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The Prevalence and Correlates of Depression and Hopelessness among Sex Offenders Subject to Community Notification and Residence Restriction Legislation

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Abstract Little research has investigated the prevalence of mood disturbance among sex offenders despite the fact that psychological distress may bear some relationship to community reintegration, and ultimately, recidivism. All offenders on New Jersey's sex offender Internet registry were mailed surveys about their experiences with, and perceptions of, notification and residence restriction statutes, the Beck Depression Inventory-II (BDI-II), and the Beck Hopelessness Scale (BHS). On average, respondents (N=104) reported mild to moderate levels of depressive symptoms (M_{BDI}=17.1) and hopelessness (M_{BHS}=6.9). Additionally, offenders who reported being negatively affected by residence restrictions and notification statutes reported higher levels of both depression and hopelessness. Given evidence that sex offender specific legislation may de-stabilize offenders, this research highlights the importance of managing affective states in this population.

Keywords sex offender · depression · community notification · residence restrictions

The Adam Walsh Child Protection and Safety Act of 2006 (AWA) is illustrative of the growing movement in the United States to enact legislation that seeks to monitor and confine sex offenders with the goal of minimizing or preventing sexual

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recidivism. Title I of the AWA, also known as Sex Offender and Registration and Notification Act (SORNA), extends and strengthens registration and notification requirements and introduces national standards for implementation. As of this writing, however, only three states have substantially implemented SORNA (Ohio, Florida, and Delaware). Though states initially had until July 2009 to implement the Act, all jurisdictions have been given until July, 2010 (and many have requested extensions to 2011) due to widespread SORNA implementation challenges, particularly with regard to offense tiering, retroactivity, and juvenile registration. (U.S. Department of Justice, Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking, n.d.).

Similarly, residence restriction statutes, which prohibit certain offenders from residing within close proximity to places where children congregate, have been enacted in at least 30 states and thousands of local municipalities (Meloy et al. 2008). This legislation, which is based upon the assumption that subsequent sex offenses will be decreased by limiting convicted sex offenders' access to potential victims, typically limits sex offenders from living within 1,000 to 2,500 feet of schools, day care centers, parks or other places frequented by children (Levenson et al. 2007b; Nieto and Jung 2006).

Contrary to their intended aims, some scholars argue that these policies could actually increase the likelihood that a sex offender may reoffend by exacerbating factors associated with criminal recidivism. For instance, these laws interfere with the ability to secure and sustain employment, housing, and prosocial relationships, leading to transience, instability, isolation, shame, harassment, and lack of social support (Edwards and Hensley 2001; Lees and Tewksbury 2006; Levenson and Cotter 2005a, b; Levenson and D'Amora 2007; Levenson et al. 2007a, b; Levenson and Hern 2007; Mercado et al. 2008; Zevitz 2006). These stressors may also create or exacerbate negative mood states, which can be a dynamic risk factor for sexual offending (Hanson and Harris 1998, 2001; Marshall et al. 1999). Indeed, McKibben et al. (1994) found that negative mood states may precipitate deviant sexual fantasizing among sex offenders. Likewise, Pithers and colleagues (Pithers et al. 1988, 1983) found that negative mood states immediately preceded sexual offenses. Relatedly, Martin and Stermac (1999) found that those with lower levels of hope seemed to be at higher risk of recidivism, leading them to suggest that hope-focused strategies may show promise in reducing criminal re-offending.

Mood disorders have been found to be prevalent in samples of sex offenders. In a sample of adult males with paraphilias or paraphilic related disorders, Kafka and Prentky (1994) found that 75% had a diagnosable mood disorder, with over 50% meeting diagnostic criteria for dysthymia. Mood disorders were the most prevalent Axis I disorders among both groups, especially early onset dysthymic disorder and major depression (Kafka and Hennen 2002). Moreover, Raymond and colleagues (1999) found that 31% of the pedophilic offenders in their sample met criteria for a current mood disorder, while over two-thirds (67%) were diagnosed with a lifetime mood disorder. Given the practical, legal, and psychosocial consequences of a sex offense conviction, it is not surprising that sex offenders may experience acute situational mood disorders, such as depression. Recently, Stinson et al. (2005) found that nearly a third (29%) of the civilly committed sexual offenders in their sample had clinically elevated scores on the Beck Depression Inventory—II (BDI-II; Beck

et al. 1996). Furthermore, Stinson et al. (2005) found that 14% of the offenders endorsed moderate symptoms of depression and 6% of the sample endorsed symptoms of depression in the severe range. However none of the aforementioned studies investigated depression among sex offenders who were subject to community management strategies, such as notification statutes or residence restriction legislation.

Deviant sexual behavior may be conceptualized, in part, as an ineffective coping mechanism that develops in an effort to neutralize negative affective states (Pithers 1990). Endler and Parker (1990) theorized that an individual's ability to cope with negative affect plays a major role in an individual's psychological well-being when confronted with negative or stressful life events. Lussier et al. (2001) also suggested that sex offenders may engage in deviant sexual behavior as a coping strategy to deal with negative affective states and, in an examination of the developmental pathways to sexual violence, Lussier et al. (2005) found that a disruptive or violent early family life was associated with negative moods, which was further associated with sexually abusive behavior in adulthood. According to the Self-Derogation Theory (Kaplan 1975, 1980, 2001) it is postulated that individuals who have had devaluating experiences in childhood and youth develop low self-esteem and begin to engage in self-derogation. Consequently these individuals become alienated from conventional society and seek self worth through unconventional and often deviant behaviors and relationships. It could be surmised that some sex offenders may derive self worth by seeking to meet emotional needs through exploitative sexual behaviors that maximize feelings of power, control, or perceived intimacy,thereby minimizing feelings of depression and hopelessness.

Moreover, some research suggests that mood bears some relationship to treatment progress. Hanson and Harris (1998) found that among non-recidivistic sex offenders, mood improved over the course of supervision; while among recidivistic sex offenders, mood worsened over the course of supervision (Hanson and Harris 1998). Relatedly, Jeglic et al. (2001) found that sex offender treatment programs that target effective problem solving can decrease depressive symptoms.

Together, these findings suggest that there may be some association between negative affective states, such as depression and hopelessness, and sexual offending. While the aforementioned research suggests that low self-esteem and negative emotionality may show an indirect link to aggressive behavior (Marshall et al. 1999), little empirical research has addressed the prevalence of mood disturbance in sex offender populations. Based upon the research to date it was hypothesized that sex offenders subject to notification and, in some cases residence restrictions, would report elevated levels of negative mood states such as depression, hopelessness and suicidal ideation. Further, it was anticipated that those sex offenders who have more negative experiences with community notification and/or residence restrictions will also experience higher levels of negative affective states. Finally, those who reported that they perceived more negative consequences (whether they were experienced or not) resulting from community notification and/or residence restrictions were anticipated to also report higher levels of depressive symptoms and hopelessness.

This study is the first to examine the prevalence and nature of affective distress in a community sex offender population. By providing data on the perceptions and experiences of sex offenders subject to notification and residence restriction

legislation, and how these perceptions and experiences relate to affective states, this study adds to the growing literature on the collateral, or unintended, consequences of sex offender specific legislation.

Method

As part of a larger study examining the perceived impact of community notification and residence restrictions on higher risk sex offenders (Mercado et al. 2008), surveys were mailed out to all 1601 sex offenders listed on New Jersey's publicly accessible Sex Offender Registry website, which includes only higher risk (Tier II and III) sex offenders. All participants were provided with a description of the study and were informed that the questionnaires were mailed to all sex offenders on the New Jersey Sex Offender registry and that their participation was anonymous and voluntary. Along with the survey, a postage paid envelope was provided in which to return the completed survey. In addition to questionnaires assessing sex offenders' perceptions of the impact of the legislation, all participants were asked to complete the Beck Depression Inventory-II (BDI-II) and the Beck Hopelessness Scale (BHS) (described below). Of the 1601 questionnaires that were mailed, 1446 were assumed to be received by offenders, the others were returned as undeliverable. As described in Mercado et al. (2008), all addresses of undeliverable questionnaires were rechecked with the registry 3 months following the initial mailing and those whose addresses had been updated were resent the questionnaires (n=68). In total, 137 questionnaire packets were returned, reflecting an adjusted response rate of 9.5%.

Participants

Of those who answered the demographic questionnaire as well as all the questions on the BDI and BHS (n=104), the majority (59%) described themselves as between the ages of 41–64 years, followed by 25–40 (26%) and over 65 years of age (12%). The largest percentage of the respondents reported having never been married (41%), though some (30%) indicated that they were currently married and some (23%) reported having been divorced. Those sex offenders who responded to the survey described their ethnicity as primarily White (60%), followed by Black (28%) and Latino (12%). More than half (60%) of the sex offenders reported that they earned less than $20,000 per year. The majority of the sex offenders reported that their victims were exclusively female (75%) and extra familial (72%) in terms of gender and relationship. When examining the age of the victims, 43% reported having perpetrated offenses against children (aged 12 and under), 38% offenses against teenagers, and 18% reported offenses against adults.

Twelve of the participants (12%) reported being Tier III (high risk) while the majority (n=92; 88%) reported that they were assigned a Tier II (moderate risk) level. Furthermore, 35% of the sex offenders reported being involved in some sort of sex offender treatment, while the majority (65%) were not.

Our low response rate is not atypical for surveys of sex offenders, who may be concerned about their confidentiality and the implications of negative feedback. Because the response rate was low, the possibility exists that the

sample is not representative of the larger population of registered sex offenders in New Jersey. In order to assess self-selection sampling bias, Mercado et al. (2008) compared this sample to the characteristics of the sex offenders on the New Jersey Internet registry at the time of data collection and found no significant differences on any demographic characteristics including age, ethnicity, tier status or victim type.

Measures

Beck Depression Inventory - II (BDI-II; Beck et al. 1996): The BDI-II is a 21-item self-report questionnaire designed to assess the severity of depressive symptoms experienced by adults and adolescents (13 years and older). The items on the BDI-II are based upon the criteria for diagnosing depressive disorder in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV; APA, 1994). A total score between 0 and 13 is considered to be in the minimal depression range, 14–19 is mild, 20–28 is moderate, and 29–63 is considered to represent severe depression (Beck et al. 1996). A mean score of 8.36 (SD=7.16) was found in a large sample of undergraduate students (Whisman et al. 2000) while another study found a means BDI-II score of 11.10 in a sample of 33 sex offenders (Lindsay and Skene 2007). A cutoff score of 14 on the BDI-II has been found to differentiate between those with clinical depression and community samples of adults (Seggar et al. 2002). Cronbach's alpha in this sample was .91

Beck Hopelessness Scale (BHS; Beck and Steer 1988; Beck et al. 1974): The BHS is a 20-item true-false self-report scale designed to measure the degree to which one's cognitions are dominated by negative future expectations. Higher scores indicate higher levels of hopelessness and negative expectations. Scores between 0 and 3 reflect minimal hopelessness, scores between 4 and 8 are mild, 9 and 14 are moderate and a score greater than 14 is indicative of severe hopelessness (Beck and Steer 1988). Scores on the BHS of nine or more were found to be predictive of eventual suicide (5–10 years later) among a sample of depressed suicide ideators (Beck et al. 1985). Beck and Steer (1988) reported sample groups means on the BHS of 9.28 (*SD*=6.08) and 8.86 (*SD*=6.11) for suicide ideators and suicide attempters respectively. Additionally, Greene (1981) found a mean BHS score of 4.45 (*SD*= 3.09) in a sample of randomly selected Irish adults and Durham (1982) found BHS means scores of 6.62 (*SD*=4.88) and 2.32 (*SD*=2.25) for forensic psychiatric patients and college students respectively. In this sample, α=.95.

*Attitudes toward Notification and Residence Restrictions Survey (*Mercado et al. 2008). Though modified to reflect New Jersey specific legislation, this survey used an adaptation of Levenson and Cotter's (2005a) questionnaire to examine perceptions and impact of community notification and housing restrictions on sex offenders. The scale was divided into five subscales. The first subscale (negative notification experiences) contained eight items asked participants to indicate "yes," no," or "I don't know" as to whether they had experienced discrete events as a result of notification (see Table 1 for individual items). In this study these items were analyzed individually. The subscale alpha was .76. The next subscale (perceived negative consequences of notification) comprised eight questions which were rated on a 5-point Likert scale ranging from "strongly disagree" to "strongly agree" and

Table 1 Effects of negative notification experiences on levels of depression and hopelessness

Item	BDI			BHS		
	Yes Mean (*SD*)	No Mean (*SD*)	*t* value	Yes Mean (*SD*)	No Mean (*SD*)	*t* value
I have lost a job because my boss or co-workers found out through Megan's Law that I am a sex offender	19.7 (12.4)	13.7 (11.2)	2.57*	7.4 (7.1)	6.1 (6.6)	1.05
I have had to move out of an apartment or house that I rented because my landlord found out through Megan's Law that I am a sex offender.	14.8 (11.0)	16.0 (12.8)	.64	8.0 (7.4)	6.3 (6.6)	1.10
I have had to move out of an apartment or house that I rented because my neighbors found out through Megan's Law that I am a sex offender	20.0 (13.0)	16.3 (12.5)	1.22	9.0 (7.7)	6.3 (6.6)	1.53
I have had to move out of a home that I owned because my landlord found out through Megan's Law that I am a sex offender	30.1 (13.9)	15.7 (11.7)	3.26**	12.6 (8.2)	6.6 (6.7)	2.24*
I have been threatened or harassed by neighbors after they found out I am a sex offender	20.8 (12.6)	14.1 (11.9)	2.83**	8.6 (7.5)	5.3 (6.0)	2.41*
I have been physically assaulted or injured by someone who found out I am a sex offender	28.4 (10.3)	16.1 (12.2)	2.96**	14.5 (7.0)	6.2 (6.4)	3.88**
My property has been damaged by someone who found out I am a sex offender	25.1 (13.0)	14.8 (11.6)	3.72**	10.0 (7.7)	6.0 (6.4)	2.29*
A person who lives with me has been threatened, harassed, assaulted, injured, or suffered property damage because someone found out through Megan's Law that I am a sex offender	20.6 (12.8)	15.4 (12.3)	2.05*	8.7 (7.8)	5.9 (6.4)	1.91

**$p<.01$; * $p<.05$

reflected perceived negative outcomes of notification statutes such as "I felt alone and isolated because of Megan's Law" and "I am afraid for my safety because of Megan's Law". These eight items were summed and used as a continuous scale to reflect the perceived negative consequences of notification legislation. In this sample, the Cronbach's alpha for this 8-item subscale was 0.90.

The third subscale (perceived positive consequences of notification) seven items, also scored on the same five point Likert scale, reflected perceptions of positive outcomes resulting from Community Legislation including "I am more motivated to prevent reoffense so that I can prove to others that I am not a bad person" and "I agree that communities are safer when they know where sex offenders live." This subscale had a Cronbach's alpha value of 0.78.

Furthermore, those sex offenders subject to residence restrictions were asked to complete a similar series of questions on the perceived impact of housing restrictions. The fourth subscale (negative residence restriction experiences) was comprised of seven questions, rated "yes," "no," or "I don't know" (see Table 2

Table 2 Effects of negative residence restrictions experiences on levels of depression and hopelessness

Item	BDI			BHS		
	Yes Mean (*SD*)	No	*t* value	Yes	No	*t* value
I have had to move out of a house that I owned because it was too close to a school, bus stop or playground	19.8 (10.9)	15.1 (11.9)	.83	9.9 (8.0)	6.6 (6.8)	1.45
I have had to move out of a residence that I rented because it was too close to a school, bus stop or playground	24.1 (10.2)	15.4 (12.5)	2.13*	11.2 (7.9)	6.4 (6.7)	2.22*
When I was released from prison, I was unable to return to my home or apartment because it was too close to a school, bus stop, park or playground	20.1 (12.5)	15.5 (11.7)	1.14	10.8 (8.2)	6.3 (6.5)	1.71
I was unable to live with my supportive family members because the residence was too close to a school, bus stop, park or playground	24.0 (14.5)	14.9 (10.8)	2.55*	10.8 (8.0)	6.0 (6.5)	2.20*
A landlord refused to rent to me because I am a sex offender	18.4 (13.0)	13.2 (9.7)	1.57	8.8 (7.5)	5.3 (6.0)	1.75
A landlord refused to renew my lease because I am a sex offender	20.1 (14.6)	13.4 (9.3)	1.48	9.0 (8.5)	5.9 (6.1)	1.14
I have found it difficult to find an affordable place to live that was not too close to a school, bus stop park or playground	22.9 (13.0)	9.5 (8.2)	4.37**	9.9 (7.9)	5.0 (5.7)	2.65*

**$p<.01$; *$p<.05$

for individual items) were analyzed individually. Cronbach's alpha for this subscale was .68. The fifth and final subscale (perceived negative residence restriction consequences) was composed of seven questions and rated on the 5-point Likert scale. This subscale concerned the perceived impact of residence restrictions (e.g., Because of housing restrictions, I live farther away from employment opportunities" and "Housing restrictions have led to financial hardships for me") which were summed to reflect a subscale score. In this sample, the Cronbach's alpha for this subscale was 0.81.

As mentioned above, items on the negative notification experiences and negative residence restriction experiences subscales were analyzed individually. According to Huberty and Morris (1989) it is appropriate to use multiple univariate analyses when the research being conducted is exploratory in nature

Demographic information Demographic data, including age, marital status, ethnicity, income, offense history, treatment involvement, assigned risk level, and subjectivity to GPS monitoring were also gathered. Identifying demographic data, such as age, was obtained using categorical variables so as to maximally preserve anonymity.

Results

Prevalence of symptoms of depression and hopelessness

The mean score on the BDI-II was 17.1 (SD=12.5; range 0–50), reflecting a mild level of depressive symptoms being reported by the community sex offenders in this sample. This is considerably higher than the level of depressive symptoms found in college student populations (M=8.36; SD=7.16; Whisman et al. 2000). Further, the score is above the cutoff that differentiates those with clinical depression from community samples (Seggar et al. 2002). The mean score on the BHS was 6.9, (SD= 6.9; range 0–20), reflecting a mild level of hopelessness among the sex offenders in this sample. This value is also higher than that found in the general population (M= 4.45; SD=3.09; Greene 1981).

Overall, no significant differences were found on the BDI-II and the BHS between offenders of different age ranges or ethnicities. Moreover, no differences were found with regard to type of offense.

Approximately 14% of the respondents reported depression scores that fell within the moderate range of severity, while 21% reported severe levels of depression. Notably, approximately 43% of the respondents reported some degree of suicidal ideation.

Sex offenders who were identified as high risk (Tier III) reported more overall symptoms of depression (M=21.17; SD=14.55) but not hopelessness (M=9.00; SD=1.59) as compared to the levels of depression (M=17.00; SD=12.48) and hopelessness (M=10.11; SD=9.00) reported by those at moderate risk (Tier II). However neither of these differences was statistically significant.

Significant differences in levels of depression and hopelessness were found between those sex offenders who were currently in treatment (M_{BDI}=21.87; SD= 13.97; M_{BHS}=8.70; SD_S=7.61) and those who were not in treatment (M_{BDI}=14.86;

SD=11.13; M_{BHS}=5.77; SD=6.27). Specifically, those who were in treatment were found to be more depressed (t=2.65, p=.01) and more hopeless (t=2.00, p<.05) than those who were not in treatment.

Impact of Community Notification

Overall, the perceived negative notification consequences subscale (which includes feelings of isolation, loss of friends, and fear for one's own safety), was significantly positively related to feelings of both depression (r=.53, p<.01) and hopelessness (r=.37, p<.01).

An examination of the items on the negative notification experiences subscale revealed that those sex offenders who reported having lost a job, having been forced out of residences they owned, having been threatened, harassed or physically assaulted, having had their property damaged, or having had a loved one who suffered consequences as a result of community notification reported significantly higher levels of both depression and hopelessness than those sex offenders who did not report negative consequences as a result of the registry (see Table 1).

Offenders who reported that they lost a job as a consequence of community notification reported significantly higher levels of depression (t=−2.57, p<.05) but did not report significantly higher levels of hopelessness. Notably, no significant differences in levels of depression or hopelessness were found between offenders who were forced out of rental properties by either landlords or neighbors as a result of public disclosure, and those who did not report having been forced to move.

Offenders who reported more positive perceived consequences of community notification on the perceived positive consequences of notification subscale such as being more able to manage their risk and feeling more motivated to prevent offending, also reported significantly fewer symptoms of depression (r=−.24, p<.05), as compared to those who did not report as many perceived positive consequences of community notification. Those who reported positive consequences of notification did not, however, differ in terms of hopelessness scores from those who did not report benefits to notification.

Impact of Residence Restrictions

There was a significant positive correlation between scores on the perceived negative residence restriction consequences subscale and scores on the BDI-II (r=.44, p<.01) and BHS (r=.53, p<.01). More specifically, when examining the items on the negative residence restriction experiences subscale, those offenders who reported that they were unable to live close to supportive family reported higher levels of depression (t=2.55, p<.05) and hopelessness (t=2.20, p<.05) than those who did not report having been unable to live near family. Offenders who reported that they were unable to find affordable places to live that were not too close to a school, bus stop or park were also significantly more depressed (t=4.37, p<.01) and hopeless (t=2.65, p<.05) than those who did not report such. Finally, those who reported that they had to move out of rental residences due to housing restrictions also reported

higher levels of both depression and hopelessness than those who did not report such (BDI-II; t=2.22, p<.05; BHS t=2.13, p<.05) (see Table 2).

No significant differences were found on the BDI-II and the BHS between those offenders who were who were allowed to return to their former neighborhoods or residences and those who were not, and those who were subjected to electronic monitoring and those who were not. Furthermore, levels of depression and hopelessness were not found to be related to the number of times the sex offender reported having had to relocate.

Discussion

This study examined the prevalence and correlates of symptoms of depression and hopelessness in a sample of sex offenders subject to community notification, some of whom were also subject to residence restriction legislation. In general, sex offenders in this sample reported mild to moderate levels of depressive symptoms and mild to moderate levels of hopelessness. Additionally, as hypothesized, we found that symptoms of depression and hopelessness were found to be positively correlated with the degree of perceived negative impact of community notification and registration legislation. Furthermore, offenders who reported having been negatively affected by residence restrictions also reported higher levels of both depressive symptoms and hopelessness.

Overall, as predicted, sex offenders in this study reported levels of depressive symptoms and hopelessness that were higher than those of the general population. These findings are in line with previous research suggesting that sex offenders may have higher level of mood disturbance than those evidenced in normative samples. This study was unable to determine whether these offenders had existing negative affectivity which manifested prior to the sex offense arrest, or whether the depressive symptomatology occurred as a result of the arrest and subsequent consequences. Either way, these findings are cause for potential concern as some studies have found that negative mood states such as depression can precede and in fact contribute to deviant sexual behavior (Nelson et al. 1989; Ward and Hudson 1998). These findings suggest that sex offenders in the community who are experiencing depressive symptoms may be at increased risk for reoffending, and as such, and treatment interventions should address how to cope with negative mood states, including those that may be associated with sex offender specific legislation. One offender, for example, in noting that residence restrictions "force people out of areas," stated that such policies "cause anger that leads to re-offending."

While as a whole this sample appeared to exhibit higher rates of depression than those found in the general population, sex offenders who reported experiencing more negative consequences of notification and residence restrictions reported more elevated levels of depression and hopelessness. Further, perceiving more negative outcomes, whether they were experienced or not, also was related to increased levels of depressive symptoms and hopelessness. These findings suggest that community protection legislation may in fact be destabilizing to sex offenders, thus operating counter to the intended goal of decreasing sex offender recidivism. The factors most strongly associated with significantly higher levels of depressive symptoms and

hopelessness were difficulties maintaining employment or housing, and verbal or physical harassment or assault. One of the key tenants of rehabilitation is reintegration back into the community. However, if such statutes increase or exacerbate stressors (e.g., employment difficulties, transience, isolation, depression, or hopelessness) that bear some relationship to recidivism, this legislation may become counter-productive and increase risk (Levenson and Cotter 2005a, b). As Hanson and Harris (1998) noted when discussing risk factors for sexual offense perpetration, "Offenders are most at risk for reoffending when they...show sharp increases in dysphoric moods, particularly anger" (page 33).

Notably, however, offenders who were in treatment reported higher levels of distress than those who were not in treatment. Upon first glance, this finding appears counterintuitive. It is possible that depressed offenders have already been connected to treatment services as a result of their difficulties. It is also possible that sex offenders in treatment share their negative experiences with each other, resulting in vicarious or anticipatory depression related to the hardships they hear from others in their treatment groups. An alternative explanation is that those offenders in treatment, having vocalized antecedents or correlates of their offending behavior, are more cognizant of their dysphoric affective states. It is thus plausible to speculate that this may temporarily increase awareness of negative affective states, though negative affect will decrease with time. One study found that symptoms of depression decrease following sex offender treatment (Jeglic et al. 2001). However more research about the relationship between negative mood states and sex offender treatment is needed before any firm conclusions can be made.

There are several limitations to the current study. First, while 1601 surveys were mailed out, only 137 (9.5%) were returned. While this response rate is in line with those of previous studies of survey mailings to registered sex offenders (Tewksbury and Lees 2006) it still limits the generalizability of the findings as there may be some self-selection differences between those sex offenders who chose to respond as compared to those who chose not to respond. However, it should be noted that general characteristics such as age, tier level, ethnicity and victim type of those offenders who did respond were comparable to the characteristics of offenders listed on the New Jersey registry. Second, validity and reliability of the measures may be limited by the self-report nature of the study. For example, sex offenders might be more apt to exaggerate their symptoms in an effort to inspire sympathy or to focus attention on the negative psychosocial effects of contemporary policies. Furthermore, while we were able to assess levels of depressive symptoms, self report does not permit us to diagnose clinical depression. Future studies could incorporate structured clinical interviews to ascertain the level of depression within this population. Finally, the findings of this study represent a sampling of dysphoric states at one moment in time and consequently we cannot conclude that these symptoms are a consequence of community notification and registration policies. While we can speculate that there is some relationship between the variables, only longitudinal studies designed to examine affective states in relation to sex offender legislation over time can more definitively answer these questions.

Nonetheless, these findings suggest a number of important implications for practice and policy. First, given observed levels of depressive symptoms and hopelessness in this population, these issues deserve attention in the treatment

community. Serious affective symptomatology warrants clinical attention, particularly if such symptoms bear some relationship to risk for recidivism. Treatment for affective disorders that addresses the link between negative emotionality and offending would be especially prudent. By enhancing offenders' emotional regulation skills, treatment may work to promote emotional stability and thereby help prevent future sexual offense. Offenders should also have access to affordable high-quality psychiatric assessment and pharmacological intervention. These findings, taken in conjunction with a growing body of literature identifying the collateral consequences of notification statutes and residence restrictions (Levenson and Cotter 2005a, b; Levenson et al. 2007a, b; Levenson and Hern 2007; Mercado et al. 2008; Tewksbury 2005), suggest that further review of these policies is needed. As noted, research on the effectiveness of Megan's Laws has produced very limited support for its effectiveness. Furthermore only one study to date has assessed whether residence restrictions reduce sexual recidivism, finding no significant decreases in recidivism when more restrictive residence ordinances were enacted (Youstin et al. 2008). Given mounting data observing the unintended consequences of these legislative initiatives in tandem with the current data documenting increased negative affective emotionality, stakeholders should closely examine whether legislative efforts are likely to achieve their purported goals especially in light of the passage of SORNA legislation.

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