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Trauma Experiences And Symptoms Reported By American Indian And Caucasian Sex Offenders

Regina Sioux Ertz

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TRAUMA EXPERIENCES AND SYMPTOMS REPORTED BY AMERICAN INDIAN AND
CAUCASIAN SEX OFFENDERS

by

Regina Sioux Ertz
Bachelor of Arts, Chadron State College, 2012

A Thesis

Submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Master of Arts

Grand Forks, North Dakota

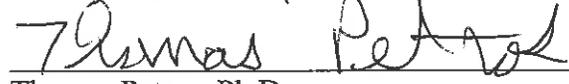
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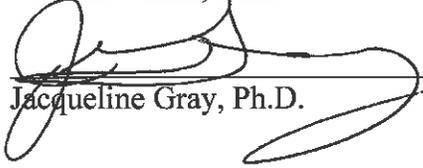
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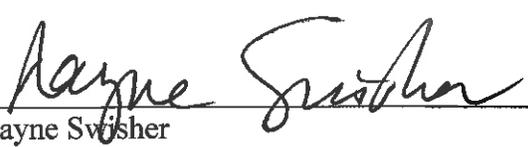


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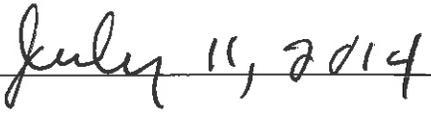


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This thesis is being submitted by the appointed advisory committee as having met all of the requirements of the School of Graduate Studies at the University of North Dakota and is hereby approved.



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PERMISSION

Title Trauma Experiences and Symptoms Reported by American Indian and Caucasian
Sex offenders

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ABSTRACT

American Indian/Alaskan Native (AI/AN) people are known to have a history of man-made trauma that corresponds to the colonization of the Americans. Trauma experienced by AI/AN sex offenders has not been evaluated in the research as it relates to their treatment planning. The lack of data reflecting intervention needs for AI/AN sex offenders is problematic. The current study hypothesized that American Indian sex offenders would report a greater number of trauma experiences, endorse increased symptoms of Posttraumatic Stress Disorder (PTSD), display more traumatic cognitions, and endorse higher dissociative experiences than Caucasian sex offenders. Statistical results yielded did not support the proposed hypotheses. Additional analyses conducted on the data revealed that American Indian sex offenders reported more adverse childhood experiences than Caucasian sex offenders and contact sex offenders reported experience higher levels of dissociation when compared to non-contact sex offenders.

CHAPTER I

INTRODUCTION

This study examined treatment needs of American Indian or Alaskan Native sex offenders. The terms AI/AN and American Indian are used differently in this paper as AI/AN is employed as a designation for all individuals of AI/AN descent while American Indian is used to designate specific groups of research subjects either from past research or in reference to the subjects for this proposal.

Data from the United States Census Bureau (USCB) (2013) indicates there are approximately 5.2 million AI/AN individuals residing in the United States. This number is expected to increase to 11.2 million by 2060. The three states with the largest population of AI/AN residents in 2011 were California with 689,320, Oklahoma with 502,934, and Arizona with 346,380. The four states with the largest proportion of AI/AN residence were Alaska with 19.7%, Oklahoma with 13.3%, South Dakota with 10.4%, and New Mexico with 10.4%. The average age of the AI/AN population was 31.3%, which is younger than the overall average age of the U.S. population (37.3%) in 2011.

AI/AN individuals have presented several health discrepancies according to the Centers for Disease Control and prevention (CDC) (2013). For example, during 2008 AI/AN mothers had the second highest infant death rate compared to other mothers and the rate was 53% greater than the death rate among Caucasian mothers. The AI/AN population had the highest rate of motor vehicle related deaths; however this rate has decreased since 2005 from 30.6% to 25.2% in 2009. In 2009 AI/AN still have the highest rate of suicide (15.6%) and the highest death rate due

to drug use (17.7%) in 2010. According to McLeigh (2010), American Indian youth 15-24 years of age commit suicide 3 times the national average for their age group and this is 10 times the national average overall. In 2009 AI/AN youth and adults had the highest prevalence rates of current smoking compared to other racial or ethnic populations. During 2011, AI/AN adults exhibited the highest prevalence rate of binge drinking (18.2%) and the highest number of drinks consumed during binge drinking (8.4%) when compared to all other race/ethnicity categories (CDC, 2013). American Indians have an alcoholism rate 5.5 times the national average (McLeigh, 2010). The prevalence rate of AI/AN adults 18 years and older who had not completed high school represented the second largest prevalence in 2011, and the rate of AI/AN who live below the federal poverty level was increased to 18.9% compared to 15.3% in 2009. Health-related quality of life includes physical and mental health and in 2010 AI/AN had the highest rate (30.8%) who identified their health as fair to poor (CDC, 2013). American Indian individuals also have a rate of depression and heart disease twice the national average (McLeigh, 2010).

A history of significant trauma experiences has been documented among the AI/AN populations and the number of AI/AN communities, families, and individuals affected by trauma will continue to grow, at least consistent with the population growth. There is a need to develop effective treatment and interventions to change this course. Studying information about treatment needs related to trauma and PTSD symptoms among American Indian and Caucasian sex offenders is essential in providing effective treatment as no research has been completed to date of AI/AN sex offenders. Additionally, little research is available addressing the treatment of AI/AN individuals who commit acts traumatizing other AI/AN people.

This study is consistent with the public health model of disease prevention, which

involves understanding how the host, agent, and environment interact. Treating AI/AN sex offenders effectively is a method of prevention related to the agent. This concept is further supported by various meta-analyses of positive treatment effects for sex offenders using sexual specific approaches developed based on cognitive-behavioral treatment methods (Hall, 1995; Hanson, Bourgon, Helmus, & Hodgson, 2009; Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005; Lösel & Schmucker, 2005; Olver, Stockdale, & Wormith, 2011). Further, this study is also consistent with emerging national trends to develop trauma-informed approaches and systems to implement these approaches. This study was not intended to provide a diagnosis of PTSD to individual participants or to identify specific treatment techniques or therapy methods for use in the AI/AN population; however, this is a potential long-term goal for further research efforts.

Review of Literature

Excessive exposure to traumatic experiences has been associated to AI/AN people in previous articles and studies. These experiences have been termed “an epidemic of violence” for American Indian woman, (Lehavot, Walters, & Simoni, 2009), and historical trauma, or historical unresolved grief (Brave Heart & DeBruyn, 1998; Denham, 2008; Johnson, 2006; Willmon-Haque & Big Foot, 2008). Witko (2006) used the term “cultural genocide” to describe the same process. Manson, Beals, Klein, and Croy (2005) noted American Indians live in adverse environments, which place them at higher risk for exposure to trauma and harmful health sequelae. However, the research regarding trauma and PTSD symptoms among AI/AN people is limited in comparison to the impact attributed to the trauma they have endured.

Trauma has historically been defined based on events people experience and this literature is expansive. These definitions were reviewed in detail by the United States Substance

Abuse & Mental Health Services Administration after making trauma and justice a strategic initiative during 2011 (SAMHSA, 2012). This effort followed requests from several federal agencies to SAMHSA for assistance because of the confusion and ambiguity over what is meant by trauma and trauma-informed approaches. SAMHSA has recognized trauma as a central role in substance use disorders and trauma experience has been linked to chronic physical diseases. An initial effort has been placed on developing a working definition of trauma, which is now available for public comment. The definition was based on considering various definitions from several sources and it is listed below.

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being (SAMHSA, 2012).

Several components of this definition are explained in greater detail. Events or series of events involve actual or extreme threat of physical or psychological harm and/or the blocking of resources needed for healthy development. These areas are experienced as traumatic by the individual and individuals are recognized as having the potential to react differently to the same event or event series. Effects are long-lasting and may be experienced immediately or after a delay. Communities are further considered as trauma does take place in a vacuum. A community can support victims or re-traumatize them, and entire communities can collectively react in the same ways as individuals react. The treatment community has the potential to re-traumatize by responding in a faulty manner relative to AI/AN cultures.

This definition is consistent with what the authors referenced above have described about trauma exposure by AI/AN individuals, families, and communities. These areas are compounded

when the number of recognized tribes and the number of enrolled tribal members are considered. There are 565 federally-recognized tribes with a wide variation in membership (USCB, 2013). Membership was deferred to tribes in 1934 when legislation was passed called the Indian Reorganization Act. Tribes were encouraged to specifically set up a constitution giving recognized criteria for determining membership and enrollment under this act. Indian Tribal Constitutions now determine who is recognized as an AI/AN and these criteria vary. Families and individual family members may identify as being AI/AN but not be recognized as AI/AN because they are not enrolled members of a tribe, and other individuals may be enrolled and not identify with this heritage. In the present study, American Indians are defined as an individual who identifies as being AI/AN.

It is important to note the initial publication of PTSD was during 1980 with the publication of the Diagnostic and Statistical Manual of the American Psychiatric Association, Third Edition (DSM-III) (APA, 1980). PTSD is currently defined in Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition, Text Revision (DSM-IV-TR) as consisting of six criteria as follows: Criterion A: exposure to an event that includes a serious threat of injury or death or to the physical integrity of oneself or others (A1), to which the person responded with extreme fear, helplessness, or horror (A2); Criterion B - the person reports at least one symptom of re-experiencing the event; Criterion C - they endorse at least three symptoms of avoidance and numbing; Criterion D - they describe at least two symptoms of hyperarousal; and they meet two more criteria of Criterion E - duration longer than 30 days and Criterion F - the disturbance causes distress or impaired functioning (APA, 2000).

There has been ongoing controversy over what constitutes Criterion A (Bovin & Marx, 2011; Cogle, Kilpatrick, & Resnick, 2012). Some of the recent areas suggested for

consideration for the A1 criterion involving life threat as betrayal (Kelley, Weathers, Mason, & Pruneau, 2012) and the central role of witnessing (Meyers, 2012). Several authors have noted concerns about needed changes in Criterion A in the publication of the pending fifth edition of the DSM. It is likely these controversies will continue for the foreseeable future and considerable research is needed to resolve the current and future disagreements as they arise. The diagnosis of PTSD has resulted in benefits as professionals engage in practice and/or research has developed common language and advanced various explanations to account for findings. This is the process supporting clinical practice and evidenced-based treatment.

A distinction is made in the literature between complex and single trauma. Paivio and Pascual-Leone (2010) distinguish between a single episode of trauma as representing Type I Trauma and complex trauma which refers to repeated exposures to traumatic events as Type II Trauma. Complex trauma is further defined as repetitive or prolonged stressors involving abandonment by caregivers, or other responsible adults, and occurs at developmentally vulnerable times in a victim's life (Ford & Courtois, 2009). They also note posttraumatic sequelae involve changes in mind, emotions, body, and relationship experienced after the psychological trauma takes place. These changes are defined as causing severe problems with disassociation, emotional dysregulation, somatic stress, or relational or spiritual alienation. Single event and complex trauma is highly represented in the lives and communities of AI/AN people.

Consequences of severe trauma experiences in the AI/AN population have been linked to the development of alcohol disorders with the number of traumas having a dose-dependent effect (Boyd-Ball, Manson, Noonan, & Beals, 2006). The theory of historical trauma has suggested many AI/AN individuals are affected by cultural losses and injustices endured by previous

generations. Recent research by Wiechelt, Gryczynski, Johnson, and Caldwell (2012) found historical trauma symptoms were significantly associated with alcohol abuse in the past month, lifetime use of non-marijuana illicit drugs, and lower family cohesion. They also note urban AI/AN people report high degrees of historical trauma compared to reservation samples in previous research. It is important to reflect the general understanding that man-made trauma has a higher potential to result in PTSD than trauma resulting from natural disasters or other similar sources, and the traumatic experiences associated to AI/AN people has been man-made.

Additional vulnerability for trauma also exists in the AI/AN population related to mental health, physical health, and high risk behavior. These areas included emotional dysfunction as the rates of depressive illness and suicide are higher in AI/AN populations (Byers, 2006; Olson & Wahab, 2006). An urban study of AI/AN in New York City found 65% of the respondents have experienced some form of interpersonal violence, 28% reported childhood physical abuse, 48% reported rape, 40% noted a history of domestic violence, and 40% reported multiple victimization events (Evans-Campbell, Lindhorst, Huang, & Walters, 2006). The subjects who experienced high levels of emotional trauma also identified depression, dysphoria, help-seeking behaviors, and high HIV-risk sexual behaviors. AI/AN have also been found to have the highest rates of cardiovascular disease in the U.S. (Bullock & Bell, 2005). Additionally, specific tribal groups have some of the highest rates of type 2 diabetes in the world, and higher rates of risky sexual behavior have been documented among young American Indians (Balsam, Huang, Fieland, Simoni, & Walters, 2004). Rates of smoking and chewing tobacco are higher among American Indian individuals and smoking has been associated to anxiety and depression; however, the use of smokeless tobacco is less associated to lifetime psychiatric problems (Sawchuk et al., 2012).

These vulnerabilities, or risk factors, indicate the process of experiencing trauma begins early in lives of AI/AN people, including AI/AN sex offenders. Specific traumatic events noted in the literature include sexual abuse, physical abuse, neglect, poverty (Willmon-Haque & Big Foot, 2008), and intimate partner violence (Mylant & Mann, 2008). Forms of severe maltreatment in childhood was strongly associated to lifetime PTSD and moderately associated to lifetime substance use disorders (Duran et al., 2004). One study of American Indian adolescents in residential substance abuse treatment reported an average of 4.1 lifetime traumas. The threat of injury or witnessing injury was the most common. Sexual traumas were the least common but more predictive of a diagnosis of full PTSD when these youth had experienced six or more traumas and had a diagnosis of stimulant abuse or dependence (Deters, Novins, Fickenscher, & Beals, 2006). Traumatic events for children can further include witnessing acts of aggression, exposure to behavior they cannot understand, and aggressive statements (Garbarino, Dubrow, Kostelny, & Pardo, 1992).

Garbarino et al. (1992) have elaborated considerable information regarding trauma and children. They begin by noting there are two definitions of danger. One definition is the likelihood an individual will suffer injury while the other definition is a feeling of impending harm. These areas may be weakly correlated in the minds of children. Adults understand what is dangerous and they can reason abstractly. Children are at a disadvantage in various ways. They are at greater risk for injury because they are less powerful physically and they are more easily shocked due to limited psychological maturity. Children often believe in the reality of threats and they need reassurance adults will protect them. All these conditions are often present in a traumatic environment, especially when adults have the inability to be available emotionally or physically to children.

The number of traumas, or accumulation of risks, was found to stifle intellectual development for four-year-old children in a study published in 1987 (Sameroff, Seifer, Barocas, Zax, & Greenspan). Their data indicated four-year-old children's full scale verbal IQ scores remain in the average range until after the third or fourth risk factor was added. Many children are likely to experience some type of trauma growing up but most children seem to cope adequately with one or two trauma experiences. Information available in the literature indicates AI/AN individuals are likely to have more than two or three trauma experiences as children (Campbell & Evans-Campbell, 2011; Ehlers, Gizer, Gilder, & Yehuda, 2012; Goodkind, LaNoue, & Milford, 2010).

Effects of violence and danger go beyond suppressing intelligence as they also give rise to repressive environments. This stifles creativity and fosters rigid thinking. These environments isolate individuals from resources and result in people having difficulties forming attachments, learning trust, developing confidence about themselves and social realities, effective coping with stressors, and repression of emotional learning. Children's parents are often angry, frightened, traumatized, and psychologically unavailable. Trauma reactions result in suppressed emotions due to a constant need for emotional, and sometimes physical survival, observing rather than emotionally experiencing the environment, and result in multiple symptom patterns. When these traits are untreated the responses and actions can be passed on to children through modeling.

Although American Indian individuals have a high prevalence of being exposed to traumatic events, additional studies have found only 12% of these individuals develop PTSD. However, American Indian children and adolescents who experience sexual and multiple traumatic experiences may be at higher risk for developing PTSD (Gnanadesikan, Novins, Beals, & AI-SUPERPPF Team, 2005). A previous study by Jones, Daughilnais, Sack, & Somervell

(1997) yielded a prevalence rate of diagnosable PTSD of 3% for American Indian eighth to eleventh grade students. The studies by Deters et al. (2006) and Beals et al. (2005) found similar rates of PTSD in their samples. These differences reflect several studies; however, there has been no epidemiology study to date identifying the overall prevalence rate of PTSD in AI/AN people. It is likely this rate will differ based on several factors as suggested by Westermeyer (2001).

The implications for psychology involve several areas of treatment planning and providing treatment for AI/AN sex offenders. There is a great need for evidence-based treatment of sex offenders in Indian country. This study is an initial step to determining if assessment and treatment model validated for Caucasian sex offenders is adequate for the use of American Indian sex offenders. Potentially, assessment and treatment may need to address how various forms of trauma, including historical grief, are acted out by AI/AN impacted by these experiences.

Rotheram-Borus, Swendeman, and Chorpita (2012) have determined evidenced-based interventions require innovations that disrupts pathological processes. These interventions must be robust to serve more people in less time and at lower cost. Further, they note an individual's health rests on the daily routines the person develops and maintains. These interventions become both prevention and treatment methods; and a life-style for the people involved. Most individuals are familiar with the destructive life-style of trauma and maladaptive numbing of painful emotions being lived by many AI/AN. Information from treatment programs and from probation and parole agencies indicates American Indian sex offenders have higher rates of treatment failure than Caucasian sex offenders. They also display patterns of resistance and become contrary to following probation and parole requirements.

The most common treatment failure has to do with addictive behaviors and/or substance

use. These patterns should be addressed as part of treatment within sex offender programs rather than using alternative referral sources such as chemical dependency options if they are related problems to the same general issue of trauma. Another issue is gaining an understanding of what is referred to as horizontal violence. Horizontal violence is operationally defined as expressing aggressive behavior towards someone in your family or community because another person has traumatized you in some way.

Additional applications are present for better understanding of the concept of identifying with aggressors, or what is often called Stockholm syndrome. This issue is most relevant to situations of domestic violence or intimate partner abuse, which appear at very high in AI/AN communities and families. One of the far-reaching implications is based on considering ways to prevent the development of PTSD after a person has been exposed to a traumatic situation. Two examples of this phenomenon have been recently discussed in the literature. One is to prevent the rehearsal and strengthening of traumatic memories, or what is called reconsolidation of memories, and the other is the potential use of pharmacological agents to gain the same effect.

Steckler and Risbrough (2012) recently noted many humans experience at least one traumatic event during their life and up to 10% of them will develop PTSD. Reconsolidation is a process where the memories become permanent and give rise to recollections of the traumatic event. Their notion contests that by blocking this process, it can modulate stress effects by disrupting memory reconsolidation at the brain level. These interventions must be applied immediately after the trauma has occurred (Costanzi, Cannas, Sarauli, Rossi-Arnaud, & Cestari, 2011). A recent example of this process was reported by Holbrook, Galarneau, Dye, Quinn, and Dougherty (2010a & 2010b) related to combat injured military personnel experiencing a lower risk for development of PTSD when morphine was administered during trauma care. Patterns of

binge alcohol consumption by American Indians may also obtain this effect as the goal of binge consumption can be viewed as preventing memory reconsolidation. This process is based on the understanding that both morphine and alcohol impact stress hormones through the hypothalamic-pituitary-adrenal (HPA) axis, or glucocorticoids, in the body (Rose, Shaw, Prendergast, & Little, 2010; Spencer & Hutchison, 1999).

Psychological techniques are being developed for this same purpose using relaxation and reprocessing techniques. The reconsolidation hypothesis was recently tested experimentally by Rothbaum et al. (2012). Their research approached emergency room patients who were being seen due to a traumatic event. These events included rape, car accidents, or physical assault. Half of the patients approached agreed to participate in the study and the patients who did not agree became a control group. The treatment consisted of recounting the trauma to confront the anxiety they experienced. Members of the treatment group saw a trained therapist and described the trauma they experienced and recorded the experience. They were then instructed to listen to the recording every day. A brief technique was also taught to them by the therapist employing breathing and relaxation. Findings indicated this intervention was effective in reducing PTSD in the study group.

Evidence-based treatment of sexual offenders has been developed utilizing Cognitive-Behavioral Therapy. The same is true for treating victims of trauma. The Indian Country Child Trauma Center has been instrumental in developing evidence-based treatment models to support AI/AN traditional beliefs and parenting practices to combat the cumulative effects of trauma on children (BigFoot & Funderbuck, 2011). This program is housed in the University of Oklahoma Health Sciences Center and efforts have been focused on identifying valid methods to replace misguided attempts at providing support to AI/AN populations who have been impacted by

trauma (BigFoot, 2011). The program utilizes Trauma-Focus Cognitive-Behavioral Therapy techniques. This study is an attempt to begin the process of developing trauma focus methods for treating AI/AN sex offenders who require such services as part of their treatment to assist in improving public safety for AI/AN communities.

Various sources of data indicate children and young adolescents are the most common victims of sexual abuse. Significant research evidence exists indicating individuals who suffer maltreatment are more likely to display maltreatment towards others. A significant Australian study recently published through the Australian Institute of Criminology provides an example of life-time offending and victimization over 45 years for individuals who experienced childhood sexual abuse. According to this study, victims of childhood sexual abuse commit a higher rate of sexual offenses and present a greater risk of being sexually re-victimized than people without a history of sexual victimization. Another finding identifies males who were sexually abused at 12 years of age or older are particularly at risk to sexually offend in the future (Ogloff, Cutajar, Mann, & Mullen, 2012).

There is a need for evidenced-based research to provide the foundation of trauma-informed approaches as defined by SAMHSA (2012). This refers to how a program, agency, organization, or community thinks about people who may be at risk for experiencing trauma. In many cases this may mean a change in organizational culture and focusing on consumers and consumer satisfaction. Three key elements are noted to develop a trauma-informed approach. These elements involve a realization of trauma prevalence, recognizing how trauma affects everyone involved with the program, and including this knowledge in practice. The following definition is offered by SAMHSA (2012) to combine these elements.

A program, organization, or system that is trauma-informed realizes the

widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings.

Trauma is generally associated to several changes in the person's functioning. One of these changes is in how people think, or traumatic cognitions. Sex offender treatment programs have long-established the need to address thinking errors or cognitive distortions as these areas impact offense cycles. It is important to address these types of thoughts and several issues related to therapeutic involvement to achieve the successful treatment completion for sex offenders. This study investigated these traumatic cognitions to yield possible distinctions between the treatment needs of American Indian and Caucasian sex offenders.

Past studies of PTSD rates in AI/AN individuals have not considered the potential impact dissociation may have in the reported prevalence rates of PDST, and related symptoms, because dissociation is likely to result in under-reporting symptoms (Carlson, Dalenberg, & McDade-Montez, 2012; Dalenberg & Carlson, 2012). It is common knowledge individuals often disassociate when they are being abused, or in response to abuse, and this becomes more probable when the abuse has been repetitive. The literature indicates many AI/AN have been subjected to a high-frequency of different types of traumas, which indicates a potential for them to display increased symptoms of dissociation. The excessively high rates of comorbidity impairments in the AI/AN population, such as alcohol and drug use, may also represent dissociative patterns, or a desire to numb painful emotions related to abuse. Other substances are also used to numb painful emotions including food. Other techniques humans employ to numb such emotions include anger, bad relationships, and sex. Additional information regarding

dissociative responses indicates it is a difficult concept to define and existing definitions are impacted by conceptual inflexibility (Bowman, 2011; Cardeña and Bowman, 2011; Nijenhuis and Van der Hart, 2011).

Research on trauma has given rise to resilience as a psychological construct (Bonanno, 2012). Resilience is viewed as a personal characteristic, as the absence of psychopathology, and as a general term to convey average levels of psychological adjustment. Windle (2011) noted this trait is experienced differently across an individual's life in various ways. This definition includes effectively negotiating, adapting, or managing different sources of trauma or stress. Most of the research in this area has been developed by studying children and adolescents. Resilience is also defined within a cultural context and needs to extend across the lifespan of individuals affected (Jobson, 2011; Mancini & Bonanno, 2010). A literature review indicates there is little information published about resiliency in AI/AN people and this area requires further definition.

The literature presents strong evidence that AI/AN sex offenders are likely to have significant trauma histories. It is probable their trauma experiences and prevalence rates of PTSD are greater than their Caucasian counterparts. They would further be expected to display higher frequencies of traumatic cognitions, and endorse dissociative experiences greater than Caucasian sex offenders. This literature can be summarized by reflecting on a line from Apollo 13, "Houston, we have a problem." Solving this problem takes the same focused commitment and utilization of resources/efforts required to return a damaged spacecraft to Earth as in the Apollo 13 experience. Further research is needed to develop assessment and treatment methods for victims, offenders, families, and communities, training of treatment providers to use these methods, and ongoing evaluation of the techniques to improve effectiveness. This study is an

initial point for this process to begin.

Specifically, this study focuses on the comparison of the number of traumas experienced by American Indian and Caucasian sex offenders currently receiving sexual specific treatment, the level of self-reported PTSD symptoms for each group, traumatic cognitions endorsed by both groups, and the number of dissociation symptoms presented between the groups. The following hypotheses were evaluated and are stated in an alternative form:

Hypothesis 1: American Indian sexual offender participants would report a greater number of trauma experiences than the Caucasian sex offender participants.

Hypothesis 2: American Indian sexual offender participants would endorse increased symptoms of PTSD than the Caucasian sex offender participants.

Hypothesis 3: American Indian sexual offender participants would display more traumatic cognitions than the Caucasian sex offender participants.

Hypothesis 4: American Indian sexual offender participants would endorse higher dissociative experiences than the Caucasian sex offender participants.

CHAPTER II

METHODS

Participants

Participants were 85 (54 Caucasian, 31 American Indian) volunteer American Indian and Caucasian adults (age range: 20-83, education range: 7-17, American Indian income range: 0-2,000, Caucasian income range: 500-6,000) male sex offenders receiving sexual specific treatment through Chrysalis Association in Rapid City, South Dakota. The participants were a convenience sample and the population was representative of the community. Two psychologists and a License Professional Counselor provide these services: Dewey J. Ertz, Ed.D., Donald A. Janz, Ph.D., and William A. Moss, Psy.D.

Materials and Procedures

The material used to gather data consisted of a consent form, a data form, the Trauma History Screen (THS), Posttraumatic Checklist - Specific Version (PCL-S), Posttraumatic Cognitions Inventory (PTCI), and Dissociative Experiences Scale-II (DES-II). A Certificate of Confidentiality was obtained through the United States Institutes of Health (NIH) to protect the privacy of the subjects by allowing the researcher, or treatment providers, exempting them from releasing information which potentially could be used to identify subjects in this research.

Data collection took place by requesting the individuals who were treating the offenders to ask for volunteers to participate in this study. It should be noted every potential subject asked to volunteer agreed to participate. Each volunteer subject was seen individually by their clinician to review the consent form (see Appendix A) and explain any questions they had. Once the

consent form had been signed, subjects were asked to complete the data form (see Appendix B). The data form includes questions about age, living arrangements, where the subject grew up (either on or off the reservation), legal status, total number of convictions, number of sexual convictions, number of contact and non-contact convictions, months served in jail, past and current treatment (specifically the type and duration of treatment), education level, if the subject was an abuse survivor (including: sexual, physical, neglect, and emotional), employment status, and monthly income. Subjects were then asked to complete the four instruments noted above.

The first instrument subjects were asked to complete was the THS, which was developed by Carlson et al. (2011). This instrument was selected because it is suitable both for clinical and research purposes, and it can be administered to a wide population with its low reading level, common language, and simple responses are used. The events listed on the THS were used to define specific trauma experiences. This instrument is a brief self-report measure examining 11 events and one general event, including military trauma, sexual assault, natural disasters, and other traumas associated to the AI/AN populations. Subjects were asked to indicate whether the event occurred (*yes* or *no*) and the number of times this event happened. Additional dimensions were assessed for each event endorsed, which included: age when it happened, a description of what happened, whether there was actual or a threat of death or injury, feelings of helplessness and feelings of dissociation, and a 4-point scale for duration of distress (*not at all* to *a month or more*) and a 5-point scale for distress level (*not at all* to *very much*). This instrument also has good test-retest reliability, construct, and convergent validity. The results were then reviewed to identify all trauma areas meeting the first criterion in DSM-IV-TR for PTSD (APA, 2000). Subjects were then asked to complete the PCL-S for each event identified meeting the first criteria for PTSD.

The PCL-S was developed by Weathers, Litz, Herman, Huska, and Keane (1993) and measures the criteria B, C, and D for PTSD as defined in the DSM-IV-TR (APA, 2000). The instrument is a 17-item self-report, which is easily read and takes little time to complete. Individuals were asked to rate how much they were bothered by a problem area in the past month. Items were rated on a five-point scale ranging from 1 (*not at all*) to 5 (*extremely*). According to the DSM-IV-TR (APA, 2000), the disturbance must cause significant distress or impairment, which was associated with a cutoff value of 3 on the PCL-S. This cutoff value was used to determine if the subject was endorsing PTSD symptoms in relationship to an identified stressful experience in the THS. The scores on the THS and PCL-S were then compared between American Indian and Caucasian sex offenders to determine if there were differences between the two groups.

The PTCI is a 33-item screening instrument developed by Foa, Ehlers, Clark, Tolin, and Orsillo (1999) to identify trauma-related thoughts and beliefs in relationship to PTSD. It was developed from clinical observations and theories of post-trauma psychology. Results yield a total score and information in three areas: negative cognitions about self (21 items), negative cognitions about the world (7 items), and self-blame (5 items). Research suggests the three PTCI scales correctly discriminated 86% of the traumatized individuals into those with and without PTSD. This is maintained even after controlling for depression and state anxiety, as well as for age, sex, race, and type of assault. This instrument has good internal consistency and test-retest reliability of the total scale as well as good construct validity as supported by moderate to high correlations (Foa et al., 1999). The inventory was completed by having the subject read and rate each item on a seven point scale of 1-*totally disagree*, 2-*disagree very much*, 3-*disagree slightly*, 4-*neutral*, 5-*agree slightly*, 6-*agree very much*, and 7-*totally agree*. The total score and three

areas were scored by adding up the item totals for the respondents using the numeric system above and dividing by the total number of items. These scores were then compared to the cutoff scores provided by Foa et al. (1999) to determine if the individual has experienced trauma with PTSD. The cutoff scores include the following: Total = 133.00, Negative Cognitions About Self = 3.60, Negative Cognitions About the World = 5.00, and Self-Blame = 3.20. These scores were also then compared between American Indian and Caucasian sex offenders to determine if there were differences between the two groups.

It should be noted there is controversy in the literature regarding the PTCI which suggests an association between self-blame cognitions and total PTSD symptoms is not supported (Beck, Coffey, Palyo, Gudmundsdottir, Millder, & Colder, 2004; Cieslak, Benight, & Lehman, 2008; Kolts, Robinson, & Tracy, 2004; Moser, Hajcak, Simons, & Foa, 2007). However, no one hypothesis of these studies has been supported to date. It is suggested self-blame may be interacting with PTSD symptoms depending on the trauma type and the diagnostic type (Blain, Galovski, Elwood, & Meriac, 2013). Further, Blain et al. (2013) replicated prior research to investigate this controversy and investigated the relationship between the PTCI cognitions (self, world, and self-blame) and a four-factor symptoms cluster including: re-experiencing, avoidance, numbing, and hyperarousal. Results indicated self-blame may be more predictive of emotional reactions such as intense guilt, shame, despair, anger, and sadness. Based on the research, this instrument was utilized to determine if an individual has experienced no trauma, has experienced trauma but no PTSD, and has experienced trauma with PTSD, as well as if they are engaging in negative cognitions about self, world, and self-blame.

The DES-II is a 28-item self-report measure and was selected to determine if subjects were dissociating at a level consistent with PTSD and to evaluate how often AI/AN people may

under report trauma symptoms due to dissociative experiences. During the scales original development, Bernstein and Putnam (1986) indicated a three factor analysis could also be gained from this scale, which include: amnesia (e.g., memory loss), depersonalization/derealization (e.g., the recurrent experience of feeling detached from one's self and the loss of connection with the immediate environment), and absorption (e.g., being distracted from what is happening around you) (Carlson & Putnam, 1993). There are studies supporting the three factored structure (Carlson et al., 1991; Ross, Ellason, & Anderson, 1995; Ross, Joshi, & Currie, 1991; Schwartz, Frischholz, Braun, & Sacha, 1991; Stockdale, Gridley, Balogh, & Holtgraves, 2002); however, the items loading on the specific dimensions vary across the studies (Olsen, Clapp, & Parra, 2013). In a review of the study completed by Carlson et al. (1991), Waller (in press) discovered the DES items and the Pearson correlations were distorted by skewness, which can produce spurious factors. Waller reanalyzed the factor analysis and his results indicated when skewness was controlled for, only a one factor model is supported for dissociation (Carlson & Putnam, 1993). Additional studies in the literature also support a one factor solution and suggests a single dimension is sufficient (Fischer & Elnitsky, 1990; Olsen et al., 2013).

Based on this research, a one factor solution was used for the purpose of this study. Questions were answered by marking a percentage of the time specific dissociative events take place for the respondent on a scale of 0-100%. The instrument is easy to understand and the questions are framed in a normative way that does not stigmatize the respondent for positive responses. A variety of dissociative experiences are included and many of areas represent normal experiences. This instrument has very good test-retest reliability (0.78 to 0.84; Carlson and Putnam, 1993) and internal consistency (0.83 to 0.93). Additionally, it has excellent construct validity as reflected in highly significant Spearman correlations of all items with the overall

score (Bernstein and Putnam, 1986). The instrument was scored by added up the respondent's answers and dividing them by the total number of items (28). Based on numerous studies, Carlson and Putnam (1993) have established the cutoff score for dissociating a level consistent with PTSD of 31. This indicates a subject may be likely dissociating as a result of a traumatic event if they score at or above this cutoff.

The Adverse Childhood Experiences (ACE) data was also provided by the three clinicians providing services to the subjects in this study. The ACE scores were assessed using the 17-item questionnaire provided by Anda and Felitti. The ACE instrument contains questions about 9 categories including: psychological abuse, physical abuse, sexual abuse, neglect, family substance abuse, parental separation/divorce, violent treatment of mother, family mental illness/suicide, and family member in prison. This data was included in the final analysis. This instrument was scored dichotomously from a range of 0 = *no exposure* to 10 = *exposure in all categories*. Subjects were asked to respond to questions about specific adverse experiences in the first 18 years of life.

CHAPTER III

RESULTS

Analyses focused on determining whether there were any significant differences between American Indian and Caucasian sex offenders for the number of trauma experiences reported, PTSD symptoms endorsed by those trauma experiences, traumatic cognitions, and dissociative experiences. Additional demographic information was organized in a frequency distribution and is summarized in Table 1. Descriptive statistics for treatment time in months, jail time in months, total convictions, and sexual convictions are summarized in Table 2.

Table 1. Frequency Distribution for Sample Variables Used in Demographic Information

Variables	% of American	
	Indian (n = 31)	% of Caucasian (n = 54)
<i>Living Arrangements</i>		
Were currently live off the reservation	71.0	96.3
Were currently lived on the reservation	9.0	3.7
Grew up off the reservation	32.3	92.6
Grew up on the reservation	67.7	7.4
<i>Legal Status</i>		
Were on Parole	41.9	31.5
Were on Probation	58.1	68.5
<i>Type of Offense</i>		
Contact offenders	87.1	50
Non-contact offenders	9.7	44.4

Table 1. cont.

Variables	% of American	
	Indian (n = 31)	% of Caucasian (n = 54)
Contact and non-contact offenders	3.2	5.6
<i>Employment</i>		
Unemployed	45.2	7.4
Worked full-time	41.9	63.0
Worked part-time	3.2	13.0
On disability	6.5	1.9
Receiving assistance	3.2	0.0
Receiving unemployment	0.0	3.7
Were retired	0.0	11.1
<i>Abuse Survivor</i>		
Sexual abuse	45.2	27.8
Physical abuse	45.2	25.9
Neglect	19.4	11.1
Emotional abuse	38.7	27.8

Table 2. Means and Standard Deviations of Sample Variables

Variables	American Indian (n = 31)		Caucasian (n = 54)	
	M	SD	M	SD
Treatment Time (in months)	27.23	34.68	20.91	19.17
Jail Time (in months)	58.35	62.42	33.17	70.14
Total Convictions	1.87	1.69	2.46	3.23
Sexual Convictions	1.58	1.84	1.41	1.14

Before analyses were conducted, correlations were evaluated to determine any significant relationships among the sample variables and treatment instruments for the entire sample. Analyses yielded a weak positive relationship ($p < 0.05$) between age and jail time ($r = .250$) and between education level and income ($r = .245$). A moderate negative relationship ($p < 0.05$) between total convictions and education level ($r = -.351$) and a moderate positive relationship ($p < 0.05$) between age and income ($r = .486$) also resulted. Table 3 presents a summary of the correlation matrix. There were multiple positive relationships ($p < 0.05$) between the trauma instruments, and these relationships ranged from weak to strong correlations. Table 4 presents a summary of the correlation matrix. However, there were no significant correlations between the trauma instruments and demographics/sample variables.

Table 3. Correlation Matrix for Sample Variables from a Sample of 31 American Indian and 54 Caucasian Sex Offenders

Variables	1	2	3	4	5	6	7
1. Age	–						
2. Treatment Time	-.015	–					
3. Jail Time	.250*	.189	–				
4. Total Convictions	-.042	-.045	.165	–			
5. Sexual Convictions	.066	.098	.030	.184	–		
6. Education Level	.125	-.091	-.059	-.351**	-.140	–	
7. Income	.486**	-.069	-.109	-.058	.166	.245*	–

Note. * $p < 0.05$ (2-tailed), ** $p < 0.01$ (2-tailed)

Table 4. Correlation Matrix for Trauma Instruments from a Sample of 31 American Indian and 54 Caucasian Sex Offenders

Trauma Instruments	1	2	3	4	5	6	7	8
1. THS	–							
2. PCL-S	.216*	–						
3. PTCI	.214*	.336**	–					
4. Neg. Cog. About Self	.157	.314**	.963**	–				
5. Neg. Cog. About the World	.293**	.240*	.808**	.666**	–			
6. Self-Blame	.143	.314**	.703**	.587**	.438**	–		
7. DES-II	-.049	.551**	.360**	.342**	.269*	.301**	–	
8. ACE	.295**	.462**	.329**	.290**	.324**	.236*	.261*	–

Note. * $p < 0.05$ (2-tailed), ** $p < 0.01$ (2-tailed)

Additional correlations were evaluated to determine any significant relationships among the sample variables and treatment instruments for American Indian sex offenders. Analyses yielded a moderate positive relationship ($p < 0.05$) between age and jail time ($r = .568$) and between age and total convictions ($r = .465$). There was also a moderate positive relationship ($p < 0.05$) between treatment time and jail time ($r = .395$) and between sexual convictions and income ($r = .495$). Table 5 presents a summary of the correlation matrix. There were multiple positive relationships ($p < 0.05$) between the trauma instruments, and these relationships ranged from weak to strong correlations. Table 6 presents a summary of the correlation matrix. There was a positive moderate relationship ($p < 0.05$) between Self-Blame and total convictions ($r = .427$).

Table 5. Correlation Matrix for Sample Variables from a Sample of 31 American Indian Sex Offenders

Variables	1	2	3	4	5	6	7
1. Age	–						
2. Treatment Time	.290	–					
3. Jail Time	.568**	.395*	–				
4. Total Convictions	.465*	-.015	-.022	–			
5. Sexual Convictions	.351	-.086	.065	.197	–		
6. Education Level	-.208	-.259	.023	-.088	-.191	–	
7. Income	.325	.132	.229	.091	.495**	-.134	–

Note. * $p < 0.05$ (2-tailed), ** $p < 0.01$ (2-tailed)

Table 6. Correlation Matrix for Trauma Instruments from a Sample of 31 American Indian Sex Offenders

Trauma Instruments	1	2	3	4	5	6	7	8
1. THS	–							
2. PCL-S	.176	–						
3. PTCI	.321	.340	–					
4. Neg. Cog. About Self	.276	.292	.972**	–				
5. Neg. Cog. About the World	.334	.312	.855**	.742**	–			
6. Self-Blame	.279	.366*	.780**	.705**	.540**	–		
7. DES-II	-.072	.625**	.314	.295	.287	.250	–	
8. ACE	.370*	.539**	.414*	.390**	.380*	.322	.298	–

Note. * $p < 0.05$ (2-tailed), ** $p < 0.01$ (2-tailed)

Final correlations were conducted to determine any significant relationships among the sample variables and treatment instruments for Caucasian sex offenders. Analyses yielded a weak positive relationship ($p < 0.05$) between education level and income ($r = .301$) and between treatment time and sexual convictions ($r = .385$). There was also a moderate positive relationship ($p < 0.05$) between treatment time and income ($r = .550$) and a moderate negative relationship ($p < 0.05$) between total convictions and education level ($r = -.456$). Table 7 presents a summary of the correlation matrix. There were multiple positive relationships ($p < 0.05$) between the trauma instruments, and these relationships ranged from weak to strong correlations. Table 8 presents a summary of the correlation matrix. There was a positive moderate relationship ($p < 0.05$) between the ACE and sexual convictions ($r = .357$).

Table 7. Correlation Matrix for Sample Variables from a Sample of 54 Caucasian Sex Offenders

Variables	1	2	3	4	5	6	7
1. Age	–						
2. Treatment Time	-.229	–					
3. Jail Time	.168	-.010	–				
4. Total Convictions	-.169	-.052	.248	–			
5. Sexual Convictions	-.112	.385**	-.015	.229	–		
6. Education Level	.224	.083	-.060	-.456**	-.098	–	
7. Income	.550**	-.056	-.072	-.170	.124	.301*	–

Note. * $p < 0.05$ (2-tailed), ** $p < 0.01$ (2-tailed)

Table 8. Correlation Matrix for Trauma Instruments from a Sample of 54 Caucasian Sex Offenders

Trauma Instruments	1	2	3	4	5	6	7	8
1. THS	–							
2. PCL-S	.350**	–						
3. PTCI	.152	.506**	–					
4. Neg. Cog. About Self	.089	.518**	.958**	–				
5. Neg. Cog. About the World	.278*	.245	.766**	.607**	–			
6. Self-Blame	.067	.403**	.645**	.507**	.353**	–		
7. DES-II	-.042	.323*	.495**	.464**	.325*	.430**	–	
8. ACE	.251	.369**	.341*	.279*	.369**	.239	.158	–

Note. * $p < 0.05$ (2-tailed), ** $p < 0.01$ (2-tailed)

The THS was analyzed by giving a count to the number of traumas per event. Similarly, the PCL-S was analyzed by giving a count to the number of traumas meeting the full criteria of PTSD as defined in the DSM-IV-TR (APA, 2000). This data was organized to determine the most frequently endorsed trauma exposures and PTSD symptoms endorsed by those trauma experiences identified on the THS. Table 9 presents a summary of the frequency distributions. The most frequently endorsed type of trauma experience for American Indians and Caucasian sex offenders was “Sudden death of close family or friend.” However, the frequency for PTSD symptoms endorsed by these trauma experiences was different for both groups. The most frequently endorsed trauma experience producing PTSD symptoms for American Indian sex offenders was “Suddenly abandoned by spouse, partner, parent, or family.” While the most frequently endorsed trauma experience producing PTSD symptoms for Caucasian sex offenders

was “Some other sudden event that made you feel very scared, helpless, or horrified.” These other sudden events included: being hit by a car, attempting suicide, and experiences related to the subjects’ offense (being searched and arrested for the possession of child pornography, going to court for a sexual offense, and committing a sexual offense). Further, American Indian sex offenders most frequently experienced a total number of 5 trauma experiences and a total number of 2 trauma experiences which endorsed PTSD symptoms. Similarly, Caucasian sex offenders most frequently experiences a total number of 3 trauma experiences and a total number of 3 trauma experiences which endorsed PTSD symptoms.

Table 9. Most Frequently Endorsed Types of Trauma Exposure and PTSD Symptoms Related to the Types of Trauma Experienced on the THS Instrument

Type of Exposure	% of American	
	Indian (n = 31)	% of Caucasian (n = 54)
A really bad car, boat, train, or airplane accident.	48.4 (6.5)	25.9 (1.9)
A really bad accident at work or home.	19.4 (3.2)	16.7 (3.7)
A hurricane, flood, earthquake, tornado, or fire.	16.1 (6.5)	24.1 (1.9)
Hit or kicked hard enough to injure – as a child.	22.6 (9.7)	18.5 (3.7)
Hit or kicked hard enough to injure – as an adult.	45.2 (9.7)	20.4 (1.9)
Forced or made to have sexual contact – as a child.	45.2 (16.1)	27.8 (13.0)
Forced or made to have sexual contact – as an adult.	9.7 (0.0)	0.0 (0.0)
Attack with a gun, knife, or weapon.	32.3 (6.5)	33.3 (13.0)
During military service – seeing something horrible or being badly scared.	0.0 (0.0)	5.6 (1.9)
Sudden death of close family or friend.	80.6 (16.1)	61.1 (11.1)
Seeing someone die suddenly or get badly hurt or killed	58.1 (16.1)	31.5 (5.6)
Some other sudden event that made you feel very scared, helpless, or horrified.	38.7 (12.9)	35.2 (14.8)

Table 9. cont.

Type of Exposure	% of American	
	Indian (n = 31)	% of Caucasian (n = 54)
Sudden move or loss of home and possessions.	38.7 (3.2)	35.2 (9.3)
Suddenly abandoned by spouse, partner, parent, or family.	58.1 (19.4)	24.1 (7.4)

Note. The number in parentheses is the frequencies of PTSD symptoms meeting all the criteria for PTSD on the PCL-S instrument in relation to the trauma experience identified on the THS.

The PTCI and the three cognitions (self, world, and self-blame) were analyzed by determining the frequency of American Indian and Caucasian sex offenders who met the cutoff scores of experiencing trauma with PTSD for each domain. As stated previously, the cutoff scores include the following: Total = 133.00, Negative Cognitions About Self = 3.60, Negative Cognitions About the World = 5.00, and Self-Blame = 3.20. This same analysis was done for the DES-II to determine the frequency of American Indian and Caucasian sex offenders who met the cutoff score (total = 31) of dissociating at a level consistent with PTSD. Table 10 presents a summary of the frequency distributions. It should be noted the total PTCI score was inconsistent with the total count of PTSD symptoms meeting all the criteria for PTSD on the PCL-S in relation to traumatic experiences identified on the THS. According to the PCL-S, 41.9% of American Indian and 40.7% of Caucasian sex offenders have experienced trauma with PTSD.

Table 10. Frequency of Traumatic Cognitions (PTCI), Negative Cognitions About Self, Negative Cognitions About the World, Self-Blame, and Dissociating (DES-II) at a Level Consistent With PTSD

Trauma Instruments	% of American	
	Indian (n = 31)	% of Caucasian (n = 54)
PTCI	9.7	7.4
Negative Cognitions About Self	12.9	13.0
Negative Cognitions About the World	16.1	14.8
Self-Blame	29.0	42.6
DES-II	19.4	11.1

To evaluate the hypotheses that American Indian sex offenders reporting more trauma experiences, endorse more PTSD symptoms related to those trauma experiences, have more traumatic cognitions, and dissociate more often than Caucasian sex offenders, a one-way analysis of variance (ANCOVA) was conducted on all the instruments. The independent variable consisted of ethnicity (American Indian and Caucasian). A covariate was used to control for the effect of treatment time in months. It was hypothesized previous treatment time may affect the traumatic cognitions scores as sex offender treatment is based around cognitive restructuring. Data screening for outliers led to the transformation of the ACE scores for Caucasian sex offenders. Caucasian subjects with an ACE score greater than or equal to 9 were recoded as 8. After the adjustment, ACE scores varied significantly with ethnicity, $F = 6.039, p < 0.05, \eta^2 = .069$. Table 11 presents a summary of the ANCOVA results and descriptive statistics. Comparison of adjusted group means, as displayed in Table 11, reveals American Indian sex offenders have significantly more adverse childhood experiences than Caucasian sex offenders. No statistically significant difference was found for the THS, PCL-S, PTCI, the three PTCI cognitions: Negative Cognitions About Self, Negative Cognitions About the World, and Self-

Blame, and DES-II. Table 12 presents a summary of the means and standard deviation for the remaining instruments.

Table 11. ANCOVA Results and Descriptive Statistics for the Adverse Childhood Experiences by Ethnicity Controlling for Treatment Time

Ethnicity Type	Adverse Childhood Experiences				
	Observed Mean	Adjusted Mean	SD	n	
Caucasian	2.94	2.94	2.36	54	
American Indian	4.36	4.36	2.78	31	
Source	SS	df	MS	F	η^2
Treatment Time	.005	1	.005	.001	0.00
Ethnicity	38.73	1	38.73	6.04*	.069
Ethnicity*Treatment Time	16.42	2	8.21	1.23	
Error	525.925	82	6.414		

Note. $R^2 = .069$, $Adj. R^2 = .047$. Adjustments based on Treatment Time mean = 23.21.
* $p < .05$

Table 12. Means and Standard Deviations of the Trauma Instruments by Ethnicity

Trauma Instruments	Ethnicity			
	American Indian (n = 31)		Caucasian (n = 54)	
	M	SD	M	SD
THS	18.16	31.06	16.32	30.53
PCL-S	1.90	3.90	.963	1.36
PTCI	79.07	41.15	87.82	35.27
Neg. Cog. About Self	2.05	1.24	2.25	1.16
Neg. Cog. About the World	3.25	1.71	3.66	1.40
Self-Blame	2.67	1.47	2.97	1.39
DES-II	19.76	22.36	13.73	12.47

During the final phases of analysis, an additional evaluation of the number of trauma experiences reported, symptoms of PTSD endorsed by those trauma experiences, traumatic cognitions, and characteristics of dissociation was conducted between by those subjects identified as contact sex offenders and non-contact sex offenders. It should be noted four subjects (1 American Indian, 3 Caucasian) identified themselves as both contact and non-contact sex offenders. According to McCarthy (2010), dual offenders are more sexually deviant and pose a greater risk to reoffend than online-only offenders, and this risk level is consistent with contact only offenders. Additionally, little is known about online offender treatment (Seto, 2013, p. 225). As a result, these subjects were recoded as contact sex offenders and were included in the analysis in this manner.

To evaluate the differences between contact and non-contact sex offenders, a one-way ANCOVA was conducted on the THS, PCL-S, PTCI, the three PTCI cognitions: Negative Cognitions About Self, Negative Cognitions About the World, and Self-Blame, DES-II, and ACE instruments. The independent variable consisted of type of offense (contact sex offense and non-contact sex offense). The covariate was previous treatment time in months. No statistically significant difference was found for the THS, PCL-S, PTCI, the three PTCI cognitions: Negative Cognitions About Self, Negative Cognitions About the World, and Self-Blame, DES-II, and ACE. However; an independent *t*-test was conducted for the DES-II as a results of Leven's test of equal variances being found significant ($p < 0.05$), which suggests unequal variances among the two groups. Statistical results yielded the DES-II scores varied significantly with type of offense for equal variances assumed, $t(83) = 1.695$, $p < 0.05$, $d = .43$, and unequal variances assumed, $t(80.86) = 2.076$, $p < 0.05$, $d = .43$. Table 13 presents a summary of the independent *t*-test results and descriptive statistics. Comparison of group means, as displayed in Table 13,

reveals contact sex offenders displayed significantly more dissociative experiences than non-contact sex offenders. Table 14 presents a summary of the means and standard deviation for the remaining instruments.

Table 13. Independent t-test Results and Descriptive Statistics for the Dissociative Experiences Scale-II by Offense Type

	Offense Type				95% CI for Mean Difference	t	df	d
	Contact (n = 58)		Non-Contact (n = 27)					
	M	SD	M	SD				
DES-II ^a	18.02	18.92	11.43	10.30	-14.34, 1.14	1.695*	83	.43
DES-II ^b	18.02	18.92	11.43	10.30	-12.92, -.273	2.076*	80.86	.43

Note. a = *t*-test with equal variances; b = *t*-test with unequal variances

**p* < .05 for one-tailed test

Table 14. Means and Standard Deviations of the Trauma Instruments by Offense Type

Trauma Instruments	Offense Type			
	Contact (n = 58)		Non-Contact (n = 27)	
	M	SD	M	SD
THS	16.64	33.32	17.74	24.10
PCL-S	1.48	3.02	.926	1.33
PTCI	82.90	37.39	88.33	38.24
Neg. Cog. About Self	2.13	1.15	2.29	1.27
Neg. Cog. About the World	3.41	1.52	3.74	1.53
Self-Blame	2.87	1.47	2.84	1.33
ACE	3.66	2.73	3.07	2.35

To evaluate on this comparison further, a 2 x 2 ANCOVA was conducted on the THS, PCL-S, PTCI, the three PTCI cognitions: Negative Cognitions About Self, Negative Cognitions About the World, and Self-Blame, DES-II, and ACE instruments. The independent variables consisted of ethnicity (American Indian and Caucasian) and type of offense (contact sex offense and non-contact sex offense). The covariate was previous treatment time in months. No statistically significant difference was found for the THS, PCL-S, PTCI, the three PTCI cognitions: Negative Cognitions About Self, Negative Cognitions About the World, and Self-Blame, DES-II, and ACE. Table 15 presents a summary of the means and standard deviation for each instrument. Thus, the results provided some evidence that American Indian differ from Caucasian sex offenders in adverse childhood experiences. Additionally, these results provide some evidence that contact and non-contact sex offenders differ in dissociative experiences as a result of trauma.

Table 15. Means and Standard Deviations of the Trauma Instruments by Ethnicity and Offense Type

Trauma Instruments	Ethnicity			
	American Indian		Caucasian	
	Contact	Non-Contact	Contact	Non-Contact
	(n = 28)	(n = 3)	(n = 30)	(n = 24)
	M	M	M	M
THS	19.11	9.33	14.333	18.79
	(32.54)	(6.43)	(34.42)	(25.34)
PCL-S	2.11	0.00	.900	1.04
	(4.06)	(0.00)	(1.37)	(1.37)
PTCI	80.86	62.33	84.80	91.58
	(41.41)	(42.19)	(33.81)	(37.41)
Neg. Cog. About Self	2.10	1.52	2.15	2.38
	(1.27)	(.788)	(1.04)	(1.30)
Neg. Cog. About the World	3.29	2.86	3.51	3.85
	(1.62)	(2.85)	(1.44)	(1.35)
Self-Blame	2.74	2.07	2.99	2.93
	(1.49)	(1.22)	(1.46)	(1.33)
DES-II	20.52	12.62	15.69	11.28
	(23.14)	(13.67)	(13.10)	(10.17)
ACE	4.39	4.00	2.97	2.96
	(2.81)	(3.00)	(2.51)	(2.31)

Note. Standard deviation is presented in parentheses under the reported mean.

CHAPTER IV

DISCUSSION

As outlined previously, the purpose of this study was to determine if sex offender treatment methods, which have been previously validated for primarily Caucasian sex offenders, are appropriate for use with American Indian sex offenders. It was reasoned there may be discrepancies in treatment needs between these populations due to research documenting increased exposure to trauma for AI/AN populations. There were four alternative hypotheses tested by this research for American Indian and Caucasian sex offenders on four trauma instruments: American Indian sex offenders would report more trauma experiences, endorse more PTSD symptoms related to those trauma experiences, have more traumatic cognitions, and display more dissociation. Trauma history was identified through two instruments: the THS and the ACE. Additional analysis was conducted after the collection of data to evaluate the differences among contact sex offenders and non-contact sex offenders on the four trauma instruments. This analysis was extended further to evaluate the differences among American Indian contact and non-contact sex offenders and Caucasian contact and non-contact sex offenders for the same four instruments. The results provided support to the trauma histories among American Indian and Caucasian sex offenders as well as dissociative experiences among the contact and non-contact sex offenders. However, there were no results significantly different results to support the remaining alternative hypotheses.

The results indicate the vast majority of this sample have been exposed to multiple trauma exposures, endorse PTSD symptoms from those trauma exposures, experience high rates

of traumatic cognitions, and dissociative experiences. American Indian sex offenders reported higher exposure to trauma and endorsed more PTSD symptoms from those trauma exposures for many of the experiences on the THS compared to Caucasian sex offenders. Specifically, American Indians reported higher rates of being in a really bad car accident versus Caucasians. The rate of being hit or kicked hard enough to injure as an adult was higher for American Indians than the rates among Caucasians. The American Indian subjects reported a higher prevalence rate for the sudden abandonment by spouse, partner, parent, or family compared to the rates of Caucasian subjects. Finally, American Indian sex offenders reported a higher prevalence rate for being sexually abused as a child compared to the Caucasians. Further, the rates of PTSD symptoms endorsed by this exposure was higher for American Indian versus Caucasians; however, these rates were far lower than the rate of reported sexual abuse.

These results support concerns in the research regarding trauma and PTSD symptoms among American Indian sex offenders being limited and further research in this area is warranted. Additionally, these results are consistent with the research suggesting the process of experiencing trauma begins early in life as children and young adolescents are the most common victims of sexual abuse. These results are also consistent with findings which have shown individuals who suffer maltreatment are more likely to display maltreatment towards others.

To elaborate on these results further, the total number of trauma experiences reported and overall prevalence rates of PTSD were also highly elevated among the sample; however, the groups did not represent statistical significance in these areas. Although the prevalence rates of PTSD among American Indians has differed across studies – in the present study, American Indians have displayed highly elevated rates of PTSD, where as in other studies, American Indians have displayed lower rates of PTSD. Caucasian sex offenders presented similar highly

elevated rates of PTSD. The PTSD rates in both samples are considerably higher than the lifetime prevalence rates of PTSD (8%) in the general adult population of the U.S (APA, 2000). Although significant results were found between the groups in this study, the results support the need for trauma assessments as part of psycho-sexual evaluations for both American Indian and Caucasian sex offenders.

In regards to the remaining alternative hypotheses, American Indian sex offenders reported experiencing higher levels of dissociation compare to Caucasian sex offenders. Further, Caucasian sex offenders reported experiencing higher scores of traumatic cognitions compared to American Indian sex offenders. In addition, the rates of the three cognitions measures on this instrument (self, world, and self-blame) were fairly consistent between the two groups (see Table 12). It should be noted the rates of self-blame were highly elevated for both American Indian and Caucasian sex offenders. The data from this research suggests self-blame may an important consideration in treating American Indian and Caucasian sex offenders. Despite the controversy in the research not supporting the association between self-blame cognitions and total PTSD symptoms – in the present study, both American Indian and Caucasian sex offenders reported high prevalence rates of self-blame. This could be indicative that sex offenders are experiencing intense guilt, shame, despair, anger, and sadness.

It is also possible treatment delivery utilized in sex offender treatment strongly relates to the questions asked on the PTCI in the cognitive domain of self-blame. Examples of these questions include: “The event happened because of the way I acted.” “The event happened because of the sort of person I am.” “Somebody else would have stopped the event from happening.” These questions, especially the first question, are issues typically addressed in sex offender treatment. Sex offenders are assessed for the degree to which they take responsibility

for their actions as this relates to their treatment planning. A goal in treatment is for sex offenders is to develop alternative responses to similar situations of which their offense occurred to prevent them from reoffending. While this cognitive domain may not be successfully utilized in other populations, in this sample, evidence is provided supporting the concept of sex offenders strongly engaging in self-blame cognitions. As a result, this instrument could become a vital tool to use during the treatment planning for sex offenders as it will allow clinicians to further assess the degree to which they take responsibility for their actions or blame victims.

Statistical results yielded no significant differences between the two groups in the alternative hypotheses, except in the area of adverse childhood experiences. Given the body of research supporting the position of American Indians having been exposed to more traumas, the prevalence rates of PTSD, and the traumatic cognitions and dissociative experiences as the result of exposure to trauma, the lack of an interaction between these areas and ethnicity was surprising. This finding should be addressed through further research to determine if these results are replicated. Possible hypothesis for this research might include utilizing different measures specifically referenced to trauma experiences AI/AN encounter. The instrumentation utilized in this research has not been normed for AI/AN populations, so the instruments may be biased. Future research should be explored to validate these measures for AI/AN populations. Another alternative could be to develop an instrument able to account for trauma exposure most common to AI/AN people. An additional hypothesis for the lack of significance in the results could be due to cultural variables for the American Indians subjects not accounted by the instruments. Additional research accounting for cultural variables, such as the level of acculturation, in American Indian sex offenders may produce alternative outcomes.

The statistical test examining the ACEs was statistically significant between the two

groups. American Indian sex offenders reported higher rates of adverse childhood experiences; however, no previous studies have been conducted to compare these results. The present study is the first to look at the relationship between these variable and American Indian/Caucasian sex offenders. However, there is a growing body of literature supporting significant consequences from adverse childhood experiences. Previous research has associated higher ACEs scores with lower academic performance, teenage pregnancy, and delinquency, (English, Widom, & Brandford, 2004), as well as substance abuse and PTSD symptoms (Douglas et al., 2010; Walling, Eriksson, Putman, & Foy, 2011). Additionally, higher rates of ACEs are related with characteristics of childhood sexual abuse and with the number of stressors in adulthood (Easton, 2012). This is also true with physical and mental health issues (Thomlinson, Prater, Stone, & Rushefsky, 2013). All of these factors have been shown to have high prevalence rates among AI/AN populations (CDC, 2013; Boyd-Ball et al., 2006; Byers, 2006; Duran et al., 2004; Evans-Campbell et al., 2006; McLeigh, 2010; Olson & Wahab, 2006; Sameroff et al., 1987).

The significant difference in ACEs scores provide further support to include formal trauma measures during psycho-sexual evaluations for both American Indian and Caucasian sex offenders. Most importantly, the assessment of adverse childhood experiences should be conducted for American Indian sex offenders as they presented with more adverse childhood experiences than Caucasian sex offenders in these results. This could reflect a need for different treatment planning when working with American Indian sex offenders. Changes may also be necessary in the delivery of treatment with American Indian sex offenders versus Caucasian sex offenders due to these findings.

The additional analyses conducted yielded results of no significant differences between the two groups among the four instruments, except in the area of dissociative experiences. In this

sample, regardless of ethnicity, contact sex offenders showed significantly more dissociation symptoms than non-contact sex offenders. In regards to traumatic cognitions, non-contact sex offenders reported experiencing higher scores of traumatic cognitions compared to contact sex offenders. Further, the rates of trauma experiences, PTSD symptoms endorsed by those trauma experiences, and the other three cognitions measures (self, world, and self-blame) were fairly consistent between the two groups (see Table 14). However, there were no evidence to support the remaining instruments. The significant interaction for the area of dissociative experiences between ethnicity and type of offense was an unanticipated result. It is possible treatment might trigger episodes of dissociation and result in a need for longer time in treatment for contact sex offenders. Clinicians may have to do more to ensure contact sex offenders can manage their dissociative experiences effectively to prevent relapse. While little is known about non-contact sex offender treatment, this result provides insight on the assessment and treatment needs for non-contact sex offenders. A need is present to consider this result as further research is completed regarding the assessment and treatment needs of contact, non-contact, and sex offenders who have both contact and non-contact offenses.

The final analysis comparing differences among American Indian contact and non-contact sex offenders and Caucasian contact and non-contact sex offenders yielded results of no significant differences between these groups and the four instruments. Mean differences between these groups varied across the trauma instruments (see Table 15). Possible conclusions for these results are similar to those outlined in the trauma measures for ethnicity alone. Further research is needed to evaluate these differences.

The overall results in this study support the use of current techniques used for Caucasian sex offenders with American Indian sex offenders with two exceptions. The first expectation is

the need to consider the greater impact adverse childhood experiences has had on American Indian sex offenders. The second exception is contact sex offenders, regardless of ethnicity, reported significantly greater dissociative experiences. Both of these exceptions may impact progress of sex offenders in treatment. For example, episodes of dissociation may hinder progress and require longer time in treatment. Another need for sex offenders might include treatment of their dissociation so they can be more actively involved during treatment sessions. Further, American Indian and Caucasian sex offenders reported high prevalence rates of trauma and PTSD. These results support the practice of treating sex offenders related to the areas discussed is warranted. By incorporating formal trauma measures in psycho-sexual evaluations, clinicians may provide more adequate treatment for sex offenders.

It should be noted this study has a final limitation. This limitation is based on treatment methods utilized between the three clinicians who participated in the study. All three treatment providers incorporate the treatment of trauma in conjunction with the subject's treatment for their sexual offense through collaboration. There is a need to conduct further research to look at other samples and providers to identify differences in the treatment methods provided. The present study has provided a model for the study of American Indian sex offenders and future research may provide alternative outcomes which can be compared to these results.

APPENDICES

Appendix A
Consent Form

INSTITUTION: University of North Dakota

PRINCIPLE INVESTIGATOR: Regina S. Ertz, BA

STUDY TITLE: Trauma Experiences and Symptoms Reported by American Indian and Caucasian Sex Offenders

INTRODUCTION

You are invited to participate in a research study. This study is focused on understanding the number of trauma experiences and the different types of trauma experiences American Indian and Caucasian sex offenders have experienced during their life. I am a graduate student in the clinical psychology program at the University of North Dakota. This study will be part of my training to become a clinical psychologist. No agency or individual is sponsoring this study.

All American Indian and Caucasian sex offenders being treated at Chrysalis Association or by other programs in South Dakota who are 18 years of age and older are invited to participate. It is important that you understand the following information before saying you will give your permission to be part of this research study.

1. Taking part in this study is entirely voluntary and you can quit being a part of the research at any time today.
2. Your only involvement in the study will be today and you will not lose any services you would normally receive if you decide not to take part.
3. By taking part in the study you may or may not benefit personally, but the knowledge will be gained from your participation that will benefit other sex offenders in treatment.
4. You will be asked to provide information about your history of experiencing trauma, how these experiences have affected you, and to complete various short tests about your feelings and thoughts.
5. I will ask you to sign a form to give me permission to use this information. You will not be identified personally and no information will be shared that someone can use to identify you.
6. You have the right to refuse to sign the approval to be a part of this research after you have read the information. Saying that you do not wish to participate will not limit your treatment or any other activities.
7. The benefits, risks, any discomfort that I can identify, and other information about this research study are presented below. Please feel free to ask me or anyone else you wish to talk to any questions you have.
8. I will publish the results of this research but no information will be included in this publication that can personally identify you.

Trauma can be defined in many ways. I am studying emotional reactions to trauma that usually involves events that produce painful emotional reactions and attempts to cope that do not help

the person or may even cause more trouble for them. My purpose in conducting this study is to identify if American Indian and Caucasian sex offenders present the same type treatment needs. If you agree to participate in the study you will be asked to give me some information about your history and to complete four different questionnaires. There will be no testing of your DNA, other types of physical test, or examinations completed.

OTHER IMPORTANT INFORMATION FOR YOU TO UNDERSTAND

Possible Risks: The information you will be asked to share may cause you to feel bad but this is the same information you will be asked to share during an evaluation of your sexual history and during sex offender treatment. You will not be asked to disclose information that may cause you to get into trouble and you have the right to refuse to answer any verbal or written questions presented to you as part of this research study. No information will be asked about your sexual attitudes, preferences, or practices; information relating to the use of alcohol, drugs, or other addictive products; information pertaining to illegal conduct; information that, if released, might damage your financial standing, employability, or reputation within the community or might lead to social stigmatization or discrimination; information pertaining to your psychological well-being or mental health; and genetic information or tissue samples. You should avoid giving information about these areas on you own while completing the information requested during your participation in this study.

Benefits: There are potential benefits to you in participating in this research. You may gain a better understanding of how past events have impacted you and you can sign a release form so that this information is provided to people who are trying to help you such as your sex offender counselor, or a probation or parole officer. Another benefit is that the information you provide to me may reflect treatment needs that I can discuss with your sex offender counselor or other people if you sign a release form to allow me to share this information.

Confidentiality: A Certificate of Confidentiality has been granted through the United States Institutes of Health (NIH) to protect your privacy if you agree to be a subject in this study. This certificate allows me to be exempt from releasing information that could be used to identify you. You need to know that this certificate does not protect you from the following situations:

- Voluntary disclosure of information you make or any disclosure that you have consented to in writing, such as to insurers, employers, or other third parties;
- Voluntary disclosure by the researcher of information on such things as child abuse, reportable communicable diseases, possible threat to self or others, or other voluntary disclosures provided that such disclosures are spelled out in the informed consent form;
- Voluntary compliance by the researcher with reporting requirements of state laws, such as knowledge of communicable disease, provided such intention to report is specified in the informed consent form; or
- Release of information by researchers to Department of Health and Human Services as required for program evaluation or audits of research records or to the Federal Drug Administration as required under the federal Food, Drug, and Cosmetic Act.

Research related injuries: There are no funds available to pay for mental-health care if you have a bad emotional reaction resulting directly from this research study. However, you are currently involved with receiving psychological and/or mental-health services so it is likely that any bad emotional reaction you have from this study can be addressed through the services.

Payment: The services you receive through this research study will not be paid by anyone. No payment will be offered to you as a subject because this might influence people to become subjects without considering potential risk they may encounter.

Stopping your involvement: You may withdraw from participating in this study at any time. There will be no loss of benefits or other activities if you make this choice. Your cooperation in completing the information is appreciated and allows me to gain important information about sex offender treatment needs for American Indian and Caucasian sex offenders.

Follow-up: The only follow-up activities that will take place will involve me contacting individuals that you have given me permission to contact as noted in the benefits section above. If you have other questions after today you can also contact your sex offender counselor as he or she will have information about how to contact me.

Responsibility for the study: The University of North Dakota has responsibility for the conduct of the study. I am the principal investigator as a student at this university. My work is supervised directly by my advisor, J. Douglas McDonald, Ph.D. Dr. McDonald and two other professors at the University of North Dakota will be involved in reviewing the data collected but they will not have access to your identity or name.

Consent document: A copy of this consent document will be offered to you after it is signed by both of us. It is suggested that you keep this copy for your reference and personal records.

Problems for questions: Should any questions or problems arise regarding this study or any that research-related reactions take place you can contact me through Chrysalis Association in Rapid City, South Dakota, by calling (605) 341-8647. You can also contact me as the principle investigator, at (605)393-7646 or my advisor at the University of North Dakota, Dr. McDonald, at (701)777-4495.

Research participants' rights: You may contact my advisor, Dr. McDonald, as noted above; or the Institutional Review Board at the University of North Dakota at (701)777-4279 about any questions you have regarding this research study. This includes questions you have about your rights as a research subject.

Signature: As a representative of this research study I have explained the purpose, procedures, the benefits, and the risks that are involved. Any questions that have been raised have been answered to the subject's satisfaction.

Signature of person obtaining consent

____/____/_____
Date

STATEMENT BY RESEARCH SUBJECT

I have volunteered to take part in this research study.

I know I can stop taking part at any time without changing my treatment or losing activities.

I am satisfied that my personal information will be confidential and protected.

I know that the results of this research may be published but I will not be identified during this process.

I am aware of possible risk and other emotional discomfort I may experience by participating.

I have had the chance to ask questions and my questions have been answered to my satisfaction.

I have read this form and I understand. I agree to take part in this research project titled Trauma Experiences and Symptoms Reported by American Indian and Caucasian Sex Offenders.

Printed name of research subject

Signature of research subject

___/___/_____
Date

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