Effects of Normalization on Self-Esteem and Loneliness in Juvenile Sex Offenders

Colleen E. Harden
Knox College

I examined the effect of exposure to normalizing data on the self-attitudes of juvenile sex offenders (JSOs). I hypothesized that self-esteem levels would rise whereas loneliness levels would drop in a sample of male JSOs (n = 17; age range = 14-20) after completion of a normalizing intervention. Participants’ self-esteem and loneliness was evaluated pre- and postintervention. Results showed a significant increase in self-esteem and a significant decrease in loneliness, suggesting that the use of normalizing interventions in sex-offense-specific treatment with JSOs may help facilitate group therapy and increase self-esteem while decreasing loneliness in an efficient manner.

Self-Esteem and Social Isolation in Juvenile Offenders

According to Rosenberg (1965), self-esteem is a favorable or unfavorable assessment of oneself. Low self-esteem (or an unfavorable appraisal of oneself) is related to externalizing behaviors like aggression, antisocial attitudes, and delinquent acts in teenagers (Donnellan, Trzesniewski, Robins, Moffitt, & Caspi, 2005), as well as to poor peer and family relationships (e.g., Wells & Rankin, 1983). Many JSOs in treatment report problems of social isolation (or loneliness) from their peers (DiGiorgio-Miller, 1994). Indeed, Marshall et al. (2005) suggested that offenders’ self-perceived lack of skill and confidence in establishing social relationships may lead to offending behaviors in an attempt to achieve social goals (e.g., relatedness, support, intimacy).

Smith et al. (2005) found high-risk JSOs scored lower in self-esteem and higher in social isolation than lower-risk JSOs. The authors used scores on risk factors (e.g., more serious offenses, behavior problems) to assign the risk of reoffending levels (high, medium, and low) in a sample of 161 male JSOs. They then surveyed the participants on measures of aggression, self-esteem, and social avoidance and distress, finding that high-risk JSOs had lower self-esteem, higher social avoidance, higher social discomfort, and higher aggression than low- and medium-risk JSOs. Smith et al. noted “high-risk offenders appear to be less socially skillful, avoiding social situations and experiencing discomfort when the situation is not avoidable. Their reluctance to

Faculty mentor: Gail M. Ferguson
engage in social interactions is probably worsened by their lower self-esteem” (p. 99). When socially-isolated juveniles such as JSOs do not have a peer environment in which to exercise developmentally-appropriate sexual and aggressive instincts, they may form dominant relationships with younger children in which it is easier to offend.

Social Comparison
One of the ways people form their self-concept is through comparisons with others in the social group (Festinger, 1954); people determine their self-esteem through favorable or unfavorable evaluations of this self-concept. The proximity and perceived similarity of in-group members appear to make a person’s in-group (versus out-group) social comparisons more influential to his or her self-evaluation (Crocker & Major, 1989; Hillman, Wood, & Sawilowsky, 1998).

Members of a stigmatized (i.e., disadvantaged) group serve as a safer basis for social comparison because comparisons with more-advantaged out-group members may lead to threats to self-esteem (Crocker & Major, 1989). Therefore, members of stigmatized groups tend to compare themselves to their in-group. Marshall, Marshall, Serran, and O’Brien (2009) suggested that an offender’s self-evaluation can suffer considerably when out-group others (e.g., nondelinquent peers, family members, teachers, members of the legal system) learn of his or her deviant behavior. The offender’s self-esteem may suffer when out-group others behave negatively toward him or her. Delinquent juveniles may then attempt to protect their self-esteem by comparing themselves to the delinquent in-group (Crocker & Major; Marshall et al., 2009). Therefore, providing the opportunity for in-group social comparisons by making in-group norms more salient to JSOs may have the effect of increasing self-esteem and social connectedness.

Self-Esteem Interventions and Normalization
Various therapeutic programs have attempted to raise self-esteem in JSOs, with the hope that higher self-esteem would reduce or eliminate offending behaviors and lead to more beneficial social interactions. Eastman (2004) noted that interventions aimed at reducing cognitive distortions regarding the sexually abusive acts (e.g., denial, justification) appeared to be the best method to prevent re-offending. Other programs, both residential and nonresidential, use cognitive-behavioral techniques and group therapy or outdoor settings to increase self-esteem (e.g., Coping Course: Rohde, Jorgensen, Seeley, & Mace, 2004; wilderness programs: Romi & Kohan, 2004). However, these programs require substantial time and resources, and it would be beneficial to discover quicker, less costly ways to increase self-esteem levels in JSOs. Normalizing interventions may be effective in working with JSOs.

A normalizing intervention is a process by which peoples’ symptoms are recast in light of the group norms; essentially, people see data that demonstrate that others have the same symptoms or behaviors. The effects of normalization encourage people with debilitating problems or symptoms to realize they are not alone in their suffering and that others in their therapy group are experiencing similar or the same troubles; this realization can decrease feelings of isolation and increase self-esteem (Koller, Marmar, & Kanas, 1992). In a group setting for JSOs specifically, a normalizing intervention could boost self-esteem and social connectedness. Research has noted normalization in group therapy can promote healing through the sharing of symptoms and common experiences, development of social skills and support systems, and increase in affinity with others in the group. These occurrences work to raise the self-esteem and functioning levels of the group members as well as to decrease feelings of social isolation (Battegay, 1971; Koller et al.). I expected that through exposure to normalizing data JSOs would experience more feelings of normality and would feel more comfortable talking about their sexual offenses in therapy.

The Present Study
I sought to investigate the effects of a normalizing group intervention on JSOs’ self-esteem, feelings of social isolation, feelings of normality, and comfort with disclosure about their sexual offending histories in therapy. By recognizing through concrete data (i.e., group means) that other juveniles in their therapy group have committed sexual offenses beyond their index sexual offenses, JSOs can realize their actions are more normative than they thought, thus increasing self-esteem and decreasing feelings of loneliness. I investigated the impact of a normalizing intervention on self-esteem and loneliness levels as well as feelings of normality and comfort with disclosure in therapy in JSOs. I hypothesized that

1. JSOs’ self-esteem levels would show an immediate rise after exposure to a normalizing intervention, whereas loneliness levels would drop.
2. Levels of self-esteem and loneliness would be inversely related.
3. JSOs would show increased feelings of normality and increased comfort with disclosure in therapy after exposure to a normalizing intervention.
Method

Participants
The college IRB approved the study and protocol prior to asking JSOs to participate. Seventeen male JSOs from two Midwestern U.S. counties participated in the study; 28 were invited to participate (60.7% participation rate). Sixteen participants were Caucasian; one was African-American. In order to avoid raising concerns among participants about confidentiality, participants did not report their names, ages, or races on surveys. However, based on clinic records, the participants ranged from 14 to 20 years. Two of the 17 participants were above the age of 18; they participated in juvenile sex-offense-specific therapy and this study because they committed their sexual offenses and began therapy before 18.

Each participant had been adjudicated for committing one or more sexual offenses as a juvenile and had been referred to one of two outpatient counseling centers. I received parental permission for each participant under 18 to participate in a study on teenagers’ feelings about group therapy and to access the participants’ clinical histories. The two participants over 18 signed identical consent forms but did not require parental consent. I informed the participants that involvement in the study was voluntary and that they could drop out of the study with no penalties at any time.

I also informed the participants that their information was confidential and would not be shared with any outside agencies. To match pre- and postintervention surveys, 16 of the participants at the first treatment center drew unique identification numbers out of a hat; they kept their number in their personal therapy binders. I told these participants that their numbers and surveys would never be identified with their names in any way, verbally or written. Each participant knew his identification number, but nobody, myself and my assistant included, knew which participant had which number. For one participant, who was the only participant at the second treatment center, I assigned him his own identification number and informed him that no one besides he and myself would ever know his identification number. For this participant, and the 16 others, there are no written or computer records of their identifying information or their identification numbers. After completion of the study, I debriefed the participants.

Measures
Self-esteem. I employed the 10-item Rosenberg (1965) Self-Esteem Scale (SES), a well-established and widely-used measure to assess self-esteem. The reported internal consistency of the scale is .88 (Fleming & Courtney, 1984); I also found a Cronbach alpha of .88 in this study. Higher SES scores indicate higher self-esteem levels.

Loneliness. I used the 20-item University of California at Los Angeles (UCLA) Loneliness Scale (Version 3; Russell & Cutrona, 1988) to measure participants’ levels of loneliness (determined by the discrepancy between actual and ideal levels of social contact). The scale is a widely-used measure of loneliness; Russell and Cutrona (1988) found a Cronbach alpha of .92. I also found a Cronbach alpha of .92 in this study. The respondent indicates his or her levels of loneliness along a 4-point Likert scale (1 = Never, 4 = Always). Possible scores range from 20 to 80; higher scores indicate higher levels of loneliness.

Therapy questions. I included a page of researcher-designed questions (Appendix A) directly asking the participants about their feelings of normality (i.e., how similar they feel to their peers) and their comfort with disclosure in therapy (i.e., how comfortable they feel sharing details of their sexual offense with others in their therapy group). These questions are unvalidated and uncoded. Higher scores indicate increased feelings of normality and comfort with disclosure. I found Cronbach alphas of .75 for questions addressing feelings of normality and .83 for questions addressing comfort with disclosure in therapy in this study.

Procedure
I assessed the self-esteem and social isolation levels of the participants at two time points: just before participants estimated their lifetime number of sexually abusive fantasies/acts (first contact point; baseline measures) and immediately after the normalizing intervention (second contact point). The amount of time between the first and second contact points ranged from 1 to 4 weeks due to participant absences. As stated before, one participant participated in the study individually, rather than in a group context, because he was the only participant at one of the treatment centers. Given the private and individual work of the procedure outlined subsequently, I do not believe this participant’s answers were affected by completing the study in an individual setting.

First contact point. Each participant chose a unique identification number out of a hat; only the participant knew his individual number and thus remained confidential. As stated earlier, I assigned the one participant who completed the survey alone at the second treatment center his own unique identification number. This number was known to me and the participant, but I assured the participant that his name would never be associated with his number or surveys in any manner.
Participants marked their individual numbers on both the pre- and postintervention surveys so that I could match corresponding surveys later. The surveys included the SES, UCLA Loneliness Scale, and therapy questions.

My assistant and I gave the participants pencils and the surveys and separated them in a room so that no one could see anyone else’s paper. Participants filled out the preintervention survey to assess baseline self-esteem levels, loneliness levels, feelings of normality, and comfort with disclosure in therapy. After completing the survey the participants individually placed their surveys in a stack of others wherever they wanted, to ensure confidentiality.

Next, I gave participants calculators, pencils, and a lifetime estimates chart with common time conversions to fill in (e.g., 24 hrs = 1 day, 12 months = 1 year; see Appendix B). I asked the participants to calculate their estimated lifetime number of abusive sexual behaviors up to the present. Abusive sexual behaviors were verbally defined as thoughts/fantasies about the abusive act, thoughts/fantasies of the abusive act with masturbation, and acting out the abusive act. I used eight categories for abusive sexual behaviors first established by Smith, Seavey, and White (2003): voyeurism, exposing, frottage, bestiality, obscene phone calling, sexual activity with a younger child, sexual activity with a peer or older adult without their permission, and necrophilia. One act (fantasizing once, masturbating and fantasizing once, or acting out the sexually abusive act once) counted as one instance toward the lifetime estimates.

I operationalized the eight abusive acts for the participants (e.g., “Sexual activity with a younger child means making a child do sexual things with you”). I gave the participants an article about sports to read when they were finished estimating their lifetime number of abusive thoughts/actions so that everyone appeared to be doing work and no one saw when anyone else was done calculating. After completing the estimates chart, the participants individually placed their charts in a stack of others wherever they wanted, to ensure confidentiality.

Second contact point. One to four weeks later, the second phase of the normalizing intervention was completed. I read aloud the group total, group mean, and group median of the estimated lifetime sexually abusive thoughts/actions for each category and explained to the participants (group norms; Appendix B). I then separated the participants so that no one could see anyone else’s paper and gave them pencils to complete the postintervention survey (the same survey assessing self-esteem, loneliness, feelings of normality, and comfort with disclosure in therapy). I asked the participants to put their individual number at the top of the survey to later match their postintervention surveys to their preintervention surveys. After completing the survey the participants individually placed their surveys in a stack of others wherever they wanted, to ensure confidentiality.

Results
I conducted paired-samples t tests to determine the effect of the normalizing intervention on the self-esteem levels, loneliness levels, feelings of normality, and comfort with disclosure in therapy. I used an alpha level of .05 for all statistical tests and Cohen’s d as a measure of effect size (Cohen, 1988).

Self-Esteem
Self-esteem levels (calculated from sums of Rosenberg, 1965, SES scores), as predicted, increased significantly from preintervention (M = 31.29, SD = 4.69) to postintervention (M = 34.18, SD = 5.88), t(16) = -2.62, p = .02, d = .54. Thus, the normalizing intervention appears to have raised significantly the participants’ self-esteem levels.

Loneliness
Loneliness levels (calculated from sums of UCLA Loneliness Scale, Version 3, Russell & Cutrona, 1988, scores), as predicted, decreased significantly from pre-intervention (M = 40.82, SD = 7.36) to postintervention (M = 36.30, SD = 9.82), t(16) = 2.85, p = .01, d = .52. The normalizing intervention appears to have lowered significantly loneliness levels in the participants.

Inverse Relation Between Self-Esteem and Loneliness
I used a Pearson’s correlation analysis to determine the relation between self-esteem scores and loneliness scores. As predicted, I found a statistically significant negative correlation, r(15) = -0.70; p < .01.

Therapy Questions
Feelings of normality, as predicted, increased significantly from preintervention (M = 12.82, SD = 3.23) to postintervention (M = 14.76, SD = 2.68), t(16) = -3.80, p < .01, d = .52. The normalizing intervention appeared to increase feelings of normality in the JSOs participants.

Comfort with disclosure in therapy did not increase significantly from preintervention (M = 11.29, SD = 1.96) to postintervention (M = 12.53, SD = 3.54), t(16) = -1.85, p = .08, d = .43. Thus, JSOs’ comfort with disclosure in therapy increased slightly, albeit not significantly, after exposure to normalizing data.
Discussion

The present study assessed the impact of a therapeutic normalizing intervention on the self-esteem levels, loneliness levels, feelings of normality, and comfort with disclosure in therapy for male JSOs. The hypotheses of the study were mainly supported. The use of a normalizing intervention that emphasized group norms in the context of group therapy with JSOs appeared to increase self-esteem levels, decrease loneliness levels, and increase feelings of normality. These findings showed medium effect sizes. The normalizing intervention also appeared, to some extent, to have increased comfort with disclosure in therapy. This finding showed a somewhat small effect size.

Noting that their peers have thought about, masturbated to, and committed other sexual offenses beyond their index sexual offense appeared to make JSOs feel better about themselves, less socially isolated, and more like their peers. Past research has indicated that low self-esteem in JSOs can influence them to reoffend or act out in sexually abusive manners (Eastman, 2004; Smith et al., 2005; Worling & Curwen, 2000) and is related to aggression and other delinquent acts (Donnellan et al., 2005). In addition, Smith et al. (2005) noted high-risk JSOs experienced higher levels of social discomfort and avoidance; the authors described the typical high-risk male JSO as “a shy, awkward adolescent boy” (p. 99). The authors add that “given [the JSO’s] social disabilities, he may find himself more comfortable with younger children whom he can dominate and with whom he can feel more comfortable” (p. 99). The current study suggested that normalizing interventions can be used in sex-offense-specific therapy to increase JSOs’ self-esteem levels and decrease loneliness levels.

This study also indicated that normalizing data appear to make JSOs feel more “normal.” Because the measure used did not specify a comparison group, it is unclear whether JSOs felt more “normal” in relation to delinquent therapy peers (in-group) or nondelinquent juvenile peers (out-group; e.g., school classmates). Crocker and Major (1989) suggested that socially low-status groups (e.g., JSOs) tended to make in-group comparisons rather than out-group comparisons in an attempt to preserve self-esteem. It is possible JSOs are inclined to compare themselves to similarly-disadvantaged in-group members rather than more-advantaged out-group members to protect feelings of self-worth; future research should differentiate more clearly between these two comparison groups.

It is important to note that I did not suggest during the research sessions or at any other point in my work with the participants that committing sexual offenses was normal or acceptable behavior. When conducting the normalizing intervention by explaining the lifetime estimates results to the participants, I noted that the fact that others in the therapy group had committed additional sexual offenses beyond the index offense did not mean it was “okay” for anyone to have committed offenses, but that the behavior was normative for the group.

Limitations of this study include a small sample size as well as an almost exclusively Caucasian male sample. JSOs in outpatient therapy can be a difficult population to study; many view any outside agency (e.g., attorneys, judges, probation officers, even researchers) as a threat to their well-being (Marshall et al., 2009). Although I told the participants before their participation that their answers were purely for research and would not be shared with any outside agencies, many did not want to participate. I believe those who participated did so because they knew me well from my previous work with them and trusted that I would not improperly use their information. Future research should also include larger, more diverse samples from different backgrounds, as well as female offenders and adult offenders, who indicate similar trends of low self-esteem and social isolation (e.g., Hubbard, 2007; Marshall et al., 2009; Morton & Leslie, 2005; Thornton, Beech, & Marshall, 2004).

Another limitation of this study is the absence of a control group. This study does not provide definitive evidence that the self-esteem and loneliness levels of JSOs would not improve similarly through the course of regular therapy sessions rather than participating in a normalizing intervention. However, progress in regular therapy can often evolve slowly, whereas the shock of the normalizing data appeared to have made a strong impact. Despite this observation, future research should utilize a control group to provide a comparison sample.

Future research should also correct the methodological inconsistency of this study; some participants completed the pre- and postintervention measures within a week, and others completed the measures with several weeks’ break. Though the presence of significant self-esteem and loneliness effects with longer pre- to postintervention intervals demonstrates the strength of the findings, future research should use the same amount of time between the contact points. An ideal study would measure the participants’ self-esteem and loneliness levels several times postintervention to assess longer term effects of the normalizing intervention. Future researchers should also use additional measures (e.g., external vs. internal locus of control measures, self-concept scales) and individual participant reactions to gather even more information on the effects of normalizing interventions in therapy.

Given the time, resources, and financial constraints of the rehabilitation of JSOs, research addressing the
Specific needs of JSOs is needed to develop ways to treat JSOs quickly and effectively to minimize the risk of reoffending. JSOs' feelings of low self-esteem and acute abnormality, as well as their unwillingness to talk about their sexual offenses, severely hinder the progress of therapy. Overcoming such obstacles could allow therapy to progress more quickly and effectively. Such research is necessary to facilitate treatment and ideally protect both potential future victims as well as improve the lives and futures of JSOs.

References
APPENDIX A

This appendix includes the self-designed therapy questions addressing feelings of normality and comfort with disclosure in therapy. These questions were included in the pre- and postintervention surveys.

QUESTIONS ADDRESSING FEELINGS OF NORMALITY
Please answer the questions below using the numbers on the scale below.
1 Not at all
2 A little
3 Somewhat
4 A lot
5 Completely

1) How “normal” do you feel compared to other people your age? _____
2) When you think about your sexual offense, how much do you believe that you are similar to others who have committed sexual offenses? _____

Please answer how much you agree with the following statements using the numbers on the scale below.
1 Strongly Disagree
2 Disagree
3 Agree
4 Strongly Agree

3) I believe that I am worse than others that have committed sexual offenses.* _____
4) I believe that I am sick and disgusting for committing my sexual offense.* _____

QUESTIONS ADDRESSING COMFORT WITH DISCLOSURE IN THERAPY
Please answer the question below using the numbers on the scale below.
1 Not at all
2 A little
3 Somewhat
4 A lot
5 Completely

5) How comfortable do you feel describing the details of your sexual offense? _____

Please answer how much you agree with the following statements using the numbers on the scale below.
1 Strongly Disagree
2 Disagree
3 Agree
4 Strongly Agree

6) If someone in my treatment program told me that they committed their sexual offense and that they committed some sexual offenses that no one knew about, it would make me feel more like talking about my own sexual offense. _____
7) If someone in my treatment program told me that they had a history of having sexually abusive thoughts/fantasies, this would make me feel more like talking about my own sexually abusive thoughts/fantasies. _____
8) If someone in my treatment program told me that they had masturbated to abusive sexual thoughts, this would make me feel more like talking about my own masturbation to sexually abusive thoughts/fantasies. _____

* Reverse-scored item.

Higher scores indicate increased feelings of normality and comfort with disclosure in therapy.
APPENDIX B

This appendix includes the group norms presented to the participants in the normalizing intervention; the group norms are the aggregated data of the participants’ estimated lifetime number of sexually abusive fantasies/actions.

One instance of a sexually abusive fantasy, a fantasy with masturbation, or an action counted as one mark in the chart under the corresponding category; thus, for example, out of the 18 participants who completed the lifetime estimates chart, there were 103 total instances of fantasizing about exposing.

<table>
<thead>
<tr>
<th>Sexually Abusive Category</th>
<th>Thoughts/Fantasies</th>
<th>Fantasies with Masturbation</th>
<th>Sexually Abusive Acts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voyeurism – sexually spying on someone</td>
<td>TOTAL: 98</td>
<td>TOTAL: 41</td>
<td>TOTAL: 30</td>
</tr>
<tr>
<td>(watching them undress, seeing them naked,</td>
<td>Mean: 5.4</td>
<td>Mean: 2.3</td>
<td>Mean: 1.7</td>
</tr>
<tr>
<td>watching people have sex)</td>
<td>Median: 7</td>
<td>Median: 1</td>
<td>Median: 0</td>
</tr>
<tr>
<td>Exposing – showing your penis, vagina, or</td>
<td>TOTAL: 103</td>
<td>TOTAL: 26</td>
<td>TOTAL: 48</td>
</tr>
<tr>
<td>butt to someone</td>
<td>Mean: 5.7</td>
<td>Mean: 1.4</td>
<td>Mean: 2.7</td>
</tr>
<tr>
<td></td>
<td>Median: 1</td>
<td>Median: 0</td>
<td>Median: 1</td>
</tr>
<tr>
<td>Frottage – touching or grabbing someone’s</td>
<td>TOTAL: 158</td>
<td>TOTAL: 76</td>
<td>TOTAL: 48</td>
</tr>
<tr>
<td>butt, breasts, vagina, or penis</td>
<td>Mean: 8.7</td>
<td>Mean: 4.2</td>
<td>Mean: 2.7</td>
</tr>
<tr>
<td></td>
<td>Median: 7</td>
<td>Median: 5</td>
<td>Median: 5</td>
</tr>
<tr>
<td>Bestiality – having sex with animals</td>
<td>TOTAL: 35</td>
<td>TOTAL: 30</td>
<td>TOTAL: 24</td>
</tr>
<tr>
<td></td>
<td>Mean: 1.9</td>
<td>Mean: 1.7</td>
<td>Mean: 1.3</td>
</tr>
<tr>
<td></td>
<td>Median: 0</td>
<td>Median: 0</td>
<td>Median: 0</td>
</tr>
<tr>
<td>Obscene Phone Calling – calling someone on</td>
<td>TOTAL: 29</td>
<td>TOTAL: 20</td>
<td>TOTAL: 18</td>
</tr>
<tr>
<td>the phone and saying suggestive sexually</td>
<td>Mean: 1.6</td>
<td>Mean: 1.1</td>
<td>Mean: 1.0</td>
</tr>
<tr>
<td>inappropriate things to them – not a prank</td>
<td>Median: 0.5</td>
<td>Median: 0</td>
<td>Median: 0</td>
</tr>
<tr>
<td>call</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Activity with a Younger Child –</td>
<td>TOTAL: 133</td>
<td>TOTAL: 73</td>
<td>TOTAL: 48</td>
</tr>
<tr>
<td>making a child to do sexual things with</td>
<td>Mean: 7.4</td>
<td>Mean: 4.1</td>
<td>Mean: 2.7</td>
</tr>
<tr>
<td>you</td>
<td>Median: 9</td>
<td>Median: 5</td>
<td>Median: 2</td>
</tr>
<tr>
<td>Sexual Activity with a Peer or Older</td>
<td>TOTAL: 86</td>
<td>TOTAL: 87</td>
<td>TOTAL: 25</td>
</tr>
<tr>
<td>Without Their Permission – making someone</td>
<td>Mean: 4.8</td>
<td>Mean: 4.8</td>
<td>Mean: 1.4</td>
</tr>
<tr>
<td>your own age or older to do sexual things</td>
<td>Median: 4</td>
<td>Median: 5</td>
<td>Median: 0</td>
</tr>
<tr>
<td>with you without their permission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Necrophilia – having sex with dead</td>
<td>TOTAL: 30</td>
<td>TOTAL: 26</td>
<td>TOTAL: 0</td>
</tr>
<tr>
<td>bodies, either humans or animals</td>
<td>Mean: 1.7</td>
<td>Mean: 1.4</td>
<td>Mean: 0</td>
</tr>
<tr>
<td></td>
<td>Median: 0</td>
<td>Median: 0</td>
<td>Median: 0</td>
</tr>
<tr>
<td>TOTALS</td>
<td>672</td>
<td>379</td>
<td>241</td>
</tr>
<tr>
<td></td>
<td>Mean: 37.3</td>
<td>Mean: 21.1</td>
<td>Mean: 13.4</td>
</tr>
</tbody>
</table>

N = 18 (One participant completed his lifetime estimates of sexually abusive thoughts/actions but did not complete the study)