REPORT OF THE
DEPARTMENT OF HEALTH PROFESSIONS ON

Feasibility and Desirability of Establishing a Program of Certifying Persons Who Provide Mental Health Treatment to Sexual Assault Victims and Offenders

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 17

COMMONWEALTH OF VIRGINIA
RICHMOND
1993

COMMONWEALTH of VIRGINIA

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December 18, 1992

TO: The Honorable Lawrence Douglas Wilder
Governor of the Commonwealth of Virginia

The Members of the General Assembly of Virginia

I am pleased to transmit this report which constitutes the response of the Virginia Department of Health Professions to Senate Joint Resolution No. 41 of the 1992 Session of the General Assembly of Virginia.

This report offers the results of the Department's study on the feasibility and desirability of establishing a program for certifying or otherwise assessing the credentials of persons, particularly therapists, who provide mental health treatment to victims of sexual assault and sexual assault offenders.

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BLHjr/lbb
Enclosure

pc: The Honorable Howard M. Cullum
Secretary of Health and Human Resources

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SENATE JOINT RESOLUTION NO. 41

Requesting the Department of Health Professions to investigate the feasibility and desirability of establishing a program for certifying persons who provide mental health treatment to victims of sexual assault and sexual assault offenders.

Agreed to by the Senate, February 11, 1992
Agreed to by the House of Delegates, February 24, 1992

WHEREAS, in the spring of 1991, the Lieutenant Governor of the Commonwealth convened a task force to examine how the Commonwealth is responding to issues concerning sexual assault; and

WHEREAS, after a thorough review of recently completed and current work, the task force decided to concentrate its attention on prevention, early identification, and intervention for at-risk children and youth and to focus on victims of child abuse, particularly sexual abuse; and

WHEREAS, the task force established as a goal the development of a plan for the Commonwealth to ensure the provision of comprehensive, safe, supportive, and accessible services to all sexual assault victims under the age of 18 and to aid those victims in their recovery from sexual assault; and

WHEREAS, the task force found that there are a number of persons who offer mental health services to victims of sexual assault and that there is a wide variation in the experience, training, and education of those persons; and

WHEREAS, persons who are not qualified to provide services to victims of sexual assault, regardless of their motivations or intentions, may actually injure or impede the recovery of victims of sexual assault; and

WHEREAS, there are no generally recognized comprehensive methods in place to verify or assess the qualifications of providers of recovery services to victims of sexual assault or sexual assault offenders; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Health Professions be requested to investigate the feasibility and desirability of establishing a program of certifying or otherwise assessing the credentials of persons, particularly therapists, who provide mental health treatment to victims of sexual assault and sexual assault offenders.

The Department of Health Professions shall submit a report to the Governor and the 1993 Session of the General Assembly pursuant to the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

REPORT, FINDINGS AND RECOMMENDATIONS

Background and Authority for the Review

House Joint Resolution No. 41 of the 1992 Session of the Virginia General Assembly requested the Department of Health Professions to study the need for special certification or other credentialing of providers of mental health services to sexual assault victims and sex offenders. The request resulted in part from 1992 recommendations of the Lieutenant Governor's Task Force on Prevention and Early Intervention to Reduce the Incidence of Sexual Assault.

That task force found that there are a number of persons who offer mental health services to sexual assault victims and offenders, and that there is a wide variation in their education, training and experience. The Resolution noted that those who are not qualified to provide services to sexual assault victims and offenders -- regardless of their motivations or intentions -- may injure or impede the recovery of victims.

Related observations and recommendations were made by the Governor's Task Force on Substance Abuse and Sexual Assault on College Campuses. Recommendation 40 of that 1992 report requested the Board of Health Professions to "ascertain whether further continuing educational programs are needed to equip counselors to advise students in cases of sexual assault and to consider whether certification in this area is needed." Similar observations and recommendations were also made in the Report of the State Council of Higher Education and Task Force on Campus Rape to the 1992 General Assembly (Senate Document No. 17).

The Department and the Board of Health Professions determined to combine the requested reviews into a single comprehensive effort in the belief that the findings and recommendations of this effort will be relevant to the several concerns expressed in earlier reviews of sexual assault in the Commonwealth.

Currently regulated providers of mental health and counseling services in Virginia include psychiatrists and clinical psychologists licensed by the Board of Medicine, counseling and other psychologists licensed by the Board of Psychology, professional counselors and others licensed or certified by the Board of Professional Counselors, clinical social workers licensed by the Board of Social Work, and psychiatric mental health clinical nurse specialists regulated by the Board of Nursing.

Regulatory boards within the Department of Health Professions are authorized to promulgate regulations specifying additional training or conditions for individuals seeking certification or licensure, or for the renewal of license or certificates (Code of Virginia Sec. 54.1-103). In addition, the Boards of Professional Counselors, Psychology and Social Work are explicitly authorized to designate specialties within the professions of counseling, psychology and social work, and to cooperate and maintain liaison with other professional boards and the community "to ensure that regulatory systems stay abreast of community and professional needs." (Code Secs. 54.1-3505.1, 3605.1, and 3705.1). No board in the Department has designated providers of mental health and counseling services to sexual assault victims or offenders as a specialty.

Study Methods

The review requested by SJR No. 41 was conducted by a special task force of the Board of Health Professions, chaired by a citizen member of the Board of Health Professions and that Board's members, from the Boards of Medicine, Professional Counselors, Psychology and Social Work. Special advisors also assisted the task force. The study was coordinated with the Lieutenant Governor's Task Force on Sexual Assault and was approved unanimously by the Board of Health Professions at a meeting on October 20, 1992.

The study included a review of the public record of recent policy studies of sexual assault in the nation and the Commonwealth, a review of the scientific and professional

literature, a survey of other states, a public hearing and the solicitation and review of public comments.

The discussion, findings and recommendations which follow are based on information gathered through all these activities, but the task force found greatest guidance in the comprehensive review of the literature which forms the centerpiece of this report. That review examines major theories of the causes of sexual assault, explores issues related to the treatment of sexual assault victims and offenders, and draws implications for public policy which are warranted by the accumulated body of scientific and professional evidence.

Discussion

Sexual assault is of growing concern in our society. While there is overall consensus on the devastating and pervasive effects of sexual assault, there are differing views of its causes.

Social theory locates the causes of sexual assault in the imbalance of power in patriarchal societies, in rape myths, and in the sexual socialization of males. The psychopathology model, on the other hand, locates the causes of sexual deviance in the individual offender. Those who hold this view argue that psychological factors such as family background, patterns of deviant arousal, sexual victimization in childhood, cognitive distortions, and alcohol interact in complex ways to produce sexual assault. The best explanations of this complex behavior involve the interaction of a variety of social and psychological factors.

Whatever the causal explanations for sexual assault, the primary goals of treatment are clear: victims of sexual assault should be restored to social and psychological health, and sex offenders should be prevented from repeating the offense. The prevalence of the problem of sexual assault guarantees a continuing market for professional mental health and counseling services for both victims and offenders.

According to Virginia law, the right of every citizen to engage in any lawful profession, occupation or trade is guaranteed by the Constitution of the United States and the Constitution of the Commonwealth of Virginia. The Commonwealth cannot abridge this right except when it is necessary for the preservation of the health, safety and welfare of the public. No regulation may be imposed upon any profession or occupation except for the exclusive purpose of protecting the public interest. Four conditions must be met for the imposition of new regulation of occupations and professions:

1. The unregulated practice of the profession or occupation can harm or endanger the health, safety or welfare of the public, and the potential for harm is recognizable and not remote or dependent upon tenuous argument;

2. The practice of the profession or occupation has inherent qualities peculiar to it that distinguish it from ordinary work and labor;

3. The practice of the profession or occupation requires specialized skill or training and the public needs, and will benefit by, assurances of initial and continuing professional and occupational ability; and

4. The public is not effectively protected by other means.

(Code Sec. 54.1-100)

The Commonwealth has earlier determined these conditions to be present in the case of the general practice of psychiatry, clinical and other psychology, professional and other counseling, social work and clinical social work, and psychiatric mental health nursing by clinical nurse specialists.

The primary policy question arises as to whether treatment needs, goals, and techniques for sexual assault victims and sexual assault offenders are sufficiently different from those of these existing regulated professions to warrant specialty certification or credentialing.

The findings and recommendations which follow are addressed to these policy questions. First, the needs and characteristics

of sexual assault victims are addressed, then findings and recommendations related to offenders are presented.

Findings and Recommendations

The task force has examined available evidence related to mental health and counseling treatment needs, goals and techniques for victims of sexual assault and for sex offenders. The nature of the problem, the profile of the two client populations, the appropriate treatment techniques, and the objectives of treatment for the two groups are fundamentally different.

Mental health and counseling services for sexual assault victims may be safely and appropriately provided by members of those professions which are required to be licensed or certified to provide these services for the general population in the Commonwealth. Mental health and counseling services for sexual assault offenders should be provided by individuals who are specially trained in all aspects of offender treatment and who are certified by appropriate agencies of the Commonwealth to provide offender treatment services.

Victim Treatment. While the victims of sexual assault are legion, their reactions and responses to sexual victimization are extraordinarily diverse. Of special concern to this review are the reactions, responses, and treatment needs of victims of childhood sexual abuse.

The intensity of these responses depends on the interaction of factors such as the frequency, duration and severity of the abuse; the age, developmental level and coping style of the child; and the characteristics of the perpetrator and the sex act. Serious negative reactions are more likely when the perpetrator is the parent or parent figure of the victim, when the abuse involves genital contact, and when force is used in the commission of the abuse.

Clusters of short- and long-term effects have been documented in the victim population. Initial effects with children include fear, anxiety, depression, anger, aggression,

and sexually inappropriate behavior. These initial responses may be effectively treated if the victim is identified and appropriate professional care is provided.

Most sexual abuse, however, goes unreported, and as a consequence initial responses may increase in intensity or may manifest later in life in depression, destructive behavior, anxiety, feelings of isolation and stigmatization, poor self-esteem, poor interpersonal relationships, revictimization, sexual maladjustment, and substance abuse. Most, but not all, childhood sexual assault victims experience some combination of these long-term effects in their lifetimes.

Several systems for classifying, diagnosing and treating these effects are currently in use, notably the Post Traumatic Stress Disorder and the Traumagenic Dynamics models. Regardless of the pattern of symptoms or how the symptoms are categorized, treatment generally fits into the traditional framework of mental health and counseling services. Treatment typically addresses issues such as fear, anxiety, ventilation of feelings, altering attributions of responsibility, explaining the offense and the offender's behavior, restoring and building expectations for self-efficacy, and sex education.

Appropriate treatment requires training and knowledge of the dynamics and the emotional and behavioral consequences of abuse. In addition, professional societies suggest that the therapist who works with child victims have knowledge of child development, family dynamics related to child abuse, and the assessment of children, adolescents and families.

Comments from therapists and sexual abuse survivors clearly indicate the need for therapists to have adequate knowledge and training in victim issues and treatment. Therapists generally believe that their professional education does not adequately prepare them for their practice in these areas, and that on-going education in victim issues and treatment needs to be more widely available to practicing professionals.

There is professional consensus, however, that victim treatment falls well within the general competency of professional groups licensed or certified to provide mental

health and counseling services in the Commonwealth. Sexual assault victims come into mental health treatment with a variety of presenting problems; they do not present a single clinical picture or diagnosis. Given the prevalence of sexual assault, these patients form a significant segment of the general treatment population. Moreover, discovery of the sexual trauma earlier in life may not occur until the patient is well into the treatment relationship. Establishing and building this therapist-client relationship may be more important than the use of any specific techniques in the provision of professional services.

FINDING. The task force finds no convincing evidence of the need for special certification or credentialing of professionals who provide mental health and counseling services to sexual assault victims when these professionals are licensed or certified by boards within the Department of Health Professions to provide these services to the general population.

There is a need to better prepare mental health and counseling professionals for practices which will include significant numbers of sexual assault victims. This need includes preparation at the practice entry level and assurances of continued competency throughout the career of the practicing professional.

RECOMMENDATION. The Department recommends that the State Council of Higher Education in Virginia and the Virginia Community College System study and resolve the need for greater exposure to the causes and consequences of sexual assault in professional educational programs for current and future practitioners of psychiatry, psychology, professional and other counseling, social work, and psychiatric mental health specialty nursing. These agencies should consult with all relevant public and private agencies in documenting and filling the need for these programs.

Offender Treatment. The safety needs of the community supercede the needs of offenders in the provision of mental health and counseling services to sex offenders.

Sex offenders differ in many respects from the typical population served by mental health and counseling professionals. Most offenders do not seek or want treatment; they submit to treatment because they are mandated to do so by the judicial system. Once in therapy, sex offenders deny, minimize and rationalize their behavior in an attempt to deceive themselves and others related to the existence of their problems and their needs for treatment. Sex offenders are deceptive in that they do

not view themselves to be, or appear to be dangerous on the surface. They maintain a facade of concern and responsibility.

For these and other reasons, traditional insight-oriented therapy for sex offenders is not effective. Current approaches to treatment are based instead on the addiction model which assumes little motivation and cooperation in the initial stages of therapy. Denial and minimization are confronted throughout the treatment process. The current view of most sex offender treatment programs is that offending is an addictive behavior which can never be "cured," but can only be controlled through constant monitoring.

Treating sexual offenders requires the use of traditional psychological techniques such as covert sensitization, cognitive restructuring, aversion therapy, social skills training, and assertiveness training, and in addition may use specialized techniques such as antiandrogen drug therapy, satiation, decreasing deviant arousal and increasing appropriate arousal, confrontation, and extensive relapse prevention.

Areas of expertise the sex offender therapist should possess include knowledge of sexual deviancy and offender characteristics, the impact of sexual abuse on the victim, knowledge of the role of the criminal justice system and of laws concerning sexual assault, and knowledge of community resources. In addition, it is suggested that the therapist have supervised practical training working with the sex offender population. A qualified therapist who has such training and experience is unlikely to be unwittingly duped into collusion with the sex offender or to contribute in any other way to subsequent sex offenses.

Therapy with the sex offender can initially serve as a means for the social control of the offender. With continued treatment and relapse prevention to maintain therapeutic gains, the offender may be able to control behavior and prevent future problems.

While licensed or certified mental health and counseling professionals may be reasonably expected to be competent in some of these techniques, evidence indicates that the typical licensee may not be proficient in all the techniques, nor sensitized to the differing goals and objectives that must characterize sex offender treatment.

FINDING. The Department finds that there is a need for providers of mental health and counseling services to sex offenders to be specially certified by the Commonwealth. This additional regulation is warranted by virtue of the need for the certified provider to protect the public from the sex offender and to be accountable for the treatment provided, by emerging and unique treatment techniques applicable to this client population, and by the lack of other assurances of initial and continuing competence currently in place.

- **This certification should be <u>in addition</u> to licensure or certification within an existing professional group (psychiatry, clinical or other psychology, professional or other counseling, clinical social work, psychiatric**

clinical nurse specialist) in all cases in which a license or certificate to practice in the Commonwealth is required.

RECOMMENDATION. It is recommended that the General Assembly authorize the Department of Health Professions to develop a plan for a certification program for providers of mental health and counseling services to sexual assault offenders.

- This plan should be developed in consultation with appropriate regulatory boards and other public and private agencies, to include:
  - any recommended changes in statute required to accommodate the certification program;
  - proposed regulations to be used to implement the certification program, including all requirements for certification;
  - a timetable for implementation of the plan;
  - a system to evaluate the certification plan at the end of five years to determine its continued utility and necessity;
  - The plan should be submitted to the 1994 General Assembly for consideration and action.

LITERATURE REVIEW

I. Introduction

Sexual assault is a frequent occurrence in our society and one of increasing social concern. For a number of reasons, including secrecy, stigma, under-reporting, and the use of differing populations in studies and surveys, the exact prevalence is unknown. Studies of the general population have reported that upto 38 percent of adult women have been victims of sexual assault; surveys of clinical populations report dramatically higher rates (Salter, 1988).

The best estimates come from comprehensive studies using precise research methods, well-defined categories and narrow definitions of assault or abuse (Badgley, 1984; Russell, 1984). These studies indicate that between 22 and 38 percent of females and about ten percent of males under the age of 18 have been sexually abused. Data from rape studies indicate a similar prevalence, suggesting that there is a one-in-five chance that a woman will be the victim of a completed rape sometime in her life. When attempted rapes are included, these chances increase to one-in-three (Russell & Howard, 1983).

These alarming facts have focused strong interest in the causes and consequences of sexual assault and in the treatment of sexual assault victims and offenders by mental health professionals and others. This literature review has been prepared to assist policymakers in considering whether special credentialing of those who provide treatment to sexual assault victims or offenders may be necessary or desirable.

In the review, major theories of the causes of sexual assault will be examined (Part II); issues related to the treatment of sexual assault victims and offenders by mental health professionals, including evidence of the effectiveness of treatment will be explored (Part III); and the implications of the literature for public policy will be presented (Part IV). A reference of all sources reviewed appears as an appendix.

II. Theories of Sexual Assault

There are two dominant causal theories which, when stated in their most extreme versions, seem diametrically opposed and irreconcilable (Malamuth, Check & Briere, 1986).

- One view of sexual assault, anchored in sociological theory, finds the causes of sexual assault to be deeply imbedded in the social fabric. The sociological viewpoint argues that rape is a learned deviant behavior found in those patriarchal societies in which the social, economic and political structure support sexual violence against women and children (Brownmiller, 1975; Burt, 1980; Scully, 1990).

- Mental health perspectives focus on the psychopathology of the sexual assault offender. This model locates the problem of sexual assault in the abnormal sexual behavior of the individual offender. According to this view, some offenders are motivated by a sexual preference for children (as in the case of the child molester) or (in the case of the rapist) toward violent or aggressive interactions (Abel, Barlow, Blanchard, & Guild, 1977).

Because the two theories have very different implications for treatment and problem-solving, they are worthy of more extensive discussion.

Sociocultural Causes of Rape

The sociological perspective has traditionally focused on social and cultural values that may be responsible for all human behavior, including sexual assault. Early social research considered sexual assault as essentially sexual in nature, but in recent years a new viewpoint has emerged, stemming in large part from the resurgence of the women's movement (Darke, 1990; Scully, 1990).

This new sociopolitical framework includes attention to the nonsexual needs served by sexual assault and a redefinition of sexual assault as essentially an act of aggression containing sexual components (Darke, 1990). Currently, sexually violent behavior is thought to be motivated by power and control (Burgess & Holmstrom, 1986; Groth, 1979; Brownmiller, 1975).

Conceptualized in this manner, research has emphasized the common elements of various forms of sexual aggression previously regarded as different, linking sexual abuse of children and sexual abuse of women (Russell, 1984; Rush, 1980). The common element is the low level of social, economic and political power held by the victim.

The perspective locates the predisposition for sexual assault in the imbalance of power in patriarchal societies (Scully, 1990, Herman, 1988). Females and children are characterized by a lack of power relative to adult males in political, economic, and social domains. Most positions of power that shape and maintain the legal, financial, and social institutions are occupied by males, and a high value is placed on "masculine" modes of thought and behavior (Stermac, Segal & Gillis, 1990).

The consequences of patriarchy are apparent in the socialization of males and females alike. Masculinity is identified with attributes such as strength, intelligence, aggressiveness and independence, while femininity is associated with a lack of intelligence, submissiveness, and abdication of personal and social power to males. This sociocultural environment both reflects and maintains the power imbalance between the sexes (Darke, 1990) and accounts, at least in part, for domestic violence against women and

children. This violence, although diminished in recent times, continues to occur with disturbing frequency (Dabash & Dobash, 1979).

In addition to its focus on social structural differences in power, this perspective also takes into consideration a number of subjective influences such as belief in the "rape myth," the view of rape as "normal" deviance, and the role pornography plays in support of power differences between the sexes.

Rape Myths. Research indicates that the greater the degree of sex role stereotyping, adversarial sexual beliefs, and tolerance of interpersonal violence in the social order, the higher will be an individual's belief in rape myths (Burt, 1980). Rape myths include beliefs that:

- o characteristics of the behavior of women cause men to rape;
- o women could avoid rape if they tried;
- o women ask for and secretly enjoy rape; and
- o women use the charge of rape vindictively to punish men.

The myths result in denial or reduction in the perceived harm created by sexual assault, and in "blaming the victims" for their own victimization (Scully, 1990; Burt & Albin, 1981; Burt, 1980).

Recent social research has examined how rape myths are linked to how rape is defined and legally institutionalized (Lipman-Blumen, 1984; Scully, 1990; Burt & Albin, 1981; Burt, 1980). Acceptance of rape myths may lead to a narrow definition which excludes the reality of many rapes. Rejecting these assaults as real rapes makes prosecution harder, the victim's recovery more difficult, and the assailant's actions safer (Burt, 1980).

Rape myth acceptance has been shown to directly affect society's willingness to convict assailants. Rape research using a mock jury paradigm consistently confirms conviction rates less than ten percent (Burt, 1980). By contrast, rejection of rape myths exerts the opposite effect, tending to broaden the definition of rape and to result in more willingness to convict the offender (Burt, 1980).

Rape as "Normal" Deviance. In our culture, rape-supportive attitudes and beliefs are widely held, leading to the prevalent view that rape is an extension of normal male behavior (Scully, 1990; Herman, 1989). To understand this view fully, it is important not only to examine how socialization teaches males to have expectations about their level of sexual needs, but also the way in which socialization affects women's accessibility, which, in turn, justifies forced sexual interactions (Scully, 1990).

Findings from various studies suggest that the adolescent male subculture provides a social arena conducive to indoctrination into sexual violence (Herman, 1989). Martin and Hummer (1989) found that college fraternities, in particular, create an environment in which sexual coercion in relationships with women is commonplace and regarded as normal.

Koss, Gidycz, and Wisniewski (1987) conducted a large-scale study of college men and women that showed that more than one-half of all college women reported some form of sexual victimization after reaching the age of fourteen. Among male students, one-quarter reported involvement in some form of sexual aggression.

Other studies of the sexual proclivities of "normal" males have found that more than one-third of male college students admit to some likelihood of committing rape when assured they would not be caught or punished (Briere & Malamuth, 1983; Malamuth, 1981; Tieger, 1981; Malamuth & Check, 1980; Malamuth, Haber, & Feshbach, 1980). These attitudes exist at even younger ages. One study showed that a majority of male high school students report that date rape is acceptable under a variety of circumstances (Goodchilds & Zelman, 1984).

There is mounting evidence indicating that adolescence is a critical period in the development of sexually assaulting behavior. Clinical studies consistently reveal that between one-quarter and one-half of habitual sexual offenders admit to the onset of sexually deviant behavior in adolescence (Marshall, Laws & Barbaree, 1990; Herman, 1988; Salter, 1988).

Role of Pornography. In addition to the influence of sex role stereotypes, other aspects of the cultural climate, including media portrayals of women, contribute to sexual violence. Of particular concern is the profusion of degrading images of women and the increasing amount and degree of violence appearing in pornography (Scully, 1990). Pornography and advertisers often depict women as objects for male use (Stermac et al., 1990). Content analysis of pornography shows that the predominant theme depicts men achieving sexual goals by dominating women who enjoy being humiliated (Stermac et al.,1990). These depictions convey the message that the use of force is a part of the normal male-female relationship and trivialize the trauma of rape.

Moreover, current depictions often suggest that sexual violence has positive outcomes. Laboratory studies using male college students support the view that media depictions of victim arousal to rape can contribute to men's belief in the rape myth which holds that women enjoy being raped (Malamuth & Check, 1985).

While depictions of these kinds are pervasive in the media and especially in pornography, the evidence does not support the claim that pornography plays a causal role in sexual assault (Stermac et. al., 1990). Rather, it appears that pornography affects individuals differently at different points in their development. For example,

research indicates that while both sexual offenders and non-offenders report masturbating to pornography in adolescence, most non-offenders outgrow pornography in later years. For offenders, however, pornography may become increasingly important to sexual stimulation. Adult sex offenders also show greater compulsion to own pornography, and report that they use it more than non-offenders.

In summary, the social causes of rape include the interaction of male dominance, acceptance of interpersonal aggression, and sexual arousal. Malamuth and Check (1985) found that men with higher inclinations to act aggressively against women are likely to be affected by media depictions of rape. Rather than playing a direct causal role, pornography reinforces the views that sexually aggressive men already hold (Stermac et al., 1990).

Research of this kind highlights the importance of examining individual factors when considering the social causes and correlates of sexual assault. Although it may at times seem that the mental health/psychopathology and the sociocultural perspectives are incompatible, it is increasingly evident that sexual assault is the product of many interacting variables, and that no single variable can account for all aspects of this complex behavior (Barbaree & Marshall, 1988; Finkelhor, 1986; Malamuth, 1986).

Psychological Factors in Sexual Assault

The mental health community has traditionally viewed sexual assault in terms of "abnormal" deviance or psychopathology. While this approach has been criticized for ignoring the social and situational context in which sexual assault occurs (Scully, 1990), more recent research in the mental health/medical model incorporates social assessment as a part of the diagnosis of the sexual offender (Herman, 1988). Within the individual, sexual assault may result from many factors including social triggers and social cues that such behavior is at least implicitly condoned.

Mental health clinicians rely on classifications of individual pathology such as the Diagnostic and Statistical Manual (DSM-III-R) of the American Psychiatric Association (1987) to clarify treatment issues and goals. The classifications or diagnostic categories are based on the regularity with which certain characteristics occur together clinically. DSM-III-R identifies one class of sexual disorder as the "paraphilias."

A paraphilia is defined as a deviation or abnormality in the nature or object of an individual's sexual attraction. Paraphilias include intense and recurrent sexual images and sexually arousing fantasies involving (1) nonhuman objects, (2) the suffering or humiliation of oneself or one's partner, or (3) children or other non-consenting persons.

Although there is a specific subcategory of paraphilia for individuals who are attracted to children (pedophiles), there is no

explicit category designated for rape or rapists. Rape can, but does not always fit into the general classification of a paraphilia.

One of the simplest and best known typologies of pedophiles includes the "fixated pedophile," and the "regressed pedophile" (Groth,1978, Groth, Birnbaum & Habson & Gary, 1982).

The fixated pedophile (child molester) shows a primary and exclusive attraction to children from adolescence onward. It is believed that this condition results from arrested sexual and social maturation. This arrested maturation stems, in turn, from unresolved issues in development that inhibit subsequent normal development and persist in the pedophile's current personality functioning.

The fixated child molester avoids adult social contact when possible, and focuses his sexual thoughts and fantasies on children. Sexual activity with adults is viewed as unsatisfying, and even nonsexual contacts with adults may be associated with anxiety and feelings of inferiority. It is thought that the fixated male pedophile tends to choose boys in order to identify with the victim, perhaps as a consequence of the offender's sexual victimization in childhood (Simons, Sales, Kasziniak & Kahn, 1992).

Regressed pedophiles on the other hand are believed to "regress" temporarily into a more developmentally primitive form of sexual behavior. The regression is usually precipitated by situational stress, including physical, sexual, marital, and financial crises (Howell, 1981). The regressed pedophile prefers adult sexual partners but substitutes children because of failure in coping with adult demands. These sexual offenders tend to victimize girls because they are primarily invested in women in their adult relationships (Simons, Sales, Kasziniak & Kahn, 1992).

Groth (1987) also outlines a typology for rapists. He believes that all types of rape include three components (anger, power and sex), but the hierarchy, intensity, and inter- relationships among the three factors varies from one type of rape to another. In addition, he believes that there is sufficient clustering to distinguish several patterns of rape including "anger rape," "power rape," and "sadistic rape."

Several other researchers have developed models for classifying rape and rapists (Prentky & Knight, 1991; Overholser & Beck, 1990). The problem with these as well as with pedophile classifications is, when used, the classification criteria do not consistently differentiate the hypothesized offender types. For example, a study by Simons and his colleagues (1992) indicated that application of their own criteria for identifying fixated or regressed pedophiles produced instead a single continuous distribution rather than the two distributions hypothesized.

A theoretical distinction is also often made between "intrafamilial" and "extrafamilial" sexual abusers. Once again,

realities do not always confirm the ideal types. Abel and Rouleau's (1990), for example, found that one-third of the offenders they studied victimized both family and non-family members.

In addition, offenders do not always show clear gender preferences, evidenced by findings indicating that one-in-five offenders abused both girls and boys. This lack of clear gender preference may be explained in part by the fact that sexual offenders often have more than one current paraphilia. According to DSM-III-R reports, studies of clinical populations show that of those subjects who report paraphilias, an average of three to four is common.

Similarly, Abel, Mittelman and Becker (1985) found that one-half of their clinical sample of sex offenders, identified primarily as rapists, had also been involved in child molestation. Twenty-nine percent were also involved in exhibitionism, and a like number were voyeurs. Of his sample of child molesters, seventeen percent were also involved in rape, thirty percent in exhibitionism, and fourteen percent in voyeurism.

The clinical utility of a single typology of sexual offenders has been questioned by many, leading to the conclusion that a variety of personal factors, past and present involvement with the criminal justice system, and situational factors should be assessed on an individual basis to determine the unique factors involved in individual cases (Simons et al., 1992; Marshall & Barbaree, 1990).

Among the multiple causes and pathways for different sexual offenses and offenders, factors such as family characteristics, sexual victimization as a child, patterns of deviant arousal, and cognitive distortions may all play a role.

Family Characteristics. Family characteristics that may predispose sexual assault include poor and violent parenting. Marshall & Barbaree (1990) indicate that poor socialization in the family, especially violent parenting styles, tend to predispose the use of aggression and to cut the child or adolescent off from more appropriate socio-sexual interaction. Rada (1978) found that violence and sexual abuse were typical of the family lives of rapists.

Langevin et al. (1984) found that both mothers and fathers of rapists were poor parents with whom the child did not identify. Fathers were aggressive, drunken, and frequently involved with the police. Their sons in turn reproduced some of these same behaviors as they grew up. Knight, Prentky, Scheider & Rosenberg (1983) provide evidence that children's antisocial behavior -- developed from the context of a hostile home -- may lead to greater likelihood of committing rape in adulthood. Similar results have been found with child molesters (Marshall & Barbaree, 1990; Salter, 1988); however, Scully (1990) found that incarcerated offenders had similar histories, whether or not their offenses were sexual in nature.

Sexual Victimization in Childhood. A prevalent theory is that sex offenders were themselves sexually victimized in childhood or adolescence. This concept is referred to as the "cycle of abuse" or "generational transmission" (Ryan, 1989, Herman, 1989). The sexual offense is viewed as a reenactment of earlier trauma in an attempt to overcome it through identification with the aggressor (Herman, 1989, Ryan, 1989; Groth & Birnbaum, 1979).

Overholser and Beck's (1989) study indicated that 58 percent of child molesters and one-quarter of rapists in their sample reported being sexually abused as children. Only six percent of a control group of non-sexual offenders reported such abuse.

Several problems arise when the "cycle of abuse" theory is applied to sexual assault. The most obvious is the failure of the theory to explain why the majority of offenders are male and not female, since the more widespread abuse of girls as children would predict a higher incidence of adult female offenders as an outcome (Kaufman & Zigler, 1989; Herman, 1989). In addition, while socialization theory would predict that the cycle of abuse would lead men to become the sexual offenders and women to become the girlfriends, wives and victims of these offenders, there are no long-term studies that have followed abused children into adulthood to support this prediction. The sole evidence comes from retrospective studies which are plagued with problems such as sample bias.

The case of the pedophile appears to be an exception to the accumulating evidence against the cycle of abuse theory. In particular, histories of past abuse appear to be common in pedophiles who prefer male victims. Among homosexual pedophiles, rates of abuse in childhood range from 40 to 60 percent (Herman, 1989). Homosexual pedophiles are different from other sexual offenders in that (1) the deviant behavior has a particularly early onset, (2) there is a lack of interest in consenting adult sexual relationships, and (3) the behavior is extremely compulsive and resistant to treatment (Becker, 1989; Herman, 1989).

Thus, while there is some data to suggest that childhood sexual trauma for boys may be a particularly significant risk factor for the development of sexually abusive behavior directed at males, and while many sex offenders may have been sexually victimized, a causal relationship cannot be inferred (Brown & Finkelhor, 1986).

Deviant Sexual Arousal. A "normal" sexual arousal pattern is characterized by low arousal to children and stronger arousal to adults, particular to adults in mutually consenting relationships. Deviant arousal patterns may include arousal to inappropriate sex partners (e.g., children), arousal to sexual violence, or both. Although deviant sexual arousal patterns are often linked to sexual offenders, these factors, too, are more properly conceptualized as correlates than as causes.

Because self-reports of deviant sexual arousal may be highly unreliable, a more direct assessment of sexual arousal is often made with the penile plethysmograph. Use of this instrument is currently the most valid and reliable means of determining sexual preference (Salter, 1988).

Freund (1978) developed this device which records the volume changes in the penis as it becomes erect. A transducer charts changes in tumescence in response to stimuli which include photographs or slides, audiotapes or videotapes. Videotapes are believed to be the best stimuli (Salter, 1988). Audios or videos may record or depict children ranging in age from preschool to adolescence, or adults of either sex. In addition, varying degrees of force and violence may be depicted or recorded in the stimulus material.

A review of the research by Salter (1988) indicated that the plethysmograph has been useful in (1) differentiating rapists from nonrapists, (2) determining an individual's interest in sexual sadism, (3) identifying child molesters, (4) separating recidivists from nonrecidivists, and (5) measuring responses to treatment.

Certain qualifications need to be made about the differing effectiveness, propriety, and limitations of the plethysmograph when the technology is applied to various types of sex offenders.

- In general, the plethysmograph has more reliably identified the deviant arousal patterns of pedophiles than those of rapists (Marshall & Eccles, 1991).

- Freund's (1987) cumulative work with the plethysmograph and child molesters revealed a consistent preference for children among nonfamilial child molesters; these results have been replicated by others (Murphy & Barbaree, 1988).

- This preference may be especially pronounced among pedophiles with an early onset of deviant arousal. The response may be so well ingrained that arousal to children is virtually automatic.

- With incest offenders, a group not aroused exclusively by children, Freund (1987) found a normal response pattern.

- Studies of rapists in which an arousal pattern was demonstrated indicate that arousal is a function of the frequency and amount of violence used in the commission of the crime. This means that deviant arousal may be characteristic of the most habitual and violent offenders (Abel et al., 1977 Abel et al, 1978).

- However, assessments of rapists which compare erectile responses to verbal descriptions of rape with responses to consensual heterosexual interactions have not shown good criterion-related reliability (Murphy & Barbaree, 1988).

These differing response patterns may be due to the ability of some offenders to suppress erectile responses at will or when instructed to do so. In addition, some offenders are able to moderate erectile responses to nonpreferred stimuli. In some circumstances, aggressive cues neither enhance the sexual arousal of rapists nor inhibit the sexual arousal of "normal" males (Barbaree, 1990). Faking of responses may also occur if the subject loosens the transducer or is not fully attentive to the stimulus material (Marshall & Eccles, 1990).

Moreover, the plethysmograph cannot determine whether an individual has committed a sexual assault. As a consequence, the most highly contended issue is whether or not evaluation can or should contribute to a determination of guilt or innocence (Marshall & Eccles, 1991, Becker, 1989).

In summary, assessments of deviant arousal patterns appear to be most useful in the evaluation of nonfamilial child molesters and the most habitual and violent rapists. Sexual arousal to aggressive stimuli does not appear to be an exclusive or essential characteristic of all identified rapists or pedophiles. Conversely, the absence of a deviant arousal pattern alone cannot confirm that an individual is not a sexual offender.

<u>Role of Cognitive Factors and Distortions.</u> While a variety of cognitive factors and distortions are often reported as characteristic of sex offenders, these factors are more accurately described as playing a mediating role in cases of sexual assault (Segal & Stermac, 1990)

Offenders' denial, minimization, and blaming of factors outside their control are factors which occur with such frequency as to require special attention.

- o Denial of the seriousness of the consequences of their behavior protects offenders from guilt and negative affects such as shame (Salter, 1988).
- o Assessment of denial and minimization is important because the degree of denial reflects the motivation of the sex offender to participate actively and fully in treatment.
- o In addition, minimization of the sexually abusive behavior makes recurrence more likely (Murphy, 1990).

While denial and minimization are common among all sex offenders, other cognitive factors do differ for rapists and child molesters.

- o In general, rapists' cognitions are consistent with (and influenced by) gender stereotypes and rape myths discussed earlier.

- Child molesters, however, have been found to hold different views of children in both sexual and nonsexual domains. Pedophiles are more likely than other sexual offenders and normal individuals to view children as seductive, as wanting sex with an adult, as able to consent to sex with adults, and as unharmed by sexual activity (Gore, 1988, Stermac & Segal, 1990).

- Child molesters also differ from other respondents in that (1) they perceive benefits to the child as a result of the sexual contact, (2) they attribute greater responsibility to the child than to themselves, and (3) they perceive less need for punishment of the perpetrator (Segal & Stermac, 1990).

Nonsexual cognitive distortions have also been studied. Howell (1978) examined the views of homosexual pedophiles and matched controls of adult males, adult females and children. She found that homosexual pedophiles viewed adults as domineering, overbearing and more threatening than the control group. Children were viewed by the pedophiles as submissive, non-threatening and easier to relate to due to their submissive status.

An examination of cognitive mediators may be especially important in predicting sexual abuse for situational (regressed) pedophiles (Segal & Stermac, 1990). Cognitive factors may play a facilitating role for the situational pedophile who starts to ruminate and has to fight off the urge for sexual contact with children. Segal & Stermac (1990) believe that an examination of these cognitions along with the rationalizations used for sexual intercourse with children may help the offender cope with his problems and may also elucidate a pathway for sexual assault.

In summary, while denial and minimization are common features in all sex offenders, rapists tend to be more influenced by pervasive sexual stereotypes and rape myths. Conversely, pedophiles hold unique views of children in both a sexual and nonsexual manner.

<u>The Role of Alcohol.</u> Peters (1976) and Rada (1976) reported that about one-half of their several samples of sex offenders were drinking at the time that they committed the offense. Abel et al. (1985) found that 30 percent of child molesters indicated that drinking increased their attraction to children, whereas 45 percent of rapists indicated that alcohol increased their desire to rape. These findings must be interpreted with caution because sex offenders may offer these as rationalized excuses for their inappropriate behavior (Overholser & Beck, 1989).

Alcohol consumption may be viewed as one of many contributing factors leading to the sexual offense. George and Marlatt (1986) found that alcohol expectancies (expectations of intoxicated behavior) are associated with an increased attraction to violent and erotic material. Thus, alcohol consumption may have a disinhibiting effect on the sexual offender's deviant sexual arousal. Studies of

non-sexual offenders convicted of violent crimes have also indicated similar disinhibiting effects. Therefore, alcohol may be viewed as a factor that decreases the effects of social and physical barriers that otherwise would inhibit or restrain the offender (Rada, 1976).

III. Treatment Issues and Modalities

In this section, we move from discussion of theories of the causes of sexual assault to examination of treatment issues. The treatment of offenders will be first considered, followed by the treatment of victims. At the outset, it is recognized that most sex offenders assault many more than one victim in their deviant careers, and that as a consequence, the number of sexual assault victims far exceeds the number of offenders.

Offender Treatment

The many sociological and psychological factors involved in sexual assault indicate that different etiologies and factors are associated with offending by different individuals. These characteristics and factors hint at some of the issues that should be addressed in offender treatment.

The report of the National Adolescent Perpetrator Network (1988, p.28) explicitly states some of these factors and other issues that should be addressed, including:

- accepting responsibility for behavior without minimization or externalizing blame;
- identification of a pattern or cycle of offense behavior;
- ability to interrupt the cycle before an offense occurs and to control behavior as a consequence;
- victimization in the history of the offender;
- development of victim empathy to the point that victims are seen as people rather than objects;
- power and control, as well as lack of control;
- the role and reduction of deviant sexual arousal;
- developing a positive personal sexual identity;
- understanding the consequences of offending behavior to oneself, the victim, and the victim's family;
- family issues or dysfunctions which support or trigger offending;

- cognitive distortions and irrational thinking which support or trigger offending;
- identification and expression of feelings;
- appropriate social relationships with peers;
- appropriate levels of trust in relating to adults;
- addictive/compulsive qualities contributing to reinforcement of deviancy;
- role of substance abuse in functioning;
- skills deficits which interfere with successful functioning;
- need for relapse prevention; and
- options for restitution/reparation to victims and the community.

Current programs incorporate many of these elements into treatment, necessitating a comprehensive, multifactor, multimodal and eclectic approach to intervention with sexual offenders. Because sexual aggression is a complicated and multidetermined problem, and not every offender is the same, treatment must be individualized to meet the complex needs of each sex offender (National Adolescent Perpetrator Network, 1988). Therefore, not every treatment technique or method is, or should be used for each individual.

Some treatment techniques used in sexual offender treatment programs are well known because of their wide application to clinical populations; others are highly specialized and relatively unknown outside offender treatment programs. Among the more specialized techniques are castration, antiandrogen drug therapy, and psychological techniques such as behavior therapy, cognitive-behavior therapy, and relapse prevention.

Castration. Surgical castration, or removal of the testicles, was widely used in Europe in the past. Its use has declined, but it has not been completely abandoned as a therapy (Hucker & Bain, 1990). Castration produces an abrupt and dramatic reduction in the circulation of testosterone, the principle androgen produced by the testicles. Testosterone is linked to sexual and to aggressive behavior (Money, 1987). Decreased production and lower levels of circulating testosterone are believed to reduce sex drive, and to decrease sexual fantasies and the ability to respond sexually (Cook & Howells, 1981).

Although some follow-up studies have recorded remarkably low rates of recidivism among castrated individuals, (Marshall, Jones, Ward, Johnston, & Barbaree, 1991), the effects are variable. For

example, while studies have found that many castrated males report decreased frequency of intercourse, masturbation, sexual fantasies, and sexual arousability, about one-half report continuing sexual potency, masturbation, and participation in sexual intercourse (Hucker & Bain, 1990). Some evidence (Heim, 1981) suggests that individuals castrated at an earlier age (i.e. younger than 44) are more likely to be sexually active than those castrated later in life (i.e., older than 44).

Moreover, while testosterone plays a major role in sexual arousability, it is not the sole contributor. Sexual activity can continue in the absence, or at very low levels of testosterone (Hucker & Bain, 1990). Some researchers have noted that for chronic offenders who have developed an ingrained pattern, sexual behavior is not necessarily dependent on physiological arousal, and that "you can castrate the body, but you cannot castrate the mind" (Rada, 1978, p.143).

The decline of castration in Europe has been affected by these variable findings and by the increasing influence of legal and ethical concerns (Becker, 1990). In addition, the advent and use of antiandrogen drugs that produce similar but reversible effects have increased treatment options.

Antiandrogen Drug Therapy. Antiandrogen drugs play an important role in the treatment of sexual offenders, particularly those men who have poor control over their strong sex drive (Marshall and Eccles, 1991). Antiandrogens are synthetic analogues to hormones (progestins) normally produced in males. Increasing the levels of these antiandrogens allows them to compete with and, in many cases, triumph over the arousal effects of androgens (Money, 1987). Antiandrogen therapy is popular because it produces the same effects as castration, but the effects are reversible once treatment is discontinued (Marshall, Jones, Ward, Johnston, & Barbaree, 1991).

The two major types of antiandrogens used to treat sexual offenders are Medoxyprogesterone Acetate (MPA) and Cyproterone Acetate (CPA).

MPA has received the most attention in the United States (Bradford, 1990). Money (1987) initially implemented MPA treatment and has to date conducted the most extensive research with the drug. His findings indicate that MPA acts mainly by breaking down and accelerating the metabolism of testosterone in the liver. It also reduces the production rate and level of testosterone in the blood stream.

Depo Provera (progestin) is a long-acting, injectable form of MPA. As distinct from the erotic activation role played by testosterone, progestin is erotically inert and acts on brain cells to produce a period of calm in which the sex drive is at rest (Money, 1987). Depo Provera also decreases the testosterone level, temporarily decreasing penile erection, ejaculation and sperm production.

MPA had been shown to be particularly effective when combined with counseling. Studies show immediate improvement in internal control and maintenance through a follow-up period when drug therapy is combined with psychotherapy (Bradford, 1990). It serves to lower the risk of recidivism while internal control and other changes are induced by psychotherapy. In addition, its negative side effects are relatively few and minor (Money, 1987).

CPA acts by stopping or drastically reducing the production of androgens and blocking their sites of action. The result of such action is suppression of sex drive, decrease in sperm production, reduction in erectile and ejaculatory capacity and decrease in sexual fantasies. The negative side effects are dose dependent and unlikely to occur at the dosages used to treat sexual offenders (Bradford, 1990).

Several studies support the effectiveness of CPA. For example, Lachet and Lachet (in Bradford, 1990) found CPA treatment effective in a majority of patients followed up for five years. These offenders reportedly showed no recidivism when treatment was discontinued. In addition, Bradford and his colleagues (cited in Marshall, Jones, Ward, Johnston, & Barbaree, 1990) found that CPA induced greater sexual inhibition to pedophilic visual stimuli and covert sexual fantasies compared to pretreatment levels and to those treated with a placebo.

Although it is well documented that antiandrogen drugs can reduce recidivism (Bradford, 1990), these medications are not meant to eliminate sexual offending. They are instead used principally as a means to reduce excessive sexual drive when this drive places the offender at serious and immediate risk of committing an offense, or when offenders are unresponsive to psychological intervention. Drug therapy combined with counseling is more effective in helping the offender regulate and control his sexual behavior than drug therapy alone (Bradford, 1990).

Moreover, drug therapy is effective only when offenders remain in treatment. Research has not been able to demonstrate conclusively the effectiveness of drug treatment because of offender attrition and noncompliance in taking the medication (Bradford, 1990). The problem of noncompliance is increased when the offender cannot be closely monitored (e.g., in outpatient or in noninstitutional programs).

General guidelines have been suggested for the use of antiandrogen therapy. These include obtaining free and voluntary consent, adhering to medical contraindications, and the gradual decrease of medication once a certain level of self control is gained. In addition, clinicians are cautioned that MPA or CPA may not be effective alone, especially with chronic offenders whose behavior is at times divorced from physiological cues and takes on a life of its own (Marshall, Jones, Ward, Johnston, & Barbaree, 1990).

Psychological Therapies and Techniques. Because of the recent integration of behavior and cognitive-behavioral therapy, it is not always possible to differentiate these formerly distinct techniques (Marshall & Eccles 1991). It is more useful to review a number of techniques which may be grouped informally as behavior or cognitive-behavioral therapies, depending on the role behavior or cognition plays, and to add discussion of more recent work in relapse prevention.

Behavior therapy techniques include satiation, aversive therapy, increasing nondeviant arousal, social skills training, and assertiveness training. Cognitive-behavioral therapy uses some of these same techniques as well as others such as confrontation, covert sensitization and cognitive restructuring.

Satiation. Satiation can be either verbal or physical. In verbal techniques, the sexual offender is taught to use his deviant thoughts in a repetitive manner to the point of satiation with the very stimuli used to become aroused (Becker, 1990). In physical satiation, the offender is instructed to masturbate to the point of orgasm while fantasizing aloud about sexually appropriate themes. The offender then continues to masturbate after switching to a very detailed description of his deviant fantasies. The detailed elaboration of deviant fantasies is continued for as long as an hour. This is designed to produce boredom. These techniques can be used in therapy sessions or in the client's home, with audiotapes that can be checked later by the therapist (Marshall & Barbaree, 1990).

Aversive Therapy. Aversive therapy is also used to decrease deviant sexual arousal. It is implemented in a variety of forms from the use of a mild shock to less aversive negative stimuli. The main goal is the association of an aversive event or action with a paraphilic stimuli and deviant sexual arousal. Nonparaphilic (nondeviant) cues are also presented but have no aversive consequence.

For example, a rubber band might be snapped against the arm in association with the presentation of a slide of a nude child. No negative reinforcement then occurs when nondeviant slides are shown.

Another method might deliver an aversive stimuli when the offender exceeds some predetermined criteria of penile tumescence increase during an audiotaped description of a violent rape. The aversive stimuli is not delivered when sexual arousal is followed by a slide or description of consenting adult sex.

Aversive therapy is no longer in frequent use, especially in the electrical shock form (Marshall & Barbaree, 1990).

Increasing Nondeviant Arousal. In addition to decreasing deviant arousal and fantasies with satiation and aversion therapy, attempts are made to increase appropriate sexual arousal and fantasies involving sex between two consenting partners. Initially, the client is asked to become aroused and masturbate to a deviant sexual fantasy. A few seconds before ejaculation, the deviant sexual fantasy is switched to an appropriate theme. Gradually, through repeated therapy, the moment of switching fantasies is moved back in time until the client is able to masturbate and achieve orgasm using the appropriate sexual fantasies (Quinsey & Earls, 1990).

Social Skills Training. Social skills training is used to help the offender learn the skills necessary to relate to people in an appropriate and comfortable manner. This includes teaching communication skills, family interaction skills, coping with aggressive feelings, and problem solving. Offenders are taught alternates to aggression as means of problem solving through the therapist's modeling of such behaviors as well as through feedback and interaction while role-playing common problem situations.

Assertiveness Training. Assertiveness training is a means to help people who experience difficulties in expressing their feelings openly. This technique is especially useful for pedophiles who view adults as dominant and threatening (Cook & Howell, 1981). Training the pedophile to become more assertive, along with social skills training, enables the offender to cope with adult relationships and thereby eliminate the need to seek out children (Cook & Howell, 1981).

Confrontation. Confrontation is used by the therapist to point out the negative and destructive behavior or to counter the offender's minimization and denial. Confrontation must be direct, firm and responsible, but not condescending, humiliating or derogatory (National Adolescent Perpetrators Network, 1988). Confrontation is intended to help the offender gain greater self- understanding and to take responsibility for his actions.

Covert Sensitization. Covert sensitization is a technique which cognitively pairs an aversive experience with deviant sexual arousal or fantasy. In this method, the client is instructed to relax and image one in a series of paraphillic scenes which have been arranged in an order of increasing sexual arousal. When sexual arousal to the scene occurs, the client is asked to immediately bring into mind a highly aversive image or consequence. For example, an adolescent offender may be asked to actively imagine being sent to a correctional facility or having peers learn of the offense (Becker, 1990). Gradually, the offender works up to the most sexual arousing, using the same or more aversive images or negative consequences (Marshall, Laws, & Barbaree, 1990).

Cognitive Restructuring. Most sexual offenders know that their behavior is contrary to society's mores, yet they continue to engage in these deviant behaviors (Becker, 1990). The irrational or rationalized thought processes which support or justify sexual offending are referred to as cognitive distortions or errors in thinking (National Adolescent Perpetrators Network, 1988). Sex offenders may have cognitive distortions in the form of "permission-giving" statements that justify their behavior. An example of such a statement is: "I would never have had sex with a child unless the child really wanted to do it."

Cognitive restructuring confronts the offender's rationalizations about why it is acceptable to participate in deviant behavior and corrects such irrational thinking with rational thoughts.

Relapse Prevention. Relapse prevention is quickly being incorporated into many treatment programs. In relapse prevention, sexual offenders are taught to identify and cope with situations that may threaten or undermine their control of inappropriate arousal and result in a return to their old patterns of behavior. In addition, it deals specifically with longterm maintenance of behavior changes.

This model views sexual offending as compulsive behavior or an addiction. Researchers investigating components associated with relapses in compulsive behaviors such as alcoholism, overeating and gambling have identified three main risk situations: a negative emotional state, interpersonal conflict, and social pressure. These were found to be the primary determinants in about three-quarters of all relapses, regardless of the substance abused (Marlatt & Gordon, 1980).

Pithers, Buell, Kashima, Cumming & Beal (1987) conducted similar research with sex offenders, looking for multiple determinants of sexual aggression to identify a relapse process. Contrary to the belief that many sexual assaults are impulsive acts, these researchers identified a pattern of precursors to sexual offending. This pattern or sequence includes strong negative affect, fantasy, cognitive distortion, planning, and, finally, sexual assault.

The first change from typical functioning in the relapse process was affective. This was either a strong emotional state or feeling "moody" or "brooding." Most offenders also appeared emotionally overcontrolled; they frequently left a hostile interaction without expressing anger. An overwhelming majority of rapists (94 percent) reported intense anger precipitated by interpersonal conflict. Conversely, pedophiles reported feeling anxious or depressed.

The next change in the relapse process involved deviant fantasies. Fantasies were translated into thoughts including

cognitive distortions. For example, clients often devised rationalizations for their behaviors that minimalized the effects of their soon-to-be-committed acts. In addition, distortions included objectifying and dehumanizing women, or ascribing adult characteristics to children (Pithers et al., 1987).

Next, as fantasies and cognitive distortions continued, the offender engaged in a process of passive planning in which they thought about how to commit the offense. This planning was finally manifested in their behavior: commission of sexual assault (Pithers et al., 1987).

A major goal in relapse prevention is to identify the specific pattern of precursors in order to enhance maintenance of change in compulsive behaviors. This includes a detailed analysis of the precipitating situations, cognitions, and affect that have preceded past offenses. Skills training is then used to enable the client to recognize and avoid situations that increase the probability of a relapse. The client is taught adaptive coping behavior that may be used when a risk situation is encountered.

It is believed that the relapse prevention component should not be added to treatment until minimization and denial are broken, and the client has developed emotional and intellectual empathy for victims. Only after recognizing the harm that they have inflicted are offenders sufficiently motivated to maintain the vigilance required by the relapse prevention model (Salter, 1988; Pithers et al., 1987).

Once the relapse prevention approach is added to treatment, its goal is to maintain the process of behavior change. It is specifically designed to help the client maintain control of the problem behavior over time and across situations. An important implication is that an offender can never be "cured," but must constantly monitor his thoughts, feelings, behaviors and environment. Mis- conceptions about being "cured" are believed to set the individual up for failure (Pithers et al., 1987). As a consequence, relapse prevention should be ongoing, with outpatient follow-up after initial treatment or incarceration.

Treatment Effectiveness. The effectiveness of offender treatment is a critical issue. but assessing effectiveness is quite problematic. Effectiveness assessments produce widely varying recidivism rates and inconclusive results, and there is little consensus regarding which indicators, beyond recidivism, should be used to assess treatment effectiveness.

An extensive and recent attempt to analyze research on the effectiveness of treatment for sexual offenders was conducted by Furby, Weinrott, & Blackshaw in 1989. After reviewing a number of older and current outcome studies, the authors concluded that (1) it is impossible to know or infer recidivism rates for untreated

offenders, and (2) there is little or no evidence to suggest that clinical treatment reduces recidivism rates.

While this attempt was laudable, the review was plagued by so many methodological problems that meaningful conclusions about treatment effectiveness were precluded (Marshall, Jones, Ward, Johnston, & Barbaree, 1991).

One of the most common criticisms of treatment studies is the failure to provide a control group with which to compare treated sexual offenders (Marshall, Jones, Ward, Johnston, & Barbaree, 1991). Withholding treatment from a dangerous control group of offenders is ethically problematic. Other criticisms stem from difficulties in comparing different subtypes of offenders and from failure to differentiate institutions in which they receive treatment. This latter consideration is important because individuals discharged from prisons, hospitals, and community settings differ in their offense histories.

For example, repeat offenders have been found to have recidivism rates ranging from one-third to nearly three-quarters of all offenders, while first-time offender recidivism rates are between ten and twenty-one percent (Marshall, Jones, Ward, Johnston, & Barbaree, 1991).

Another troublesome variable is the selection criteria used for entry into treatment (Furby, Weinrott, & Blackshaw, 1989). Offenders in institutional programs are often judged to be at the highest risk and may be excluded from treatment, thereby lowering the reported recidivism rate (Marshall, Jones, Ward, Johnston, & Barbaree, 1991).

This difficulty reflects the larger problem of who receives treatment. Those who are legally apprehended may receive treatment by order of the judicial system, but sex offenders who are not caught rarely seek treatment. As a consequence, unapprehended offenders are unrepresented in treatment studies. This diminishes the validity of reported treatment recidivism rates.

The use of recidivism rates or other single variables as indicators of effectiveness is also problematic. The most obvious problem is that an offender may repeat the offense and not be detected. As a consequence, when police reports and other public records are used to assess recidivism, these measures are likely to be inaccurate. In addition, recidivism rates vary with the length of follow-up; there is a steady increase in recidivism over the full range of follow-up (Marshall, Jones, Ward, Johnston, & Barbaree, 1991). This may be due to fewer external controls as the offender reintegrates into the community, raising the likelihood of committing another offense. The lack of uniformity in many studies and difficulty in specifying the length of follow-up limits the public policy conclusions that may be drawn from assessment studies (Furby, Weinrott, & Blackshaw, 1989).

Use of single outcome variables is also questionable because of the complexity of sexual offenders and their behavior. Treatment effectiveness should ideally include cognitive, emotional, and other behavioral measures.

Other problems abound. Most of the studies are old and do not follow the current trend of including multifactors, multimodes of treatment, and maintenance of treatment gains through relapse prevention. Furby, Weinrott, & Blackshaw (1989) admit that many of the studies they evaluated could be considered "obsolete" due to the constant evolution and refinement of treatment models.

A final and very important difficulty is that many of these studies do not present recidivism rates separately for each type of offender. The possiblity exists that some treatment techniques are effective only for some types of offenders, or that there are varying degrees of effectiveness with different types of offenders (Furby, Weinrott, & Blackshaw, 1989). For example, Marshall and Eccles (1991) point out that cognitive therapy may not be as effective with rapists as it is with child molesters and exhibitionists, yet some therapists continue to treat rapists and child molesters as if they are clinically identical.

Despite these difficulties, there is scientific optimism about assessing treatment effectiveness. Current approaches, while still evolving, are more comprehensive and focus to a greater extent on long-term changes. Many treatment programs are trying to specialize treatment based on the type of offenders and individualizing treatment to the specific characteristics or problems of each offender. As a consequence, there may be current programs that are quite effective despite the fact that their effectiveness has not been validly and reliably measured.

It has been suggested that recidivism rates are likely to be lower when an extensive social services network exists, both during treatment and follow-up (Furby, Weinrott, & Blackshaw, 1989). Current programs are attempting to coordinate treatment with other agencies involved with the offenders, including the court system, parole and probation officers, child protective workers and the victims' therapists.

Prentky & Burgess (1988) note that the benefits of treating the offender include victim protection, community protection and cost-effectiveness. They found that the cost of investigating, prosecuting and incarcerating one repeat offender, coupled with the provision of minimal assessment and treatment of the victim, was much higher than providing treatment for the offender. Given the devastating effects on the victim, many view any reduction in recidivism rate due to treatment as beneficial (Marshall, Laws, & Barbaree, 1990).

Differences in Treating Sex Offenders and Other Clients. Salter (1988) and O'Donnell, Leberg & Donaldson (1987) have outlined a number of ways in which the therapeutic process, the therapist, and

the sexual offender differ from traditional therapy with a clinical population.

A critical difference is that the insight-oriented approach typical of mental health therapy is not effective with sexual offenders. In fact, the use of insight therapy may be one of the reasons early sex offender therapy was considered useless (O'Connell, Leberg, & Donaldson, 1987). More effective programs have now been developed based on the addiction model. These approaches presume little motivation and cooperation on the part of the client; denial and minimalization are understood as symptoms of the disorder (O'Connell, Leberg, & Donaldson, 1987).

Sex offenders also differ from other mental health clients in that they rarely refer themselves for treatment. Denial, minimization and rationalization are used to self-deceive and to deceive others regarding the presence of problems and the need for therapy. Moreover, once in treatment, many sex offenders are unwilling to make the necessary commitment to bring about the changes required to prevent committing another offense (O'Connell, Leberg, & Donaldson, 1987).

It has also been noted that sexual offenders' problems are much more severe than first appearance would suggest. Offenders do not view themselves as dangerous or harmful in any way because they maintain a facade of concern and respectability. As a group, they tend to have held long-term employment and to have been involved in the community in other productive ways (O'Connell, Leberg, & Donaldson, 1987).

In addition, they <u>appear</u> to be nonviolent and repentant for their actions. They tend to be unrealistically optimistic about their ability to control their behavior and to prevent another offense from occurring. While the typical client is considered to be the best source of information (even though their perceptions are biased), the sex offender is not to be trusted, at least initially when denial is strongly present.

As a result, the sex offender's therapist does not follow the offender's goals for treatment but rather sets strict rules, guidelines and goals for treatment. The therapist also takes a firm value stance rather than the nonjudgmental posture typical of most mental health therapy. Sex offender treatment also uses confrontation to a much greater degree than is typical with other treatment populations, both in individual and group treatment. Unlike members and therapists in many support groups, all participants in offender group therapy must continuously identify and challenge cognitive distortions and rationalizations that may lead to committing another offense.

Limited confidentiality is also characteristic of sex offender treatment, especially when the treatment is coordinated with other social agencies, the legal system and prisons. Sex offender treatment necessarily involves information sharing among agencies,

both to validate offender's reports and to exert additional social control.

O'Connell, Leberg, & Donaldson (1987) also suggest that therapists maintain a balance between respect and collusion. While the therapist should respect the sexual offender as a human being and believe in the offender's capacity for change, the therapist must constantly be on guard to prevent collusion with the sex offender, or to contribute to the commission of a subsequent offense.

Clinical Competencies of the Sex Offender Therapist. Despite the fact that no published competency standards for sex offender therapists currently exist, Salter (1990) notes the growing consensus as to the necessity for sex offender therapist specialization.

Some personal qualities and competencies the sex offender therapist should possess have been suggested by O'Connell, Leberg, & Donaldson (1987) and the National Adolescent Perpetrator Network (1988). Four major areas of expertise are identified:

- knowledge of sexual deviancy and offender issues;
- impact on sexual abuse victims;
- criminal justice issues; and
- knowledge of community resources.

In terms of sexual deviancy and offender issues, the therapist should understand the treatment issues previously discussed, including deviant arousal patterns, the role of alcohol in sexual abuse, patterns of offense behavior, and knowledge of different types of sexual deviancy.

The therapist must also understand the impact of sexual abuse on victims including:

- Knowledge of the ways in which victims are vulnerable to being "set up" and sexually assaulted;
- Understanding the victim's physical, mental and emotional areas of vulnerability;
- Understanding the impact of child molestation on children;
- Understanding the impact of sexual assault on the victim's life;
- Helping offenders see the implications of their acts from the victim's perspective; and
- Awareness of how nonoffending caretakers respond to the disclosure of the sexual abuse.

The therapist must also be familiar with criminal justice issues and with local and state laws concerning sexual assault. This familiarity must include knowing the organization and rules of the criminal justice system the laws that govern policies and actions of individuals in the system (who is accountable to whom). The therapist must be familiar with the multiple agencies that investigate sex crimes and, more generally, with who has what information and how to obtain it. Success will often depend on obtaining information from multiple sources to decrease the likelihood of individual or agency bias. Above all, the therapist must recognize the needs for safety of the victim and the community aas well as the needs of the client.

In addition, the National Adolescent Perpetrator Network (1988, p. 40) suggests that the therapist should have the following professional qualities:

- A combination of education, training and experience;
- Awareness of various theories, their development over time, and their current application;
- Awareness of access to, and limitations of, appropriate resources and supervision;
- Awareness of sex offender issues and what is known and unknown;
- Ability to clearly express method and rationale for what is done in evaluation and treatment;
- Openness to multidisciplinary and eclectic approaches;
- Ability to respond to individual needs;
- Knowledge of policies relating to confidentiality, risk management, client participation and confrontation; and
- Continuing awareness research and development in the field.

Knowledge alone is insufficient; it must be supplemented with clinical experience. O'Connell, Leberg and Donaldson (1987) note that the typical therapist usually has only one kind of direct experience with sex offenders. They suggest that a substantial portion of the therapist's practice should involve sex offenders, or that the therapist should have long-term experience in treating sexual deviancy. In addition, it is important that the therapist have experience with clients who are defensive and manipulative.

Victim Treatment

Children respond in very different ways to sexual abuse (Finkelhor, 1984). Their responses stem from factors including the nature of the sexual act, the perpetrator, the frequency, duration and severity of the abuse, and their own differences in age, developmental level, and coping skills. Because the majority of sexual abuse is committed by individuals who are related to or known by the child (Russell, 1984), discovery of the abuse will also profoundly affect the family context. Reactions of the family and the child will differ widely (Conte & Schuerman, 1988; Friedrich, 1988).

Despite this variation, some consistent responses are well documented. While girls are more likely to report abuse than boys (Russell, 1984), boy's and girl's responses are remarkably similar, both initially and in the longer term (Finkelhor, 1990; Conte, Berliner, & Schuerman, 1986; Urquiza & Crowly, 1986). When differences occur, they are usually on the dimension of "externalized/internalized." Boys more often act out aggressively, while girls more often are reported to be depressed (Conte, Berliner, & Schuerman, 1986).

In addition, the similarity of responses by boys and girls indicates there is convincing evidence that impacts are most negative when the offender is the parent or parent figure, when the molestation involved genital contact, and when force is used (Finkelhor, 1990).

Effects of Sexual Abuse. A large body of research documents the negative effects of childhood sexual abuse on later functioning. Research findings vary depending on research methods and comparison groups.

For example, Lusk & Waterman (1986) studied only sexual abused children and found seven "clusters" of effects on children: affective problems; physical effects; cognitive effects; behavioral symptoms; self-destructive behavior; psychopathology; and, sexualized behaviors. In comparing sexually abused children to normal children, Conte & Schuerman (1988) found victims to be more likely to show poor self-esteem, aggressive behaviors, fearfulness, contentiousness, concentration problems, withdrawal, acting out, and the need to please others.

Brown and Finkelhor (1986) reviewed the literature on the effects of child sexual abuse and outlined initial and long-term effects that were found consistently. Despite these consistent findings it is safe to conclude only that the effects are found in some, but not all of the victim population.

Initial Effects. Research consistently documents the following initial effects on the sexually abused child:

- **Fear** of abandonment: fear that the nonoffending parent will choose the offending parent over the child, and fear of punishment and retribution mentioned by the perpetrator during the molestation.

- **Anxieties** which may include eating and sleeping disorders, phobias, and nightmares.

- **Depression** is evident even in young children including reactions to losses, confusion and sadness, and withdrawn or subdued behaviors. Because children often mask depression, signs may include unusual fatigue and development of physical illnesses.

- **Anger and hostility** tend to build up over a period of time and may be related to the duration of the sexual abuse. Anger may also be directed to the parent or other close relatives who failed to protect the child or report the abuse (Rencken, 1989).

- **Aggression** may be manifest in behaviors such as active defiance, disruptive behavior within the family, and quarreling or fighting with siblings and classmates.

- **Sexually inappropriate behavior** may include open and excessive masturbation, excessive sexual curiosity, frequent exposure of genitals, repetition of sexual acts with other children, and atypical sexual knowledge.

According to Finkelhor (1990), the initial effects may subside or decrease, especially if the child receives treatment. However, since most of sexual abuse goes unreported (Salter, 1988), the response may increase and manifest itself in problems in later life.

<u>Long-term Effects.</u> The most frequently cited long-term effects (Brown and Finkelhor 1986) are:

- **Depression** is the most commonly reported symptom in adults molested as children. The link between sexual abuse and depression has been confirmed in both clinical and nonclinical populations.

- **Self-destructive behavior**, including current or past attempts to harm oneself or commit suicide, and suicidal ideation.

- **Anxiety and tension** effects may include anxiety attacks, nightmares, difficulty sleeping, nervousness, and extreme tension.

- **Feelings of isolation and stigma** are particularly apparent in victims of incest in which the family does not communicate and becomes isolated from the community. In addition to perceptions, the victim may actually be stigmatized by family members and the community.

- **Poor self-esteem** is evident in may victims because of the sexual abuse itself as well as the verbal abuse that may have accompanied it. There may also be resulting feelings of helplessness and inability to control current life situations.

- **Diminished interpersonal skills** include problems in relating to both men and women, continuing problems with parents, and difficulty in parenting and responding to one's own children. Fear, hostility and a sense of betrayal often lead to difficulty in trusting others.

- **Revictimization**, including rape and abuse by husbands and adult partners frequently occurs among women who have been sexually abused as children.

- **Sexual maladjustment problems** include the inability to enjoy sexual activity, avoidance or abstinence from sex, or, conversely, a compulsive desire for sex.

- **Substance abuse** is found in both male and female victims, but occurs to a greater extent in males.

An essential caveat is that it is unclear if these long- and short-term effects are representative of all victims, or are more typical of patients seen in treatment (Brown & Finkelhor, 1986). In fact, not all victims show symptoms. Finkelhor (1990) indicates that one-fourth to one-third of victims are asymptomatic, measured by a number of assessment techniques. Some children may have coping mechanisms adequate to manage the stress, or strong external social support systems, or they may have been abused for a shorter period of time without the use of force and violence (Finkelhor & Brown, 1990).

Explanatory Models. Two main models have been proposed to explain the effects of sexual abuse: Post Traumatic Stress Disorder (PTSD), and the Traumagenic Dynamics model of child sexual abuse (Finkelhor & Brown, 1985; Finkelhor, 1990; 1988).

PTSD was originally formulated to explain the delayed consequences of the trauma of war. It has been increasingly applied to other trauma experiences of adults, and has recently been extended to apply to children who are victims of natural disasters or violent crime -- including sexual abuse -- or who have witnessed a violent death (Finkelhor, 1988).

PTSD is defined by the DSM-III-R (APA, 1987) to include:

- An experience or event that would be markedly distressing to almost anyone;
- Reexperiencing the trauma (for example through recurrent memories or dreams, or repetitive play in children);
- Avoiding stimuli associated with the trauma, for example through memory loss or repression of thoughts and feelings;
- At least two of the following -- hyperalertness, sleep problems, irritability, problems with memory or concentration, or intensification of symptoms when exposed to stimuli related to the traumatic event.

Although PTST provides a structured way of looking at sexual abuse, and many of the symptoms experienced by sexual assault victims fit into the pattern, not all victims or effects are accommodated within the PTSD model (Finkelhor, 1988). While the model includes components such as nightmares, intrusive imagery, and blunting of affect, it does not include symptoms such as fear, depression, self-blame, and sexual problems found in sexually abused children and adults (Finkelhor, 1988).

An alternate to PTSD is the Traumagenic Dynamics model of child sexual abuse (Finkelhor & Brown, 1985). This model incorporates PTSD and includes both affective and cognitive components. It is an eclectic and comprehensive model that suggests different dynamics to account for the variety of symptoms (Finkelhor, 1988).

This model proposes four trauma-producing dynamics to account for the impact of sexual abuse: (1) traumatized sexualization; (2) betrayal; (3) stigmatization; and (4) powerlessness. Each dynamic is associated with some effects, but the same effect may be explained by more than one dynamic or a combination of dynamics (Finkelhor & Brown, 1985).

Traumatic sexualization results from the inappropriate sexual contact and relationships that typically occur in sexual abuse situations. For example, the child may be rewarded for deviant or inappropriate sexual behavior and, in turn, learn to use sex inappropriately to manipulate others and to meet their needs. As a result, the child victim may become confused and have serious misconceptions about sexual behavior.

The effects of traumatic sexualization are apparent in children's sexual preoccupation, compulsive masturbation and sex play, and age-inappropriate sexual knowledge and behaviors. In adulthood, these symptoms are manifested in problems such as aversion to sex, flashbacks during sex, and difficulty with arousal and orgasm. As a result of their own inappropriate sexualization, adults may also find themselves inappropriately

sexualizing their children in ways that may lead to physical and sexual abuse (Finkelhor, 1988; Finkelhor & Brown,1985).

Betrayal results when children realize that someone they loved and trusted has harmed them. The realization may come while the abuse is occurring or when the child discloses the abuse. The victim may also feel betrayed by the nonoffending parent or other family members who were unwilling or unable to protect the child.

There are a number of associated effects. The victim may become depressed, extremely dependent and clinging, or regress to behaviors such as thumbsucking or bed-wetting. In adulthood, the symptoms may manifest in overdependence and impaired judgement. The adult victim may search for a trusting relationship, but have impaired judgements about the trustworthiness of other people.

Stigmatization refers to negative messages about the self such as "badness" and worthlessness. These messages make the child feel guilty, shameful and responsible, both when the abuse is occurring and also when it is disclosed. As with the other dynamics, the degree and type of stigma differ for different children (Finkelhor, 1988).

The effects of stigmatization may be isolation and alienation, or movement to other stigmatized activities such as drug abuse and criminal activity (Finkelhor, 1988). Extreme forms of stigmatization may lead to suicide attempts and other self-destructive behaviors.

Powerlessness results from the child's inability to prevent or stop the abuse and from violence, coercion and threats to the child's life when these occur. The social interventions following disclosure may add to the child's lack of control over what is occurring.

The effects of powerlessness are fear and anxiety, as well as PTSD symptoms such as nightmares, phobias, somatic complaints and sleep problems.

All four dynamics are not necessarily present in all cases (Finkelhor, 1989), and the degree to which the dynamic is experienced differs. Conte & Schuerman (1988) note that the validity of both PTSD and the traumagenic model is unknown. The models may best be used as guides to understanding sexual abuse and to increase the therapist's ability to intervene and prevent some of the serious negative consequences (Finkelhor, 1988).

Therapeutic Issues and Treatment. While there has been a great deal of research on the multiple adverse effects of childhood sexual abuse, there has been relatively little effort to translate theoretical constructs into therapeutic intervention techniques (Wheeler & Berliner, 1988). The proposed treatment approaches

appear to be generic: individual therapy initially for the victim and each family member, followed by group and family therapy.

There has been no systematic outcome evaluation for any set of treatment procedures used with this population (Wheeler & Berliner, 1988). As a consequence, there is little formal knowledge to guide practitioners in using specific techniques in working with abused clients. The available information is based on clinical anecdotes and case studies (MacFarlane & Waterman, 1986).

Several researchers and clinicians, however, have outlined issues that should be addressed in treatment and how existing techniques can be used to ameliorate the negative consequences of abuse (Salter, 1988; MacFarlane & Waterman, 1986; Rencken, 1989; Long, 1986; Wheeler & Berliner, 1988). Some of the key issues in treatment address fear and anxiety, ventilation of feeling, guilt, altering attributions of responsibility, explaining the offense and the offenders behavior, restoring expectations of self-efficacy, and sex education.

Fear and Anxiety. One of the first areas to be addressed in therapy is safety. Because children do not feel safe following the discovery of the sexual abuse, the therapist must pay attention to the child's actual and perceived safety. Treatment of fear and anxiety involves reducing arousal to fear-producing cues and teaching management strategies for decreasing subjective feelings of anxiety (Wheeler & Berliner, 1988).

With young children, play therapy may be used to allow them to master fear and anxiety. The therapeutic context may be structured with puppets and dolls to encourage reenactment and disclosure about various aspects of the abuse experience. Techniques such as desensitization, graduated exposure, modeling and assertiveness training are gradually incorporated into the child's play by the therapist. Effective coping responses may be introduced by the therapist and increased by reinforcing the child's use of them (Wheeler & Berliner, 1988).

With older children, a more direct approach might combine graduated exposure with encouragement for children to talk about the abuse in a safe and supportive environment. By talking about the abuse, the memories eventually lose their capacity to elicit arousal (Wheeler & Berliner, 1988). The children may also be taught problem solving skills to cope with the discomfort of feeling anxious or afraid (Long, 1986).

Ventilation of Feelings. The appropriate expression of affect over time may reduce the ability of abuse cues to elicit arousal and fear. Feelings of anger and grief are common and therapy can provide a safe environment in which to express these and other emotions. Children can be encouraged to put their feelings into words, poems, songs, or pictures (Wheeler & Berliner, 1988). They can learn to recognize and describe

their emotions as well as learn age- appropriate and setting-specific ways to manage their emotions (Rencken, 1989).

Guilt. Most children feel some degree of guilt. The therapist may tell the child that sad feelings are acceptable. In addition, the therapist should reiterate throughout treatment that the child was not responsible for the sexual behavior, the disclosure, or the subsequent disruption to the child's and his family's life. (Long, 1986).

Explaining the Offense and the Offender's Behavior. Along with explaining that the child was not responsible for the sexual abuse, the therapist should explain the offense and the offender's behavior at a developmentally appropriate level. The child needs to know that he is not alone and that this happens to other children, but is not normal. The child needs to know that the adult is the one who made the mistake (Salter, 1988). In addition, evidence indicates that victims of trauma adjust better when they have a causal explanation. (Wheeler & Berliner, 1988). Such an explanation may involve telling the child that the offender has a problem: he wants to be sexual with children, something that most grown-ups do not want. The child may also be told that the offender tells himself that it is okay to do it even though he knows that it is wrong (Wheeler & Berliner, 1988).

Restoring Expectation of Self-Efficacy. Another goal of treatment is the restoration of expectations of self- efficacy. With young children in play therapy, coping responses may first be modeled and then gradually included in the child's play. Structuring the play so that the child gradually becomes more powerful, avoids abuse, and conquers the offender may increase the child's feelings of control, power, and subsequently, self-esteem. (Salter, 1988; Wheeler & Berliner, 1988).

Older children may learn to decrease their vulnerability by identifying the pre-abuse warning signs. Once these are identified, the child can be taught to recognize them in a real situation so that an incidence of abuse may be averted (Wheeler & Berliner, 1988). In addition, group therapy with other abused children may help to validate their feelings and increase their self-esteem as they interact with others who are coping effectively.

Sex Education. Sex education should also be included in treatment (Salter, 1988; Wheeler & Berliner, 1988). Sometimes, young children do not understand exactly what happened. The therapist may initiate sex education with books and slides and the child may eventually voice his concerns and questions. With older children, age- appropriate basic sexual knowledge should be taught. This may include learning about reproduction and body parts, learning correct terminology, and being aware of different types of sexual activities. Input from parents

is necessary to incorporate value clarification with information about sexuality (Wheeler & Berliner, 1988).

These are some of the many issues that should be addressed in treatment. Due to the multiplicity and complexity of the effects of sexual abuse, multiple treatment techniques appear warranted (Wheeler & Berliner, 1988). In addition, parents should be involved in the individual treatment of the child as well as in family therapy. The parents should be taught how to increase supervision of the child and also learn techniques or setting limits for their children. Furthermore, the family as a whole should be taught communication skills and appropriate ways of interacting with each other (Wheeler & Berliner, 1988).

Qualifications of the Therapist. Currently, there are no explicit or specific guidelines detailing the qualifications of therapists treating victims of child abuse. Alpert and Paulson (1990) note that several professional organizations are working toward the development of policy and practice guidelines.

These researchers note that there are few courses offered at the graduate level dealing specifically with sexual abuse. In most cases, information is provided in family or child therapy classes. Otherwise, knowledge and experience are gained for the first time through internships and externships. Based on this didactic and experiential void, Alpert and Paulson (1990) suggest that a content course as well as a practicum course should be offered in graduate programs. This suggestion is yet to be heeded by many graduate programs due to the lack of current knowledge and training of those professionals who would be responsible for teaching such a course (Alpert & Paulson, 1990).

There are two professional societies known to have developed statements about sexual abuse in children and the role of the therapist in investigating and providing testimony for the judicial system. Although these statements are basically recommendations for providing safety for the child in the legal system, many aspects may be applicable for therapists who routinely evaluate and treat children in clinical settings.

The American Academy of Child and Adolescent Psychiatry (1990) suggests that persons doing evaluations must be professionals with special skills and experience in sexual abuse, or should be under the supervision of an experienced professional. It is recommended that these clinicians have knowledge of child development, family dynamics related to sexual abuse, the effects of sexual abuse on the child and the assessment of children, adolescents and families. In addition, it is recommended that training should be received in the diagnostic evaluation of both children and adults.

The guidelines developed by the American Professional Society on the Abuse of Children (1990, p. 2) outline several

characteristics of the evaluator of sexual abuse in children. These include:

- An advanced mental health degree in a recognized discipline (e.g., medicine, a masters or doctorate in psychology, social work, counseling, or psychiatric nursing).

- Experience evaluating and treating children and families. A minimum of two years of professional experience with children is expected, but three to five years is preferred. In addition it is suggested that at least two years of professional experience with sexually abused children is necessary. If these conditions are not met, the evaluator should be supervised.

- Specialized training in child development and child sexual abuse documented in terms of formal course work, supervision, or attendance at conferences and seminars.

- Familiarity with current professional literature on sexual abuse and knowledge about the dynamics and the emotional and behavioral consequences of abuse experiences.

- Experience in conducting forensic evaluations and providing court testimony. If not, supervision is essential.

Finally, therapist/evaluators should approach the evaluation with an open mind to all possible responses from the child and all possible explanations for the concern about possible sexual abuse.

III. Implications for Public Policy

This literature review has been prepared primarily to guide policymakers in considering the need for special credentialing for mental health professionals who counsel or treat sexual assault victims and offenders.

The review has explored major theories of the causes of sexual assault and examined issues related to treatment, treatment effectiveness and the preferred characteristics of professionals who provide treatment to victims and offenders.

The etiology of sexual assault is complex, involving the interaction of many social and psychological variables. Given this complexity, it is not surprising that a single treatment model fails to emerge as a universal treatment of choice.

What does emerge clearly from the review is that the objectives and techniques of sex **offender** treatment differ substantially from those used in the treatment of those segments of the general population -- including sexual assault **victims** --who seek and use mental health treatment.

Treatment of Sex Offenders

The objectives of sex offender treatment focus primarily on ensuring the safety of victims, potential victims and the community, and not on the needs for self-actualization of the offender client.

The techniques of effective treatment are emergent, but they are more clearly and explicitly aligned with behavioral management and control than is the usual case in treatment. These objectives and techniques are not generally well-understood by the treatment community.

Sex offenders -- especially rapists and pedophiles -- are dangerous individuals. They are unlikely to seek treatment voluntarily. They tend to deny, to minimize, or to rationalize their behavior, attempting to deceive themselves and others into believing that they neither have a problem nor need therapy. Many are unwilling to follow through with the commitment necessary to bring about the changes required to prevent subsequent offenses.

Sex offenders' problems are likely to be much more severe than first appearance would suggest. Offenders do not view themselves as dangerous or harmful; they often maintain a facade of concern and respectability. As a group, they tend to have held long-term employment and to have been involved productively in community life. In addition, offenders appear to be nonviolent and repentent for their actions, tending to be unrealistically optimistic about their ability to control their behavior and prevent an offense from recurring. In short, the sex offender is not be trusted, at least initially when denial is strong.

The sex offender's therapist must set strict rules, guidelines and goals for treatment, rather than following offender's goals. The therapist must also abandon the nonjudgmental posture typical of therapy and assume a firm value stance. Confrontation and limited confidentiality are also characteristic of offender treatment. The addiction treatment approach -- including substantial effort directed to relapse prevention -- is in increasing use and shows promise of effectiveness. This approach presumes little motivation and cooperation on the part of the client; denial, minimalization and rationalization are understood to symptoms of the disorder.

There is growing consensus in the professional community that sex offender therapist specialization may be necessary and desirable. While the basic clinical competencies of psychiatrists, psychologists, counselors, clinical social workers and other legitimate providers are necessary to the understanding and treatment of sex offenders, these competencies may not be sufficient when the principal goal of treatment is community safety.

Treatment of Victims

A woman has a one-in-five chance of being the victim of a completed rape at sometime in her life. When attempted rapes are included, these chances increase to one-in-three. About ten percent of males under the age of 18 have been sexually abused.

This review has focused on the treatment needs of victims of childhood sexual abuse. While it is clear that the short- and long-term consequences of child sexual abuse may be devastating, the range of effects experienced by victims is very wide. In most cases, the adverse symptoms of victims fall well within the practice competencies of licensed mental health services providers. In few cases will the cause of these symptoms be immediately apparent; it is far more likely that the sexual assault will be disclosed only after a trust relationship has been established between the provider and the patient. At this point -- indeed at any point in therapy -- professional ethics and licensure standards require the provider to ensure his or own competency to continue to treat, or to refer to or consult with a more qualified professional.

While there are developing attempts to profile the most desirable training, experience and personal characteristics of professionals who treat victims of sexual assault, no consensus has yet emerged. More frequently, professionals complain that their basic preparation for practice has been insufficient in preparing them to fully understand and to treat sexual assault victims, and that graduate courses and on-going education offerings are not readily available. These are deficiencies which may be addressed without regulatory intervention by the Commonwealth.

SURVEY RESEARCH

Background

In July 1992, the appended survey was sent to all psychology, social work, and professional counseling boards in the United States. Questions included whether or not the state had a certification program and what criteria are used to certify these professionals, whether a state registry of sexual assault treatment providers is maintained (and by whom), and personal opinions regarding the advantages and disadvantages of a certification programs.

Surveys were returned from 37 states. Non-responding states were contacted by phone and asked whether they had a certification program or registry of individuals providing treatment to sexual assault victims or offenders.

Results

- No state has a certification program for sexual assault victim treatment providers. Iowa regulations require therapists working with **victims** to have 20 hours of training related to victim treatment. Oregon is considering establishing a task force to study certification. Georgia reports that a similar review will be undertaken in the future.

- One state -- Washington -- has a formal certification program for sex **offender** treatment providers. Certification requirements are appended.

- Other states have informal, voluntary procedures or guidelines for sex **offender** treatment providers.

  - A Texas interagency council maintains a registry of sex offender treatment providers.

  - In Colorado, the Department of Corrections maintains a service directory.

  - In New Hampshire, a private organization, the New Hampshire Perpetrator Network maintains a directory, as does the New Mexico Coalition against Sexual Assault.

COMMONWEALTH *of* VIRGINIA

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Survey of State Certification of Mental Health Providers of Sexual Assault Treatment

The Virginia Board of Health Professions is studying the feasibility and desirability of a state certification program for providers of mental health treatment to sexual assault victims and (especially) offenders. We would appreciate your completing the following information about certification of mental health providers in your state. You may answer directly on this questionnaire or prepare a narrative response if you wish. A self-addressed envelope is enclosed. **Please return by August 3, 1992.**

1. Does your state have a certification (or other specialty credentialing) program for providers of mental health treatment to:

Sexual assault victims? _____Yes _____No

Sexual assault offenders? _____Yes _____No

a. If yes, what criteria are used to certify these mental health providers? (Please specify if criteria are for treating sexual assault victims, offenders or both. If licensure or certification in a mental health professions such as psychiatry, clinical psychology, social work, professional counselor, etc. is a prerequisite, please specify).

b. If no, does your state have any other method of assessing the credentials of therapist who treat sexual assault victims or offenders? (please specify)

4. Does your state have a registry or directory of individuals specializing in the treatment of sexual assault victims or offenders? ______Yes _____No

If yes, who maintains this directory?

5. What do you believe are the advantages of a state certification program for mental health providers of treatment for sexual assault victims and offenders?

6. What do you believe are the disadvantages of a state certification program for mental health providers of treatment for sexual assault victims and offenders?

7. Other comments (Attach additional sheets if necessary)

Name of State Board ________________________

Name & Title of Person Completing Survey ________________________

Daytime Telephone Number (____) ________________________

Please enclose the law and/or regulations which pertain to state certification of mental health providers of sexual assault treatment.

PUBLIC COMMENTS

Background.

An informational hearing was convened in Richmond on August 20, 1992. Speakers included representatives from the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, the Shenandoah Valley Sex Offender Treatment Program, the Virginia Academy of Clinical Psychologists, therapists working with sexual assault victims and offenders, and adult sexual abuse survivors.

Results

A variety of opinion exists related to the need for certification. More comments favored certification for sex offender treatment providers than for those who treat victims. Arguments for and against certification for each population are summarized below.

Offenders.

Those **favoring** certification cited:

- o Need for minimal requirements, standards for education, training and experience in the field. Such standardization could improve treatment outcomes, prevent the unqualified from providing treatment, better protect the public, facilitate treatment approaches that have the best likelihood of success, and give disciplinary leverage to the state.

- o Courts need guidelines for resolving assault cases and a means for identifying qualified treatment providers. Clinicians are under pressure to act beyond their scope of competence. Certification could provide basis for selecting providers, better assure resolution of cases by building a cadre of expert evaluators and witnesses, establish a treatment network, increase public awareness and confidence in offender treatment.

Those **opposing** certification cited:

- o Unnecessary since codes of ethics and regulations prohibit provision of services outside the professional's area of competence. Licensing makes additional certification redundant; providers have adequate training and the public can judge competence.

- o Inappropriate since providers function across disciplinary lines, thereby confusing issues. Specialization of a narrow competence could lead to professional balkanization; difficult to

establish minimum standards; some competent providers might be excluded. Certification would lend false confidence; credentialing does not guarantee competence. Disciplinary cases in "dua licensure" professions have been difficult to adjudicate.

Victims

Those **favoring** certification cited:

- Inadequate, inappropriate treatment is likely to increase probability of increased mental health services and intervention in the future. Treatment needs are intermittent as child develops.

- Provider certification would minimize dangers and risks and raise the level of professional intervention.

Those **opposing** certification cited:

- Victims present with many problems; there is no single clinical picture or diagnosis. Certification would create the need for re-credentialing all mental health professionals.

- Certification would negatively affect access to services by decreasing the number of providers

- A therapeutic relationship is more important than the specific techniques used. A better solution would be to train all therapists in sexual abuse in entry-level and continuing education programs.

Washington State Certification Requirements

To apply for full certification as a sex offender treatment provider in the state of Washington, the applicant must meet the following criteria;

- o Have a master's or doctoral degree in a mental health field;
- o Be licensed as a mental health provider in their primary discipline, (e.g., psychiatry, psychology, social work or counselor);
- o have obtained 2000 hours of experience in the evaluation and treatment of sexual offenders. Of these 2000 hours, at least 250 hours must be in evaluation, and at least 500 hours must be in actual face to face treatment. Such experience must be obtained within 7 years preceding application;
- o Complete 50 hours of training from formal conferences, symposia, or seminars related to the treatment and evaluation of sex offenders or abuse victims within 3 years preceding application for certification. Once certified, 40 hours of continuing education are required every two years for certification renewal;
- o Take a written examination; and
- o Pay an application/ examination, initial and certification fee of $750.00.

To apply for affiliate certification process, the applicant must meet the following criteria:

- o An affiliate applicant must pass the written examination and be supervised by a fully certified sex offender treatment provider.
- o If an individual has met the minimal educational requirements (master or doctorate degree), no further experience is required.
- o If the minimal education requirements are not met (i.e., the individual has obtained only a bachelor degree) the individual must obtain 2000 hours of evaluation and treatment experience.
- o Affiliate members pay a $350.00 application, examination, initial, and certification fee.

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