.b., this is an exact, non-parametric, statistical test best suited for small sample sizes). For this analysis, the probability of a negative and positive outcome was set at .50 and .50, respectively. This means 50% of the outcomes were expected to be positive and 50% were expected to be negative. The results of this calculation showed that more people than expected (93%) reported a negative mental health outcome as a result of being on the sex offender registry. However, when analyzing participants' answers to the questions about the impact of the registry on their mental health, it is difficult to summarize and capture the poignancy of their answers, therefore a few responses are provided below.

When asked about the impact of SORNA on his mental health, a participant's answer included themes of hopelessness, worry, and feeling as though he has no support: "Yes, I am much more skidish in public, looking over my shoulder, thinking many people recognize me and either want nothing to do with me (no friends yet), or would falsely accuse me, just to put me away again and 'take another one off the streets."' When asked about the impact of SORNA on his life, another participant's response included themes of victim of vigilantism, loss of support, and shame: "The loss of friends, the harassing phone calls, the trash thrown in my yard. Being hit with bottles by passing cars and being yelled at. When the guys was killing registered sex offenders a few years ago I left my door unlocked hoping he would come for me. It has isolated me. Made me feel targeted, vulnerable, and ashamed." In regard to the impact of the registry on his life, another participant's statement, again, included themes of hopelessness, being a victim of vigilantism, and shame when he stated: "when you make life so difficult that there is no hope here people see no reason to try to reform. When getting your mail you get hit by bottles and other things from passing cars, threatening calls. I leave my door unlocked hoping a vigilante if one comes will end my shame, ya, it hurts every day." The one participant who denied any negative impact of the registry on his mental health stated: "no, I am a strong person with good family and friends that have always been there for me. " This participant seemed to indicate that he realized he was fortunate and stated, "I was lucky but most people [cannot] get jobs, places to rent, and are treated very unfairly because of this label."

Table 3.

Binomial Statistical Test for Impact of Registry on Mental Health.

				Observed		
		Category	N	Prop.	Test Prop.	Exact Sig. (2-tailed)
Content	Group 1	Negative	13	.93	.50	.002
	Group 2	Positive	1	.07		
	Total		14	1.00		

Note. Positive and negative themes were derived during the content analysis of 14 randomly selected cases.

Policy implications and recommendations. Themes for this part of the analysis were drawn from questions 13, 14, 15, and 17. Over 15 policy recommendation themes were noted in the 14 questionnaires. Despite more negative themes in regard to SORNA, half of the respondents reported that there should be a registry (*n* = 7). In addition, the majority of subjects reported that if there is a registry, it should be for police use only and not available to the general public (*n* = 10). Half of the subjects (*n* = 7) reported that they felt the current registry is unfairly singling out one class of crime, and that if a registry exists, other crimes should be listed as well (e.g., drug related offenses). Some subjects felt that the registry does not prevent recidivism thus it is irrelevant (*n* = 5). Others reported that the registry violated their rights (e.g., double jeopardy) (*n* = 5). In terms of policy recommendations, 35% of subjects (*n* = 5) reported that all sex offender cases should be reviewed one by one to avoid the placement of heterogeneous types of crimes under one homogenous category. In addition, 35% of subjects (*n* = 5) indicated that repeat offenders should have harsher penalties (e.g., register for life). A few subjects (*n* = 3) felt there should be a registry for some offenders, but not for themselves. A small portion of subjects

(n = 3) reported that they wanted to be a part of a tier system that rewarded offenders with less time on the registry for demonstrating safe behavior and participating in treatment. In terms of economic hardship, a small number of subjects (n = 3) indicated that they are currently required to pay for registration and they recommended that this financial burden be removed. Few subjects reported that the information on the registry is inaccurate (n = 2). Themes mentioned one time on the responses included needing to know more about the registry, the registry being too complex, and the registry being anti-therapeutic. Table 4 illustrates the policy implication themes and their respective frequencies.

Table 4.

Qualitative Content Analysis of Policy Implications and Recommendation Themes

Theme	Number of Cases	Percentage
Theme 1 Registry for police use only	10	71%
Theme 2 Singling out one class of crime/other crimes should register as well	7	50%
Theme 3 Registry is needed	7	50%
Theme 4 Does not prevent recidivism	5	35%
Theme 5 Registry violates rights	5	35%
Theme 6 Review case by case	5	35%
Theme 7 Repeat offenders to get harsher penalties	5	35%
Theme 8 Some need to be on registry, but not me	4	28%
Theme 9 Tier system for good behavior	3	21%
Theme 10 Should not have to pay money to register	3	21%
Theme 11 Inaccurate information on registry	2	14%
Theme 12 Need more information about the registry	1	7%
Theme 13 Registry is not therapeutic	1	7%
Theme 14 Rules are too complex	1	7%

Note. Themes derived from a content analysis of questions 13, 14, 15, and 17 from the Questionnaire.

Summary of results. Overall, participants who reported high negative experiences that they associated with being placed on the registry were likely to endorse clinically elevated symptoms of mental health distress as measures by the BIS 18's GSI. When analyzing individual responses to open-ended questions, participants overwhelmingly felt the registry was negatively impacting their mental health. Interestingly, participant's often indicated that they understood the need for the registry and 50% agreed there should be a registry. However, with that said, the majority of participants felt there should be modifications to the registry, with 71% stating it should be available for police use only.

Chapter 4

Discussion

The primary focus of this study was to establish and explore the relationship between negative experiences associated with being on the sex offender registry and mental health pathology. The literature describing the development of SORNA public policy indicates that policy makers have attempted to develop laws that can assist in protecting society through various means, including community notification (e.g., public registries) and incapacitation (e.g., civil commitment). These laws were developed in response to multiple, highly publicized, egregious crimes against children (e.g., Jacob Wettlering Act and the Adam Walsh Child Protection and Safety Act). Further, it was hypothesized that by increasing society's awareness of sex offenders living and working in their communities, as well as, restricting sex offender housing (e.g., not allowing an offender to live within a certain proximity of schools or parks), that society would be less vulnerable to attacks from these offenders. In addition to a lack of evidence to support the efficacy of these policies, studies are now documenting the unintended consequences of SORNA (e.g., Tewksbury 2005). In contrast, this investigator was interested in exploring the perceived impact of SORNA on the mental health of registered sex offenders.

Results indicate that there is a significant relationship between the registry experiences quotient (i.e., sum of negative experiences) and reported mental health distress, as measured by the BSI 18. That is, offenders on the registry who identified large quantities of negative experiences, and attributed those negative experiences to being placed on a public registry, are also likely to endorse clinically elevated symptoms of depression, anxiety, and somatization. Although the registry's negative consequences are intended to include deterrent components (e.g., using shame in order to deter future offenders from offending), the unintended

consequences of current registered offenders could have more far reaching effects. Klein (1948) stated in her conceptualization of criminals that "if there is nothing in the world but enemies, and that is how the criminal feels, his hate and destructiveness are, in his view to a great extent justified -- an attitude which relives some of his unconscious feelings of guilt" (Klein, 280). Essentially, the offender who feels persecuted is more vulnerable to punish those who are persecuting him. Findings from this study suggest that offenders are feeling hopeless, scared, and branded. Given these findings, this investigator questions whether offenders are able to successfully adjust, reintegrate, and ultimately make the needed changes when they feel as though they are being persecuted.

Negative Experiences and Mental Health

In order to assess the perceived causality of this relationship, subjects were asked open ended questions, one of which asked directly what the impact of SORNA has been on their mental health. Of the 14 randomly selected subjects, 13 (97%) reported that their mental health has been negatively impacted by being placed on the registry. Subjects reported thoughts of suicide, feelings of hopelessness, and an overall increased level of stress (e.g., "I am much more skidish in public, looking over my shoulder, thinking many people recognize me and either want nothing to do with me…or would falsely accuse me, just to put me away."). Only 1 of the 14 subjects indicated that the registry has not impacted his mental health.

The second most endorsed negative theme was "fear." Of the 14 subjects, 10 (71%) reported they were constantly afraid or worried that if they lost their job or housing they would be unable to find new work or housing, because of their sex offender status. Subjects also indicated that they feared they would be victims of vigilantism. Losing work or not being able to find work because of their sex offender status was the third most commonly reported theme (*n* =

8, 57%). Additional negative themes included feeling as though they were "branded" for life (*n* = 5, 35%). As a result of their sex offender status some participants (*n* = 4, 28%) reported that they had been victims of vigilante violence (e.g., being spit on, having glass bottles thrown at them, or being physically attacked). Some subjects (*n* = 3, 21%) reported difficulty finding suitable housing and feeling as though they have no support from friends and loved ones because of their sex offender status. Lastly, two subjects (14%) reported that their sex offender status negatively impacted their families (e.g., unable to watch son play sports or daughter was confronted at school about her father's sex offender status).

A quantitative analysis using a Pearson correlation indicated that there is a relationship between a high amount of negative experiences (REQ quotient over 67) and clinically significant levels of mental health pathology (as measured by the BSI 18). When using the content analysis to examine subjects' responses, results indicated that the majority of subjects do feel as though the registry is negatively impacting their mental health. Implications of these results are far reaching. Many of the subjects are dealing with stressors related to adjustment (i.e., finding a job, housing, and relationships) after being convicted of a felony.

Clinical Implications

Due to the extent of reported distress associated with being placed on the registry, modifications would be needed to address and manage the unique needs of registered offenders. It will be important for therapists to assist with the monitoring and treatment of mental health symptoms and transitioning into society. Therapists should be aware of the stressors registered offenders are likely to encounter, such as difficulty finding work, homelessness, and being socially ostracized by friends and neighbors. In addition to therapy designed to alleviate depressive and anxiety related symptoms, treatment should also include wrap around services

that include vocational support or job coaching (i.e., helping convicted offenders find work that fits with their skills, but does not place them or society at risk). Wrap around services may also provide the offender with education about his or her criminal status. Subjects reported confusion about their length of time on the registry, the implications of their registered status, as well as, lack of knowledge of New Hampshire laws with regard to the tier system (i.e., subjects reported they wanted a tier system in place, not realizing that New Hampshire does have a tier system in place). Education about these policies and basic problem solving may be an important aspect of therapy to address the mental health symptoms associated with being on the registry.

Positive Experiences and Mental Health

Overall, fewer positive themes were reported in regard to being registered; however, 35% (*n* = 5 of the 14 used for qualitative analysis) reported they found the registry to be useful for law enforcement to keep track of possible high risk offenders. Given the literature on the consequences associated being placed on the registry; it was surprising to this investigator to find any positive aspect associated with being on the registry. Although very few participants felt the registry was effective in preventing recidivism, the majority of participants indicated that they understood why the general public would want there to be a sex offender registry. When speaking with participants who asked for additional information pertaining to the study, individuals stated that it was not the registry itself that made life more difficult, but the fact that it was open to the public. The perceived effects on mental health were largely related to worry about losing a job or housing due to the public knowledge of their sex offender status. In contrast, a small percentage, 14% (*n* = 2 out of the 14 used for qualitative analysis) stated that it helped them become closer to their families as they felt more supported by their family and mentally stronger because of being on the registry. Interestingly, when participants rated lower

levels of distress, they had more protective factors, such as friendship, family support, and were not recognized as frequently as being a sex offender. Thus, of the quantitative sample (n = 44), those who reported low levels of negative experiences (REQ Quotient below 48) were likely to report low levels (i.e., not clinically elevated) of mental health symptoms.

Public Policy Implications

Interestingly, of the 14 randomly selected questionnaires, 7 (50%) indicated that there should be a sex offender registry; however, they also indicated that significant modifications need to be made. The most recurrent theme with regard to public policy recommendations was that there should be a registry and that it should be available for police use only (n = 10, 71%). Of the quantitative sample (n = 44), the average subject reported experiencing at least 3 of Tewksbury's (2005) collateral consequences (M = 3.6, SD = 2.9), such as job loss, denied housing, asked to leave a business or restraint, harassed in person, received harassing phone calls, denied a promotion from work, treated rudely in public, lost a friend when they found out you were on the registry, being attacked, and received harassing mail/flyers. Subjects seemed to think these collateral consequences could be curbed if their sex offender status were available for police use only.

Implications for Future Research and Recommendations

Several studies and statistics indicate that sex offenders have lower rates of recidivism then other classes of crimes (Hanson & Morton-Bourgon, 2005; Sample & Bray, 2003; Tekwsbury & Jennings 2010). Additionally, Hanson et al. (2005), indicate that the strongest predictors of recidivism include dynamic risk factors, such as sexual deviance and antisocial orientation. With regard to antisocial dynamic risk factors, Hanson et al. state that the traits clinicians should be targeting include "antisocial traits (general self-regulation problems,

employment instability, hostility)" (p. 1158). In addition, the majority of subjects during this study indicated that they have experienced at least three types of negative experiences (e.g., job loss/unable to find work, housing difficulties). These types of consequences seem to cause an increase in dynamic risk factors (e.g., employment instability). Based on this data, the sex offender policy that is in place may not be using the correct factors to determine risk and may be leading to unintended consequences such as creating at least some forms of emotional distress for some registered offenders and contributing to the increase of the same risk factors that have been associated with recidivism. Perhaps while attempting to address the very real problem of sexual offending, the existing policy may be contributing to an anti-therapeutic environment. In addition to stating that there has been no marked decrease in recidivism since the implementation of SORNA, Tewksbury and Jennings (2010) stated that offenders reported that the registry is not what prevents recidivism. Future research should focus on investigating what factors offenders believe would prevent recidivism (e.g., identify protective factors) so that therapist can assist offenders in managing stress and accessing protective resources.

Future studies may want to question whether or not the offenders are currently receiving treatment from a mental health provider, and examine to see if that variable serves as a protective factor in regard to reported mental health distress. This study explored the relationship between the negative experiences associated with being a registered offender and mental health pathology from the perspective of the offender. Results suggest that a relationship does exist, thus providers and policy makers need to consider these factors and their potential impact on this population. Specifically, policy makers who aim to create legislation to protect society should also look at policies that can assist the offender in reintegrating into society in a more successful way, thus increasing protective factors for all.

Limitations

Given the relatively low N for this study (*n*=44, 9%), the generalizability of this study is limited. Additional research is needed to explore if these relationships exist on a larger scale or if other methods would lead to more generalizable results. This study was able to document a perceived causal relationship between being placed on the sex offender registry and mental health pathology. Although this is an important relationship to identify and discuss, this study was unable to identify an objective causal relationship as the study relied on self reports and lacked a control group. Possible reasons for the low response rate could include the fact that the research itself may have caused distress. During the course of this study, this investigator received mixed feedback regarding the experience of participating in the study. Some subjects reported they were excited to have an opportunity to express what life has been like since being placed on a public registry. Others felt that being singled out for a study was yet another example of how they are subject to less privacy (i.e., the investigator used the registry to find addresses to contact offenders). In addition to feeling that they were again being singled out, participants also seemed unsure if they "had to" participate in the study as part of their probation and worried that non-compliance to the research would reflect poorly of them. Some participants emailed the investigator to inform her that the questionnaires felt like another form of harassment, thus they chose not to participate in the study.

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Appendix A

Registry Experiences Questionnaire
Informed Consent

This study was created to better understand the experiences of those placed on the sex offender registry and how those experiences affect mental health.

Participants are asked to fill out a survey, which includes the following forms:

- A registry experiences questionnaire
- A brief mental health screener

If you agree to participate in this study, the forms and questionnaires should take approximately 20 to 30 minutes to complete.

Benefits. This study will not necessarily benefit you directly. However, this is a chance to give your opinion about the sex offender registries and notifications systems.

There are some potential risks to those who take part in this study. This study asks you about what life has been like as a person who is publically registered as a sex offender. It is possible thinking about these experiences may be upsetting to you. If this happens you can contact me so I can help you find someone in your area who can help you. The topic of questions will be about what types of experiences you have had since being placed on the registry and how you deal with those experiences. Questions also ask for your opinion about the registry in general. You will NOT be asked about the specific crime for which you were placed on the registry.

All the information about you will be kept completely confidential. This survey asks for your name and information about your experiences since being placed on the sex offender registry. This information will be kept confidential. Once I receive your materials your name will be removed and replaced with a code number. Your name will not be used for any other purpose. Only I will see the finished materials. Upon completion of this study all identifying materials will be destroyed

Taking part in this study is voluntary. It is your choice to be involved in this study. You do not have to answer any question you don't want to, and you can leave the study at any time, for any reason, without penalty.

Questions. Any questions about the study and/or in the case of injury due to the project, you can email Tracy E. Shannon at Clinical.Implications@gmail.com
If you have any questions about your rights as a research participant, you may contact Kevin P. Lyness, Chair of the Antioch University New England Human Rights Research Committee,(603)- 283-2149, or Dr. Katherine Clarke, ANE Vice President for Academic Affairs, (603)- 283-2450

Thank you for participating in this study.

I have read the information provided and agree to complete the survey.

Signature of Participant and Date_____

Participant name (printed) _____

Appendix B

Original Instrument used by Tewksbury (2005)

For each question, please answer based on your personal experience, or how you feel about the issue. Your participation is completely voluntary. Please do NOT put your name anywhere on the survey; all responses are completely anonymous sand confidential.
Thank you for your participation!

When were you placed on the Indiana Sex and Violent Offender Registry?

_____Month _____Year

Is your listing on the registry: _____ 10 years _____Lifetime

For the sexual offenses that you have been convicted of, is/are the victim(s):

(please check all that apply)

_____Female _____Multiple victims

_____Male _____A relative

_____Children/Minors

Approximately what portion of your family, friends, co-workers, and other people you consider a part of your life know about your sexual offense conviction(s)?

_____Everyone _____Some people (10% - 40%)

_____Almost everyone (90% or more) _____Only a few people (less than 10%)

_____Most people (60% - 90%) _____No-one knows

_____A lot of people (40% - 60%)

Based on your listing on the Indiana Sex and Violent Offender Registry, how often are you recognized in public as a convicted sex offender?

_____Daily _____About once a month

_____A couple of times a week _____A few times a year

_____About once a week _____Once a year

_____A couple of times a month _____Never

How often do you have law enforcement officers (police) contact you, as a result of your placement on the Indiana Sex and Violent Offender Registry?

_____Daily _____About once a month

_____A couple of times a week _____A few times a year

_____About once a week _____Once a year

_____A couple of times a month _____Never

Have you ever looked at your listing on the Indiana Sex and Violent Offender Registry?

_____Yes _____No

For each of the following statements, please indicate whether you agree or disagree with each statement.

"I feel ashamed that I am on the Indiana Sex and Violent Offender Registry"

1 2 3 4 5 6 7 8 9 10

Disagree Unsure Agree

Completely Undecided Completely

"I understand why people want there to be a Sex Offender Registry"

1 2 3 4 5 6 7 8 9 10

Disagree Unsure Agree

Completely Undecided Completely

"I think that the Sex Offender Registry is a good thing"

1 2 3 4 5 6 7 8 9 10

Disagree Unsure Agree

Completely Undecided Completely

“People avoid being around or talking with me if they know I am on the Sex Offender Registry”

1 2 3 4 5 6 7 8 9 10

Disagree Unsure Agree

Completely Undecided Completely

“I feel I am being unfairly punished by being on the Sex Offender Registry”

1 2 3 4 5 6 7 8 9 10

Disagree Unsure Agree

Completely Undecided Completely

“I believe that having my picture on the Sex Offender Registry is going too far”

1 2 3 4 5 6 7 8 9 10

Disagree Unsure Agree

Completely Undecided Completely

“If I found out that the address listed for me on the Sex Offender Registry was not correct, I would contact someone to have it corrected”

1 2 3 4 5 6 7 8 9 10

Disagree Unsure Agree

Completely Undecided Completely

“If I found out that the picture on my Sex Offender Registry page was of someone else, I would contact someone to have it corrected”

1 2 3 4 5 6 7 8 9 10

Disagree Unsure Agree

Completely Undecided Completely

"If I found out that the offenses for which I was convicted were incorrect (listed as more or more serious) on the Sex Offender Registry, I would contact someone to have it corrected"

1 2 3 4 5 6 7 8 9 10

Disagree Unsure Agree

Completely Undecided Completely

"If I move or change addresses I would contact someone to update my information on the Sex Offender Registry"

1 2 3 4 5 6 7 8 9 10

Disagree Unsure Agree

Completely Undecided Completely

"Because my name and personal information is listed on the Sex Offender Registry I am less likely to commit another sexual offense in the future"

1 2 3 4 5 6 7 8 9 10

Disagree Unsure Agree

Completely Undecided Completely

As a result of your placement on the Indiana Sex and Violent Offender Registry, have any of the following ever happened to you? (check all that have happened)

_____Lost a job

_____Been denied a promotion at work

_____Lost (or denied) a place to live

_____Been treated rudely in a public place

_____Been asked to leave a business or restaurant

_____Lost a friend when they found out you are on the Sex Offender Registry

_____Been harassed, in person

_____Been assaulted/attacked

_____Received harassing/threatening telephone calls

_____Received harassing/threatening mail/flyers/notes

The final questions are about you personally. Remember all of your answers are anonymous and confidential. These items are simply to allow a better understanding of who among Kentucky's registered sex offenders has what experiences.

Your age: _____ years Your sex: _____male _____female

Your race: _____White _____African-American/Black

_____Asian _____Hispanic/Latino

_____Other:_____

Thank you for your assistance! Please return your completed survey in the postage-paid return envelope provided.

If you have any questions, please contact Dr. Richard Tewksbury, Department of Justice Administration, University of Louisville, Louisville, Kentucky 40292. Dr. Tewksbury can also be reached via email at: tewks@louisville.edu.

Appendix C

Registry Experiences Questionnaire

For each question, answer based on your personal experience, or how you feel about the issue. Your input is totally voluntary. Please do NOT put your name anywhere on this survey; all responses are totally anonymous and confidential. Thank you for your participation.

1. When were you placed on the sex offender registry?
   Month_____ Year_____

2. Based on your listing on the New Hampshire Sex Offender Registry, how often are you recognized in public as a convicted sex offender?

___Never
___Once a year
___A few times a year
___About once a month
____A couple times a month
____About once a week
____A Couple times a week
____Daily

For each of the following statements, please indicate whether you agree or disagree with each statement.

3. “I feel ashamed that I am on the sex offender registry”

1	2	3	4	5	6	7	8	9	10
Disagree Fully				Unsure Undecided					Agree Fully

4. “I understand why people want there to be a sex offender registry”

1	2	3	4	5	6	7	8	9	10
Disagree Fully				Unsure Undecided					Agree Fully

5. “I think that the sex offender registry is a good thing”

1	2	3	4	5	6	7	8	9	10
Disagree Fully				Unsure Undecided					Agree Fully

6. “People avoid being around or talking with me if they know I am on the sex offender registry”

1	2	3	4	5	6	7	8	9	10
Disagree				Unsure					Agree

Fully Undecided Fully

7. “I feel I am being unfairly punished by being on the sex offender registry”

1 2 3 4 5 6 7 8 9 10
Disagree Unsure Agree
Fully Undecided Fully

8. “I believe that having my picture on the sex offender registry is going too far”

1 2 3 4 5 6 7 8 9 10
Disagree Unsure Agree
Fully Undecided Fully

9. “Because my name and personal information is listed on the sex offender registry I am less likely to commit another sexual offense in the future”

1 2 3 4 5 6 7 8 9 10
Disagree Unsure Agree
Fully Undecided Fully

10. “Because I am on the sex offender registry I have no social supports”

1 2 3 4 5 6 7 8 9 10
Disagree Unsure Agree
Fully Undecided Fully

11. “I drink alcohol or use drugs to deal with the stress caused by being placed on the sex offender registry”

1 2 3 4 5 6 7 8 9 10
Disagree Unsure Agree
Fully Undecided Fully

12. As a result of your placement on the sex offender registry, have any of the following ever happened to you? (Check all that have happened)

___Loss of a job
___Lost (or denied) a place to live
___Been asked to leave a business or restaurant
___Been harassed in person
___Received harassing/threatening phone calls
___Been denied a promotion at work
___Been treated rudely in a public place
___Lost a friend when they found out you were on the sex offender registry
___Been assaulted/attacked
___Received harassing/threatening mail/flyers/notes

13. How has being placed on the registry impacted your life?

a) If it has been a positive experience please say how or why it has been a positive experience.

b) If it has been a negative experience please say how or why it has been a negative experience.

14. Do you think having the sex offender registry is helpful? Why or why not?

15. Do you feel being placed on the sex offender registry has impacted your mental health? If so, how?

16. If you were in charge of implementing a sex offender public policy, what changes (if any) would you make to the current system?

a) Do you think that there should be a registry? If so, who belongs on it?

b) If you do not think that there should be a registry, what type of system do you think would be helpful in keeping the public safe while protecting your privacy?

17. What is one thing you would like policy makers to know in regard to being placed on the sex offender registry?

These next questions are about you personally. Remember, all of your answers are confidential. These items are simply to allow a better understanding of who among New Hampshire's sex offenders has what experiences.

Your age: ____ Years Your sex: ___Male ___Female

Your race: ___White ___African-American/Black
___Asian ___Hispanic/Latino
____Other:_____

Thank you for your time! Please return your completed survey in the postage-paid return envelope.

If you have any questions, please contact Tracy Shannon at Clinical.Implications@gmail.com

Appendix D

Cover Letter

Dear Participants,

Thank you for agreeing to take part in this study. The specific aim of this study is to better understand what it is like to be a registered offender, and the impact of your experiences on your mental health. This understanding cannot be captured without the help of individuals such as yourself. Although there are no direct benefits for your participation, indirect benefits of this study include a deeper understanding of your experiences and how current public policy effects your mental health. This is also a chance for you to give your opinion about the registry and what kind, if any changes you would suggest to policy makers.

Included in this letter you will find four things: (a) an informed consent form; (b) a registry experiences questionnaire; (c) a brief symptom questionnaire; (d) a self addressed stamped envelope for you to return your survey. The questionnaires are brief and shouldn't take more than 15-30 minutes to finish. Please follow the directions for both the questionnaires. I ask that you fill out the questionnaires without discussing them with others. It's fine to talk about them once you finish them. Once you finish filling out the informed consent, the registry experiences questionnaire, and the brief symptom questionnaire I ask that you please put these items in the self addressed envelope provided and mail the survey.

The informed consent and symptom questionnaire will ask that you state your name and the date. This information, as well as the information you provide in the registry experiences questionnaire will be kept confidential and is needed for data collection only. Once the returned forms and questionnaires have been received, your data will be given a code and your name will be removed. All identifying information will be destroyed.

If you have any questions or concerns, please feel free to contact me. I am available by e-mail (Clinical.Implications@gmail.com). Thank you again for your valuable contribution to this study.

Sincerely,

Tracy E. Shannon, M.S., M.S.C.J.