

## INTRODUCTION

The literature consistently indicates that between 8% and 22% of all females and between 3% and 5% of all males in the United States have experienced sexual abuse before they reach the age of eighteen (Finkelhor, 1984). Finkelhor (1984) projects 210,000 new cases of sexual abuse will occur against children in this country each year. This figure is based on the conservative figures of 10% of females and 2% of males being abused and 60 million children currently under the age of 18. Scolatti (1986) claims that a conservative estimate of the number of rapes, including those not reported, to be between 100,000 and 200,000 annually. Accurate prevalence information concerning sexual deviancy is elusive because of poor reporting procedures and inconsistencies in defining the deviancies as deviant, however, it is clear that sexual deviancy is approaching epidemic proportion.

The professional community has identified the importance of addressing issues relating to sexual deviancy however, a number of problems exist. A wealth of material is available in the professional literature concerning sexual deviancy. The primary problem with this material is its inaccessibility and lack of uniformity for the professional clinician. The divergent use of terminology and conceptual frameworks makes much of the available literature virtually useless to the practitioner who is faced with overwhelming caseloads and little time to attempt to integrate and sort through this plethora of material. This book will attempt to present a summary of the current literature concerning sexual deviancy and will attempt to integrate this material into a comprehensive/coherent framework from which the clinician can develop a practical understanding of sexual deviancy. This book will also attempt to provide an introduction to the primary modalities of treatment for sexual deviancy currently in use.

## DEFINITION OF TERMS

Before embarking on a journey through the clinical literature, a few terms must be clarified. One of the fundamental problems in dealing with sexual deviancy literature is the problem of definition as we will see in later sections. The following is a brief review of some of the more basic and critical terms that will be used in this book:

**Sex Offender**--A sex-offender is an individual who has carried out an illegal sexual behavior. For the purposes of discussion in this book, only male sex offenders will be considered. Not enough solid, empirical information is available to generalize the findings of research on males to females.

**Sex Offence**--The sexually abusive behavior of an individual which results in the removal of social privilege. The term sex offence includes, but is not limited to, the following behaviors: rape, gross sexual imposition, sexual battery, attempted rape, attempted gross sexual imposition, attempted sexual battery, and promoting prostitution.

The Ohio Revised Code (1985) defines these some of these offenses as follows:

**Rape**--Engaging in sexual conduct with another, not the spouse of the offender, when any of the following apply:

- (1) The offender purposely compels the other person to submit by force or threat of force.
- (2) For the purpose of preventing the other person's judgment or control by administering any drug or intoxicant to the other person, surreptitiously or by force, threat of force, or deception.
- (3) The other person is less than thirteen (sic) years of age, whether or not the offender knows the age of such person. (pp. 28-29)

**Sexual Battery**--Engaging in sexual conduct with another, not the spouse of the offender, when any of the following apply:

- (1) The offender knowingly coerces the other person to submit by any means that would prevent resistance by a person of ordinary resolution.
- (2) The offender knows that the other person's ability to appraise the nature of or control his or her own conduct is substantially impaired.
- (3) The offender knows that the other person submits because he or she is unaware that the act is being committed.

(4) The offender knows that the other person submits because such person mistakenly identifies the offender as his or her spouse.

(5) The offender is the other person's natural or adoptive parent, or a stepparent, or guardian, custodian, or person in loco parentis.

(6) The other person is in custody of law or a patient in a hospital or other institution, and the offender has supervisory or disciplinary authority over such other person. (pp. 29-30)

**Corruption of a Minor**--A person, eighteen (sic) years of age or older, engaging in sexual conduct with another, not the spouse of the offender, when the offender knows such other person is over twelve (sic) but not over fifteen (sic) years of age, or the offender is reckless in that regard. (p. 30)

**Gross sexual imposition**--Sexual contact with another, not the spouse of the offender; causing another, not the spouse of the offender, to have sexual contact with the offender; or causing two or more other persons, to have sexual contact when any of the following apply:

(1) The offender purposely compels the other person, or one of the other persons, to submit by force or threat of force.

(2) For the purpose of preventing resistance, the offender substantially impairs the other person's, or one of the other person's, judgment or control by administering any drug or intoxicant to the other person, surreptitiously or by force, threat of force, or deception.

(3) The other person, or one of the other persons, is less than thirteen (sic) years of age, whether or not the offender knows the age of such person. (pp. 30-31)

**Sexual Conduct**--Vaginal intercourse between a male and a female, and anal intercourse, fellatio, and cunnilingus between persons regardless of sex. Penetration, however slight, is sufficient to complete vaginal or anal intercourse (Ohio Revised Code, 1985).

**Sexual Contact**--Any touching of an erogenous zone of another, including without limitation the thigh, genitals, buttock, pubic region, or, if the person is a female, a breast, for purpose of sexually arousing or gratifying either person (Ohio Revised Code, 1985).

**Sexual Compulsivity**--A compulsive, uncontrollable desire to be sexual. This is very similar to the concept of sexual addiction however no physically addictive component is implied.

**Sexual Deviancy**--Sexual behavior that is significantly different than normal as defined by the United States cultural norms and/or as defined by statistical standards. Sexual deviancy includes paraphiliac behavior in addition to traditional sexual offenses.

## Difficulties in Assessing Sexual Deviancy

Virtually every sexual deviancy theorist in recent years has acknowledged that sexual deviancy is a multifaceted problem (Berlin & Coyle, 1981; Carnes, 1985; Finkelhor, 1981; Groth, 1984). Although these theorists have acknowledged the multifaceted aspect of sexual deviancy, they have failed to provide the professional community with a comprehensive model for understanding sexual deviancy at the individual level and they have failed to establish a reliable method of assessing sexual deviancy. Scales have been developed to measure specific components of sexual deviancy (Burt, 1980; Gilbert & Gamache, 1984; Hedges, 1987; and Olson et al., 1985), however, these scales only measure one component of sexual deviancy and most of them were developed on very limited populations of sex offenders. The one instrument that does attempt a multifaceted approach to assessing sexual deviancy, the Multiphasic Sex Inventory (Nicholes & Molinder, 1984), approaches the task from a behavioral standpoint and therefore, simply attempts to measure behavior rather than personality dynamics.

Assessments have several purposes including: a) providing a common language for professionals to express information about an individual, b) determining the severity and/or dangerousness of the individual against him/herself and others, c) developing treatment recommendations, d) determining amenability to treatment, and e) making specific recommendations for case dispositions. Each of these goals of assessment has unique difficulties when applied to the sex offender.

Frequently the assessment of sexual deviants is requested by the Criminal Justice System and therefore the sexual offense and sexual deviancy is defined legally rather than in terms of the individual's dynamics or motivation for the deviancy. That is, the behavior is defined rather than the dynamics of the individual. To further complicate this situation, the definition of the behavior varies widely from state to state and from jurisdiction to jurisdiction. Beyond the inconsistencies within the criminal justice system in labeling sexual deviancy, the mental health community has also failed to develop a concise vocabulary. The Diagnostic and Statistical Manual third edition revised (1987), provides some labels. However, because these labels are grossly inadequate to describe many of the dynamics and behaviors related to sexual deviancy, few researchers or theorists have limited themselves to this vocabulary. Instead, the professional community has developed a very diverse vocabulary to describe the phenomena and this vocabulary is used very inconsistently from one researcher to another (Scolatti, 1986).

A problem closely related to the problem of labeling sexual deviancy is that of determining the dangerousness and severity of the deviancy. Because of the inconsistencies in reporting and labeling sexual deviancy, researchers have had difficulty developing reliable base rates for further acting out of subgroups of sexual deviants. Measures such as recidivism are virtually useless in attempting to determine the likelihood that a particular individual will re-offend. The majority of victims do not report their assaults to authorities, and even when the offense is reported, no suspect is apprehended in a majority of cases. To further complicate measurements such as recidivism, a sizable number of offenders successfully plea-bargain their charges to nonsexual offenses (Groth, 1979). Without objective base rates relating particular types of sexual deviancies to continued sexual acting out, the professional must rely on research that is based on self report data. Although self report data provides the professional with some basis for determining the probability of further acting out behavior, it is hardly conclusive evidence.

Another major difficulty in determining the dangerousness and severity of the sexual deviant is a lack of reliable and valid instruments to measure sexual deviancy. We as mental health professionals have learned to rely on the client's self-report of behavior and discomfort to evaluate sexual deviancy. Many of the instruments that we rely on to determine the severity of sexual deviancy are questionnaires, check sheets, and sexual histories that are highly transparent and rely on the client's honesty and openness. Those relatively non-transparent instruments that attempt to measure sexually deviant traits such as the MMPI have had, at best, marginal success differentiating sexual deviants (Hall, Maiuro, Vitaliano, & Proctor, 1986). Nichols and Molinder (1984) state:

An act of sexual deviance does not exist until it is discovered to exist. That is, the only criterion used to identify this group is the act itself. This is not to say that sexual deviance does not exist in the general population; in fact, it appears to be reaching epidemic proportions. The point here is that no test, no device, has the power to pick out a sexually deviant person from any other person in a crowd. Discovery is the only basis in which these individuals may be identified, at least at this time.

Determining the amenability to treatment and making treatment recommendations are closely related issues. Because no single diagnostic classification system has been established by the professionals working with sexual deviants, no single treatment model has been developed. Without a common language to describe the phenomena of sexual deviancy, professionals have tended to develop their own treatment procedures for their particular labels and perceptions of what "causes"

sexual deviancy. A confounding issue related to treatment recommendations is the client's motivation and/or amenability to treatment. Often the client has been sent for evaluation as a requirement of the criminal justice system and is not particularly interested in changing. Rather he/she is simply attempting to get away from the criminal justice system. For other clients, the need for sexual gratification through deviant means has become so pervasive in their lifestyles that they do not see change as feasible for themselves.

In making specific recommendations for the disposition of a particular case, the clinician is faced with determining the best solution for not only the client, but also for the victim and society as a whole. This recommendation must be made on limited information since many of the factors that would be appropriate in making a sound recommendation are often unavailable or unknowable. These unavailable/unknowable factors may include; impact of the deviant behavior on victim, the victim's response to the deviant behavior and to the possible disposition of the sexually deviant individual, the dangerousness of the sexually deviant individual, situational factors that may have influenced the deviancy and their current status, and what factors are most likely to facilitate the sexually deviant individual to act out again.

These difficulties in assessing the sexually deviant individual are not insurmountable but are severely limiting. The clinician must be aware of the limitations when assessing the sexual deviant if he/she is going to make reasonable use of the assessment.

## ETIOLOGICAL MODELS

Several theorists have attempted to establish developmental models of sexual deviancy. Each of the models presented in this book is based on different theoretical approaches to sexual deviancy. The developmental models reviewed here will include a bio-sexual model, a psycho-social model, an addiction model, a family systems model, a psychodynamic model, and a cognitive-behavioral model. None of the models presented claims to be able to entirely explain the development of sexual deviancy but some do claim to address certain subgroups of sexual deviants.

### Bio-sexual Model

Supporters of the bio-sexual model propose that sexual deviancy is the result of a combination of biological factors and environmental factors. Berlin and Coyle (1981) state:

Sexual deviation syndromes (paraphilias) are diagnosable psychiatric syndromes manifested by 1) recurrent persistent deviant fantasies, 2) intense erotic cravings that are noxious when frustrated, and 3) relatively stereotyped behaviors in the sense that exhibitionists expose themselves, whereas voyeurs "peep." These syndromes follow a predictable course, often respond to biological treatments, and may have associated organic pathologies, but their etiologies are poorly understood. (p. 125)

In a study conducted by Berlin and Coyle (1981) of 22 consecutively assessed paraphiliac patients, six were shown to have elevated levels of testosterone, two had elevated Luteinizing Hormone levels, four had cortical atrophy as the result of an auto accident, two were dyslexic, one had a childhood learning disorder, one had Klinefelter's syndrome, one had basal ganglion dysfunction, one had schizophrenia, and only four had no detected abnormalities. Roth (1977) states that the limbic system appears to be involved in emotional and motivational behavior in that lesions or stimulation within this system can lead to alterations in sexual, aggressive, and fear responses. Eichelman (1977) indicates that antiandrogen agents like medroxyprogesterone acetate (Provera) may be a beneficial treatment for some sexually aggressive individuals.

### Psycho-social Model

Finkelhor (1984) proposes a psycho-social model of child sexual abuse. This model has four primary factors as follows:

1. The potential offender needs to have some motivation to abuse a child

sexually.

2. The potential offender has to overcome internal inhibition against acting on the motivation.
3. The potential offender has to overcome external impediments to committing sexual abuse.
4. The potential offender or some other factor had to undermine or overcome a child's possible resistance to the sexual abuse.

Although Finkelhor (1984) states these preconditions in terms of child sexual abuse, they appear to apply equally well to any sexual abuse. For sexual abuse to occur, all four preconditions must be met at the same time.

If any one of the preconditions cease to be met in the process of the abuse then the sexual deviant will stop.

Finkelhor (1984) indicates that the first precondition includes three components: (a) emotional congruence (relating at the victim's level); (b) sexual arousal to the victim; (c) blockage (unavailability of more conventional sources of gratification or other sources of gratification are less satisfying). Not all three components of this precondition must be met for sexual abuse to occur. Fulfilling at least one of the factors can meet the first precondition.

Most individuals have developed internal inhibitors that prevent them from acting out on all of their desires (the Freudian Super-Ego). This lack of internal inhibitors may be the result of (but not limited to) alcohol, subculture norms, upbringing, personal experience (abused as a child), psychosis, impulse disorder, or senility. If any of these disinhibitors is present then the second precondition is met.

The first two preconditions are met internally by the sexual deviant. The last two preconditions pertain to external events. For the third precondition to be met the sexual deviant must have access to a potential victim in a "safe" situation in which he/she is able to carry out the act without being stopped. A "safe" situation means that the sexual deviant must feel that he/she has a low probability of being caught and/or prosecuted for the act. In the family system this precondition can be met in a variety of ways. Often the mother feels alienated from the father and victim and begins to deny that the abuse could happen. In other cases the mother is openly aware of the abuse but is afraid to report it because she is unable to deal with the possibility of having the family unit separated. As a result of the mother's fear of reporting the abuse and the child's inability to report the abuse to others, the offender is able to maintain the abusive behavior in a secretive, and therefore safe, environment. In other sexually deviant behavior, the precondition of safety is met by ensuring a position of anonymity by attacking a stranger and removing this individual to a desolate

place. In other situations, the sexually deviant individual makes no attempt to be "safe", but rather feels the victim will enjoy the behavior and will therefore not turn him/her in to authorities.

For the fourth precondition to be met the sexual deviant must be able to overcome the victim's resistance. This can be accomplished through threat, physical power, seduction, or manipulation. Frequently the victim has been reared in a situation that does not delineate family roles and therefore teaches that being openly sexual is "normal". In other situations, the victim experiences a need to fulfil the mother/father's role, in the mother/father's apparent absence, and therefore feels obligated to be sexual with the sexually deviant person. In traditional family therapy terminology, these examples involve triangulation, role diffusion, and role reversal.

### Addiction Model

Carnes (1983, 1985) has developed an addictive systems model of sexual deviancy and argues that sexual deviancy is the result of messages that the individual tells him/herself and how these messages are acted upon. This model is particularly useful in describing the paraphiliac individual and closely parallels the models of alcohol addiction, drug addiction, gambling addiction, and eating addiction.

The sexual addiction system begins with a set of core beliefs. These core beliefs are an accumulation of all of the individual's life experiences. Common core beliefs of the sexual addict include: (a) I am basically a bad, unworthy person, (b) no one would love me as I am, (c) my needs are never going to be met if I have to depend on others, (d) sex is my most important need (Carnes, 1983).

The faulty beliefs, myths, and values from the core beliefs form the basis for impaired thinking. The impaired thinking portion of the addiction cycle can be described as a delusional thought process that keeps the sexual addict from having contact with reality. Some common impaired thoughts include: (a) I must get sex whenever I have the opportunity, (b) he/she really wanted to have sex with me but just had to put up a show of resistance, (c) he/she tricked me into doing it, (d) they are just too conservative, (e) I am really not good enough for others to want to have sex with me so I must make others have sex with me. This impaired thinking gives the sexual addict a justification and/or an excuse for his/her behavior.

The addiction cycle has four components: preoccupation, ritualization, sexual compulsivity, and despair. Preoccupation is depicted by intrusive sexual thoughts and compulsive fantasies. In response to this

obsessive, mental search for sexual stimulation, the sexual addict often develops a special routine which leads up to sexual behavior. This ritual may include cruising bars or playgrounds, gathering sexual paraphernalia, cross-dressing, etc., and intensifies the sexual experience. The compulsive sexual behavior occurs when the preoccupation and ritualization reach a peak. This is the actual acting out of the sexually deviant behavior. Shortly after the sexual acting out, the sexual addict experiences a profound sense of guilt, hopelessness, and powerlessness. This despair may be intensified when the addict is faced with the consequences of his/her behavior.

As the addictive cycle continues within the system, the addict's life becomes increasingly more unmanageable. This unmanageability may be depicted by loss of employment, self mutilation, profound family problems, and often expenditure of large sums of money for sexual paraphernalia and prostitutes. This unmanageability then contributes to the addicts belief system and continues the addictive system.

The addiction system is a self perpetuating and escalating system. Carnes (1983) states that the sexual addict will progress through three levels if not treated. The first level is depicted by compulsive masturbation, promiscuity, pornography, and prostitution. The second level is depicted by exhibitionism, voyeurism, indecent phone calls, and indecent liberties. The third and most severe level includes such acts as child molestation, incest, and rape.

### Family Systems Model

In addition to the sexual addiction system, Carnes (1985) has adapted the Circumplex Model of Marital and Family Systems (Olson & Craddock, 1980) to describe the effects of family of origin on sexually abusive persons. Olson and Craddock (1980) contend that sixteen types of families exist and can be described by their relative positions on two intersecting continua. The first continuum deals with dependency issues and has the extremes of chaotic family structure and rigid family structure. The second continuum deals with intimacy issues with the extremes being a disengaged family structure and an enmeshed family structure.

The chaotic family system can be described as having no accountability for sexual behavior, discrepancies between values and behavior, parental sexual unmanageability and inconsistent standards and consequences. Frequently, role reversals around sexual behavior are apparent. The chaotic family system does not have any clearly defined rules or expectations and the children often are dealt with as though they are authoritatively equal with the parents.

Moralistic black and white standards, extreme efforts to control child sexual behavior, severe punishment for sexual behavior, and unreachable expectations about sexuality are common elements of the rigid family system. As a result of the extreme structure and high expectations, the child is unable to develop his/her own system of self regulation. The child may respond to the authoritarian position of the parent through rebellious direct acting out behavior.

On the other continuum, the disengaged family structure can be described as having emotional abandonment, having tension and distance around sexual matters, lacking in physical or sexual affirmation, and evading sexual issues. The disengaged system views sex as something to be discovered by the individual and not to be discussed. The child in the disengaged family is likely to feel alone and without support.

The opposite of the disengaged family system is the enmeshed family structure. In the enmeshed family system, a lack of boundaries is evident. The enmeshed family can also be described as having anxiety about a family member's sexual behavior reflecting on the family, secrecy preserved by not talking with outsiders, covert and overt sexual abuse, and limited sexual privacy. Children in the enmeshed family system do not develop a self identity. They tend to develop a communal identity with few authority lines drawn clearly.

According to Carnes (1985), most sexual addicts come from chaotically enmeshed family systems.

## Psychodynamic Model

Psychodynamic theorists claim that sexual deviancy is the result of unresolved conflicts in the unconscious. Groth (1979), one of the most noted proponents of the psychodynamic model of sexual deviancy, divides sexual abuse into the two primary categories of molestation and rape. The molestation category can be divided into fixated molesters and regressed molesters (Burgess, Groth, Holmstrom, & Sgroi, 1978). The rape category can be divided into three groups: anger rapist, power rapist, and sadistic rapist (Groth & Birnbaum, 1979).

In molestation, the offender approaches the victim as though he/she is seducing the victim and uses deception, enticement, and manipulation to gain access to the victim. The offender tends to be passive and dependent and views the child victim as "safe" and "caring". The victim is the object on which the offender projects his/her fantasies and needs. Although the molester is misusing the child, he/she hopes and/or believes that the victim is enjoying the sexual contact and wants the victim to perceive the sexual

contact as an expression of affection and acceptance.

The fixated molester's primary sexual orientation is to children (pedophilia). This interest began during adolescence and usually is persistent, to the point of being compulsive, throughout adulthood. Typically the fixated molester identifies with the victim and plans the offence in advance. In psychodynamic terminology, the offence is a maladaptive resolution of maturation issues.

The regressed molester's primary sexual orientation is to persons of similar age. However, in response to situational stressors and the effects of disinhibitors (such as alcohol), the regressed molester episodically abuses a child. This abuse is viewed as a maladaptive attempt to cope with specific life stresses.

In rape, the offender attacks the victim sexually. Access to the victim is gained through threat, intimidation, and/or physical force. The victim is usually viewed as an object by the offender and is cast into a negative role. The primary motive in rape is the expression of aggression and control.

Anger rape can be depicted as an impulsive expression of anger and depression. Anger rape tends to be episodic and often involves verbal degradation and physical battering. The victim is the target of anger resulting from perceived wrongs, injustices, and negative experiences of the offender. The offender may have a criminal record for crimes of aggression including assault and battery, disorderly conduct, and reckless driving.

Achieving a sense of control and power is the primary motivator of the power rapist. This need for power is an attempt to compensate for feelings of insecurity and inadequacy. The power rapist uses only enough force to overcome the victim's resistance and often the power rapist will verbalize demands in an instructional, directive manner rather than in a derogatory, abusive way.

Eroticized aggression, symbolic control, and an attempt to regain psychological equilibrium are the primary motivations of the sadistic rapist. The victim is subjected to ritualistic acts of torture and sexual abuse. The offender experiences a compulsive need to act out his/her fantasies of aggression and sexuality. The assault may include kidnapping, bondage, beatings, and mutilation and may continue over an extended period of time.

According to the psychodynamic model of sexual deviancy, it is important to note that the primary motivation is not sex. Rather, sex is the mode of expression for other, deeper needs.

## Cognitive-behavioral Model

In developing the Multiphasic Sex Inventory, Nichols and Molinder (1984) proposed a model of sexual deviancy based on the offender's cognition and behavior. This model can be symbolically represented by the formula:

$$X = \alpha + \beta + \varepsilon$$

$X$  = Existence of sexual deviance

$\alpha$  = Cognitive and behavioral progression

$\beta$  = Individual differences

$\varepsilon$  = Defending deviance through deception

According to Nichols and Molinder (1984), a cognitive progression of criminal thinking errors occurs before the sexual offense is committed. This cognitive progression may take a matter of seconds or years and includes:

1. The idea to commit the sexual assault.
2. The distorted view that most of society is unjust and uncaring and that he/she is a victim of this unjust system.
3. Justifications, excuses, rationalizations, and distortions "give the permission" to commit the act.
4. Fantasies about irresponsible use of power over weaker persons for pleasure.
5. The plan to "successfully" commit the offence.
6. The belief that the sexual offense can be accomplished without repercussions and the "high" resulting from this belief.
7. The immediate decision to commit the offence when the first six steps have been accomplished.

Closely related to the cognitive progression is a behavioral progression (Nichols & Molinder, 1984). In the behavioral progression, the offender hunts for his/her victim(s). This hunt may involve cruising, stalking, or manipulating a situation. The second stage of the behavioral progression involves the "playing" with the victim. This "playing" may include any behavior that intensifies the sexual assault experience for the offender such as verbal abuse, winning a child over with candy, or making the victim act out a role. The last stage of the behavioral progression is the actual sexual assault which may range from exposing to direct physical assault.

Sexually deviant individuals must defend their deviancies in order for the deviancies to be maintained (Nichols & Molinder, 1984). This defending usually takes some combination of the following forms: 1) deception through dishonesty, 2) deception through distortion, and 3) deception through denial. In deception through dishonesty, the offender attempts to manipulate the truth through a system of lies, omissions of details, and additions to the truth. Deception through distortion occurs when the offender attempts to defend his/her behavior by utilizing cognitive distortions

and justifications such as, "She/he really wants sex," "We just made love," "I just washed his penis and bathed him," or "She was curious about sex." Deception through denial occurs when the offender admits to others his/her guilt but attempts to deceive him/herself about being aroused by sexually deviant desires.

The proponents of the cognitive-behavioral model state that for the sexual assault ( $X$ ) to occur; the offender must go through a progression of cognitive distortions and behavioral stages ( $\alpha$ ) which involve the accumulation of unique behaviors and characteristics ( $\beta$ ) and must be defended internally and externally by the offender ( $\epsilon$ ) (Nichols & Molinder, 1984).

## TAXONOMY MODELS

A variety of classification systems and typologies of sexual deviancy have been established for sex offenders. The following is a brief summary of the primary taxonomy systems that have been developed over the last 40 years.

One of the earliest classification schemes of sex offenders was proposed by Guttmacher (1951) and included six classifications: sadistic rape, explosive rape, aggressive rape, young pedophile, senile pedophile, and sadistic pedophile. Many of the current classification schemes include these elements and/or derivatives of the elements. Prior to this type of classification scheme, sex offenders were considered a homogeneous group classified as "sex maniacs".

While most authors concur that a single rape incident can possess various components of different rape categories, the clear implication of each diagnostic system is that one type of rapist is separate, distinct, and non-overlapping with a different type of rapist (Tirrell & Aldridge, 1983). Unfortunately, none of the current classification schemes have been substantiated by rigorous empirical research and only one classification scheme has established minimal empirical validation (Scolatti, 1986). Primarily, the current systems of classification are hypothesized typologies designed to aid the clinician, researcher, and law enforcement personnel in dealing with sex offenders.

### Guttmacher's Classification System

As mentioned earlier, one of the first typologies of sex offenders was presented by Guttmacher (1951). In this classification system, three categories of rape were proposed: sadistic rape, explosive rape, and aggressive rape. Guttmacher describes these three types of rapists as follows:

I feel confident that there are at least three types of rapists. There is the rapist whose assault is the explosive expression of pent-up sexual impulse. He is a true sex offender. A second group that is also basically sexual in origin, although not so manifestly so, is the sadistic rapist. Masculine sexual activity is aggressive and has within it socially modified sadistic elements. But there are sick individuals in which this becomes exaggerated until it dominates the picture and culminates in sexual attack. Then there is a third type of rapist who, paradoxically enough, is apparently not a true sex

offender. He is the aggressive criminal who is out to pillage and rob, like the soldier of a conquering army. (p. 50)

In describing the pedophilic classifications, Guttmacher (1951) describes the young pedophilic as passive, immature, and insecure. The young pedophilic individual lacks the courage to attempt sexual contact with contemporaries and fears the obligation of performing satisfactorily for a sexually experienced and possibly critical adult. The senile pedophilic is described as entering his/her second childhood and thus indulges in various forms of sex play with children as growing senility contributes to regression to childhood activities. In sadistic pedophilia, aggression is discharged for its own sake and pain is inflicted as an end in itself.

### Weinberg's Incest Classifications

Weinberg (1955) proposed one of the first comprehensive models of child molesters. Three types of offenders are identified in this model and include; endogamic incest, pedophilic, and indiscriminately promiscuous.

The adult endogamic incest participant confines sexual behavior to family members, resorts to incest with his/her child or sibling because he/she does not cultivate and does not crave social or sexual contacts with peers outside the family (Weinberg, 1955). The pedophilic offender tries to seduce young children in addition to family members. Though sometimes promiscuous, the pedophilic offender is shy of or averse to adults. When the pedophilic offender does seduce adults, he/she selects very promiscuous ones who will neither resist his/her attentions nor ridicule him/her. The indiscriminately promiscuous person is described as psychopathic by Weinberg (1955). The indiscriminately promiscuous person desires and pursues adult sexual relationships and may pursue sexual relationships with children both before and after incest experiences.

### Cohen, Seghorn, and Calmas' Classification System

Cohen, Seghorn, and Calmas (1969) used a sociometric procedure to study differences in social effectiveness and to test the usefulness of their classification system on 65 pedophiles and rapists. The diagnostic procedure identified four groups of rapists and three groups of pedophiles. The seven sex offender groups include: rapist-displaced-aggression type, rapist-compensatory type, rapist-sex-aggression-diffusion type, rapist-impulse type, pedophile-fixated type, pedophile-regressed type, and

pedophile-aggressive type.

According to Cohen et. al. (1969), in some acts of rape the intent of the act is primarily aggressive with sexual feelings minimal or absent. Sexual behavior is used to physically harm, degrade, or to defile the victim in the service of the aggressive intent. For the rapist-displace-aggression type of offender, the victim is unknown to the offender and is the object for displaced aggression. For the rapist-compensatory type offender, there is a pervasive, almost obsessive, concern with feelings of sexual inadequacy and the rape is an effort to compensate for or counteract these feelings of impotency and inadequacy. The rapist-sex-aggression-diffusion type offender is not able to experience, or even fantasize, sexual desires without a concomitant arousal of aggressive thought and feelings. Further, the rapist-sex aggression-diffusion offender projects these aggressive thoughts and feelings onto his/her victim and sees the victim's struggles and protestations as seductive. The final type of rapist, the rapist-impulse type, rapes simply as another aspect of the offender's predatory nature. The rapist-impulse type offender often rapes in the context of some other antisocial act such as robbery or theft.

Three types of pedophile offenders were identified by Cohen, et. al. (1969). The pedophile-fixated type has a primary sexual interest in touching fondling, caressing, sucking, and smelling the child. The fixated pedophile usually has not been able to develop or maintain mature object relationships with peers at any stage of his/her life. The pedophile-regressed type, on the other hand, has a history of an apparently normal adolescence with good peer relationships, some dating behavior, and heterosexual experiences. In most cases, the acting out of the regressed pedophile offender is precipitated by some direct confrontation of his/her sexual adequacy by an adult. For male regressed pedophiles, the acting out may be precipitated by a threat to his masculine image by a male peer. The pedophile-aggressive type offender is primarily motivated by aggression and expresses this motivation through cruel and vicious assaults on the genitalia or by introducing the penis or elongated objects into the victim orally or anally. Primarily, the pedophile-aggressive type offender chooses victims of his/her own sex.

### Woodling, Evans, and Bradbury's Model

Woodling, Evans, and Bradbury (1977) have attempted to classify sex offenders according to personality disorders in the Diagnostic and Statistical Manual of Mental Disorders based on their clinical experience. Woodling et. al. indicate that sex offenders can be categorized as possessing one of the

following disorders: inadequate personality disorder, antisocial personality disorder, or explosive personality disorder.

According to Woodling et. al. (1977), a rape that results from a primary sexual impulse is usually committed by an individual with an inadequate personality who is overwhelmed by his/her sexual desires or combined homosexual drives. The more aggressive and destructive rapist who abuses and inflicts great bodily harm on his/her victim usually manifests both antisocial and explosive personality traits. Child molesters are described as representing an entirely separate group of sexual offenders who have pathological, heterogeneous personality factors.

### Groth's Model of Sexual Offending

Groth (Groth & Hobson, 1983) states, "Rape is a behavior; it is not in and of itself a diagnostic entity. It is a behavior anyone is capable of exhibiting, and it cuts across all conventional classifications of psychiatric conditions" (p. 159). According to Groth (Burgess, Groth, Holstrom, & Sgroi, 1978; Groth & Burgess, 1977), sexual offenders can be classified into three types of rapists and two types of molesters: anger rapists, power rapists, sadistic rapists, fixated molesters, and regressed molesters. Groth's model of sexual offending is based primarily on his clinical experience and has previously been described under the heading of Psychodynamic Model.

### Anderson, Kunce, and Rich's Three Personality Type Model

Anderson, Kunce, and Rich (1979) used Minnesota Multiphasic Personality Inventory (MMPI) profiles on 92 sex offenders (rape, child molestation, incest) to develop a taxonomy of offenders. The results of a factor analysis procedure provided three clusters of offenders.

The F, Sc type offender showed elevations on the "Fake" (F) and "Schizophrenia" (Sc) scales on the MMPI (Anderson et al., 1979). This type of offender can be described as having a "bad judgment" profile because that seems to be the theme that runs through the records. This group was most likely to indicate that the victim had asked for sex in some way, was most anxious, depressed, and suspicious, and was most likely to show long-term socially maladjusted behavior.

The Pd, Ma type offender showed elevations on the "Psychopathic Deviant" (Pd) and "Manic" (Ma) scales on the MMPI (Anderson et al., 1979). This group of offenders shows less severe adjustment problems both prior

to, and after the crime. This group presented the expected characteristics of persons with elevated Pd and Ma scales.

The D, Pd type offender showed elevations on the "Depression" (D) and "Psychopathic Deviant" scales (Anderson et al., 1979). This group tended to be older and less well-educated than the other two groups. This type offender is likely to have a substance abuse history and a previous criminal history.

### Diagnostic and Statistical Manual III

The Diagnostic and Statistical Manual of Mental Disorders, third edition-revised (1987) (DSM-III-R) provides several methods of categorizing sex offenders depending on the characterological makeup of the offender. Many diagnostic categories include sexual acting out as part of the criteria and include: Exhibitionism, Fetishism, Frotteurism, Pedophilia, Sexual Masochism, Sexual Sadism, Transvestic Fetishism, Voyeurism, Paraphilia Not Otherwise Specified, Antisocial Personality Disorder, Borderline Personality Disorder, Histrionic Personality Disorder, Manic Episodes, Bipolar Disorder, and Cyclothymia.

The diagnostic category that is most concerned with sex offenders is Paraphilia. Paraphilia is defined by the DSM-III-R (1987) as: recurrent intense sexual urges and sexually arousing fantasies generally involving either (1) nonhuman objects (2) the suffering or humiliation of oneself or one's partner (not merely simulated), or (3) children or other nonconsenting persons. The diagnosis is made only if the person has acted on these urges, or is markedly distressed by them. (p. 279) Some Paraphiliac individuals may require deviant sexual fantasies in order to obtain erotic arousal. Other individuals may resort to deviant sexual fantasies and behavior as a means of coping only during times of stress.

### Knight, Prentky, & Rosenberg's Model

Knight (1988) and Prentky, Knight, and Rosenberg (1988) have proposed one of the most comprehensive and most validated taxonomic systems to date. This model proposes six types of child molesters (Interpersonal, Narcissistic, Exploitative, Muted Sadistic, Non-Sadistic Aggressive, Sadistic) and four types of rapists (Compensatory, Exploitative, Displaced Anger, Sadistic). These groups were determined based upon a sample of 378 convicted sex offenders in Massachusetts using cluster analysis and factor analysis techniques.

In categorizing child molesters, Knight (1988) determined the following dimensions to be significant: amount of contact with children, meaning of contact, amount of physical damage, and meaning of aggression. Both Interpersonal molesters and Narcissistic molesters desire high levels of contact with children. Interpersonal molesters are described as wanting interpersonal contact with others and seek out children for a caring relationship that becomes sexual. Narcissistic molesters, on the other hand, are primarily concerned with personal sexual gratification and seek out children for this purpose. The other classifications of molesters are described as having low contact with children.

For the remaining four types of molesters, the primary distinction is in the amount of physical damage done and the motivation for the aggression (Knight, 1988). Exploitative and Muted Sadistic molesters usually do not do much physical damage to victims. Non-sadistic aggressive and Sadistic molesters usually do significant damage to their victims.

Prentky, Knight, and Rosenberg (1988) have identified rapists into four categories (theoretically seven) based on two dimensions. The first dimension is the degree of physical injury incurred by the victim. The second dimension is the meaning of the aggressive motivation intended by the offender at the time of the victimizing event. Category one, the compensatory offender, is attempting to "make up" for his/her inadequacies and typically uses a minimal amount of violence. The exploitative offender, category two, also uses a minimal amount of violence and is seeking sexual gratification and is using the victim as a sexual object. For the third category, the displaced anger offender, the motivation is to release his/her anger. The displaced anger offender may use a range of violence (from almost no violence to murder) to release this anger. The sadistic offender, the fourth category, is seeking to hurt for the sake of hurting. A sub-category, the muted sadistic offender has more control than the sadistic offender and usually resorts to humiliation and degradation rather than physical damage to the victim.

## **AN INTEGRATED MODEL**

Clearly an integrated model of sexual deviancy is called for based on the diverse and sometimes contradictory hypothesis supported by the various theorists. An integrated model of sexual deviancy should include elements from each of the supported theories and should account for the variance between individual sexual deviants. The model should be atheoretical and should simply attempt to explain the relationship between factors related to sexual deviancy rather than try to establish a causal connection (since no theorist has yet been able to establish any clear causal link). The following is an attempt to establish such an integrated model.

Five major elements must be accounted for when attempting to understand sexual deviancy: 1) biological factors, 2) developmental factors, 3) personality factors, 4) environmental factors, and 5) conditional factors. Each of these elements must be explored thoroughly to understand the dynamics of an individual sexual deviant. That is, each of these areas impact the sexual deviant's ability/motivation for committing a sexually abusive act. None of these elements can be said to be causal, however they have been shown to be correlated to sexually abusive acting out behavior.

### **Biological Factors**

Under the auspices of biological factors, three major areas must be explored. The first is neurological abnormalities. As indicated earlier, several specific neurological impairments have been associated with sexual acting out behavior. Secondly, hormonal issues must be assessed. A history of elevated levels of testosterone or Luteinizing hormone may be associated with acting out behavior (Berlin and Coyle, 1981). Finally, issues related to appearance and acceptance of body image is related to personality structures and environmental conditions to be discussed later.

### **Developmental Factors**

The second major factor to be explored is the developmental history. Issues that have been correlated to sexual deviancy include: experiencing abuse as a child, experiencing specific traumatic events as a child, and experiencing the dynamics of the family of origin. These three issues are all related to the dynamics described earlier under the heading of "Family Systems Model."

Carnes (1985) used the instrument FACES II to investigate the family

systems of sex offenders and showed that about one-half of their families of origin were extreme family types and about two-thirds of their current families were extreme while only nineteen percent of non-offender's current families were extreme. Carnes (1985) has shown that most sexual addicts come from chaotically enmeshed family systems. Olson, McCubbin, Barnes, Larsen, Muxen, and Wilson (1985) developed FACES II to measure adaptability and cohesion of the family of origin. Hedges (1988) indicates that other groups of offenders can be predicted as coming from other categories as defined by Olson and Craddock's (1980) Circumplex Model of Marital and Family Systems.

### Personality Factors

The third major factor involves the personality characteristics of the sexual deviant. Specifically, three dynamics are related to sexual deviancy: 1) level of aggression, 2) level of socialization, and 3) level of addiction.

#### Aggression

Koss, Leonard, Beezley, and Oros (1985) in a study of 93 undetected sexually aggressive men who had assaulted female acquaintances discovered that the more sexually aggressive a man had been, the more likely he was to attribute adversarial qualities to interpersonal relationships, to accept sex-role stereotypes, to believe myths about rape, to feel that rape prevention is the woman's responsibility, and to view as normal an intermingling of aggression and sexuality. Malamuth (1983) has shown that a scale defined as "acceptance of interpersonal violence" is useful in associating real-world aggression against women and men's laboratory aggression against a female. Baron (1974) has shown that the victim's pain cues tend to facilitate aggression by moderately angered subjects. Baron's results suggest that the aggression-enhancing influence of the victim's feedback increases in a fairly regular manner as the level of provocation previously experienced by aggressors rises.

Kanin (1985) studied 71 rapists and 227 controls to study date rape and the differential sexual socialization and relative deprivation of the offenders. This study revealed that date rapists, as a result of a hypersexual socialization process, are sexually very active, successful, and aspiring. These exaggerated aspiration levels are seen as responsible for instituting a high degree of sexual frustration which results in sexually aggressive behavior towards the victim.

Rapaport and Burkhart (1984) indicate that the degree of involvement in sexually coercive behavior was found to covary with personality measures of irresponsibility, a lack of social conscience, and a value

orientation legitimizing aggression, particularly against women. Their data suggested that these characterological features were necessary to potentiate the general cultural context of coercive sexuality into personally coercive sexual behavior.

Koss, Leonard, Beezley, and Oros (1985) have shown that men who reported the use of verbal coercion to obtain sexual intercourse were different from men who reported physical coercion. Like physical sexual aggression, verbal coercion was associated with a large number of sexual partners. However, physically aggressive men saw women as significantly more sexually free than verbally coercive men did.

### Socialization

According to Stack and Kanavy (1983), the greater anomie and egoism in a population, the greater the probability of deviant behavior. In their study which used the individual states in this country as the unit of measurement, Stack and Kanavy associated Catholicism with social integration and showed that the greater the proportion of Catholic individuals in the state, the lower the rate of rape. These results are supported by the argument that the more socially integrated a person is, the more the person has to lose through deviant behavior and the more support the person has for social compliance. A non-integrated individual lacks the motivation to conform to social standards.

Wiehe (1987), in a study of 32 identified child abusers indicated that abusers reflected significantly less empathic ability and an external locus of control orientation as compared to non-abusers. Yokley (1989) proposes that sex offenders lack appropriate cognitions and affect regarding the problems their behaviors cause others. Self-statements which rationalize, justify, or minimize the effect that offenders have on others are thought to contribute to this deficit (Knopp, 1982).

Overholser and Beck (1986) assessed 60 child molesters, rapists, and three control groups on measures of heterosocial skills, social anxiety, hostility, impulsivity, and attitudinal variables. Overall, heterosocial skill deficits were observed in child molesters and rapists in comparison with the control groups. Rapists displayed higher physiological indices of anxiety during role-play scenes that demanded assertive responses, and child molesters displayed a fear of negative evaluations.

Lipton, McDonel, and McFall (1987) measured heterosocial cue-reading accuracy of groups of rapists, violent non-rapists, and nonviolent non-rapists. Rapists were significantly less accurate than subjects in either control group when reading cues in simulated first-date interactions. All subjects had more difficulty reading men's cues than women's cues.

### Addiction

Reininga (1989), in a study of incarcerated offenders, showed that sex offenders share many characteristics with addicts. Carnes (1983) has developed the Sexual Addiction Screening Test which attempts to measure sexually compulsive behavior.

Erotophilia can be defined as referring to the openness of an individual to sexual activity. Fisher, Byrne, White, and Kelley (1988) constructed the Sexual Opinion Survey to measure the dimension of Erotophobia-Erotophilia. Erotophilia is associated with high levels of sexual activity, use of erotica, sexual fantasy behavior, sex education, sex-related health care, utilization of contraception, and behaving sexually during pregnancy and postpartum (Fisher, Byrne, White, & Kelly, 1988). The concept of erotophilia can loosely be equated with the concepts of sexual addiction (Carnes, 1983) and undifferentiated sexual deviancy (Hedges, 1988).

### Environmental Factors

Environmental factors typically function as the "straw that broke the camels back." They typically serve as a catharsis for expressing dynamics established by the other factors. Environmental factors might include: fighting with mate, experiencing stress from any source, taking medication, exposure to high levels of erotic material, etc. The Cognitive-behavioral Model explained above describes how these environmental factors interact with the other elements of the integrated model being presented.

### Conditional Factors

Before an individual can carry out a sexually abusive act, four conditions must be met as described by Finkelhor (1984): 1) the potential offender has to have some motivation to abuse, 2) the potential offender has to overcome internal inhibition against acting on the motivation, 3) the potential offender has to overcome external impediments to committing sexual abuse, and 4) the potential offender or some other factor has to undermine or overcome the victims resistance to the sexual abuse. These "preconditions" are outlined in some detail above in under the heading of "Psycho-social Model."

### Integrating The Factors

Each offender has a unique combination of these factors which have contributed to the sexually acting out behavior. It is because of the complex

combination of these factors that empirical support has not been established to differentiate sexual offenders (Hedges, 1990). Base on this assumption, it is impossible to determine who will become a sexually abuse person *a priori*. It is possible, however to look at how these factors interact and increase the likelihood of sexual acting out.

In applying this model to a number of sexually abusive persons *post hoc*, it has become apparent that not every factor played a major role in bringing about abuse by each perpetrator. That is, some offenders had relatively few issues related to biological factors or had relatively balanced developmental factors. However, these same people typically had extremely elevated numbers of issues in other factor areas such as extreme stress in the current environment or easily fulfilled preconditions.

## IMPLICATIONS

Clearly the development of sexual deviancy is not a unidimensional phenomena and therefore can not be treated using a single treatment approach. Any treatment of sexually abusive persons requires employment of a wide range of therapeutic strategies which address each of the factor areas identified above.

Also, because the development of sexual deviancy is not a unidimensional phenomena it is impossible to adequately assess sexual deviancy using any single assessment method. To adequately assess sexual deviancy requires a wide range of assessment techniques which account for each of the factors outlined above. Although each of the models presented has very important features, individually they fall short of providing a comprehensive approach to viewing sexual deviancy. It is only by combining the models that the clinician can begin to picture the complex interaction of the various components of offenders' lives and to visualize how these components interact to facilitate sexual abuse.

When the clinician conducts a comprehensive evaluation of the sexual deviant, the sexual deviant is provided with a framework within which they can begin to regain control over their lives. Without the "big picture," the offender is unable to make many of the necessary connections between thoughts, feelings, and behaviors that contribute to sexually deviant acting out. Additionally, by looking at the severity of each of the components of the Integrated Model, the clinician can begin to understand the origin of the sexual deviation and may be able to assess the dangerousness of a given individual more accurately.

Because of the complex nature of sexual deviancy, it is currently impossible to identify sexually abusive persons *a priori*, however it is possible to identify persons who have an increased likelihood of sexually abusive behavior based on the presence of many of the dynamics in the various factor areas. It should be noted that using this approach to assess the propensity toward sexually abusive behavior will result in an extremely high number of "false positive" identifications.

## **ETHICAL ISSUES IN THE TREATMENT OF SEXUAL DEVIANCY**

Society has indicated that sexual deviancy will not be tolerated when it infringes on the rights of others. This can be seen in the legal statutes (Barnett, 1973) and in the open hostility that is expressed towards rapist, child molesters, exhibitionists, voyeurs, and prostitutes. Although society has indicated its intolerance for these individuals, society has not made a clear statement or decision regarding the treatment of these individuals.

This section will address some of the legal and ethical issues that revolve around the treatment of sexual deviancy from the counselor's perspective. The three primary issues that will be addressed include: what is the counselor's role in determining the placement of the sexual deviant, how intrusive should the treatment of sexual deviancy become, and what role does the counselor's values play in the treatment of sexual deviancy.

### Role of the Counselor

One of the first issues in discussing the counselor's role in treating sexual deviancy is described by Finkelhor (1984) as follows: Sexual abuse falls into competing professional and institutional domains. On one hand, it is a serious child welfare problem--one of the types of child abuse which is mandated for reporting to state child protective agencies. On the other hand, it is a serious crime--eliciting community outrage and action by police and district attorneys. It is also a mental health and, in some cases, even a medical problem. Professionals in all these domains feel they have some responsibility to handle sexual abuse. Yet in most communities, no formalized division of roles exists. No single profession is entirely capable or responsible for the supervision or treatment of sexual abuse cases.

### Background Information

Frequently several of these roles are thrust onto the counselor. Many states have passed compulsive sexual deviancy laws which state that if an individual is deemed to be chronically sexually deviant by a clinician then the individual will spend a great amount of time incarcerated. This raises the issue of, what is the role of the clinician? Is the clinician working for the individual, the institution, or society? In making a decision regarding the chronicity of a particular behavior the clinician is forced to make a decision that will determine, in part, the amount of time that an individual will spend

incarcerated. Is the clinician's primary role evaluator, therapist, advocate, or judge? Should the clinician be placed in this position?

The ethical guidelines of most professional organizations offer little help in answering these questions. The Ethical Principles of Psychologists (American Psychological Association, 1981) states that the clinician is to "promote the welfare and best interests of the client" and states that the clinician has "a primary obligation to respect the confidentiality of information obtained from persons in the course of their work". Additionally the Ethical Principles of Psychologists (APA, 1981) states that when the clinician agrees to provide services to a client at the request of a third party, the clinician assumes the responsibility of clarifying the nature of the relationship.

#### Discussion of Issues

The guidelines and questions appear to be somewhat in opposition. If the clinician has primary responsibility to the client then does the clinician have a right to share information about the client with the third party? The client clearly has a right to know the relationship between the clinician, the employing organization, and himself/herself but does the sexually deviant client really have a right to not enter into the relationship?

In 1949, New Jersey became one of the first states to pass a compulsive sexual deviancy law (Brancale, Vuocolo, & Prendergast, 1972). This legislation defined sexual deviancy as the crimes of rape, carnal abuse, sodomy, impairing the morals of a minor, lewdness, indecent exposure, incest, or an attempt to commit any of these acts. When an individual in New Jersey was convicted of one of the crimes, he/she was taken to the New Jersey State Diagnostic Center for a period not to exceed 60 days. The clinicians at this facility then completed an evaluation. This evaluation was then used by the court to determine if the individual was a repetitive, compulsive sexual deviant. If the individual was so deemed, then he/she would be sentenced to the prison system for an indefinite period of time.

The position of the clinicians at the New Jersey State Diagnostic Center and at any facility that performs evaluations on sexually deviant offenders for the purpose of determining placement can be defended by the ethical principles of beneficence and justice as described by Kitchener (1984). Beneficence can be defined as the duty to do good. Removing the sexually deviant individual from society is helping to reduce the probability that this individual will be abusive for the period of time that he/she is incarcerated. This argument supports the concept of beneficence only when the counselor is viewed as working for society as a whole rather than

the individual. The concept of justice can also support this position in that equal persons have the right to be treated equally and nonequal persons have a right to be treated differently if the inequality is relevant to the issue in question. That is, the sexual deviant has a right to be treated equally with society only when he/she performs equally with society. Because of his/her sexual deviancy, the sex offender is in fact nonequal and therefore should be treated unequally. The clinician's role is then to help identify the sexual deviants uniqueness and to help the sexual deviant cope with this uniqueness.

An opposing argument can be made based on the concepts of autonomy and nonmaleficence as described by Kitchener (1984). The ethical concept of autonomy can be described as respecting the rights of others to make independent choices, even when we believe they are mistaken, as long as their choices do not infringe on the rights of others. Nonmaleficence can be summarized with the statement of "above all do no harm". The sexually deviant individual does not have the autonomy to chose whether they wish to be evaluated or treated by the very nature of being incarcerated. If the sexually deviant individual does have the right to physically refuse treatment or assessment and exercises this right, he/she is punished for their position with long sentences in prison. By conducting an evaluation that may lead to long term incarceration the clinician is doing the client harm from the client's point of view and is thus violating one of the primary concepts of ethics. However, this argument can only be considered valid when the clinician is viewed as having primary responsibility to the client.

### Balancing of Positions

A reasonable compromise can be met to these arguments and to the apparently opposing positions presented in the ethical guidelines. Society, through the legal system, has indicated that the sexual deviant gave up his/her right to autonomy with regard to sexual behavior by infringing his/her sexual behavior on others. This is beyond the power of the clinician. The clinician's primary responsibility is to reduce the probability of the sexually deviant individual from re-offending (doing good to both the client and society). Part of reducing this probability involves making a clear evaluation of the extent of the uniqueness of the sexual deviancy and allowing the appropriate individuals to become aware of this uniqueness so that the individual can be dealt with accordingly. However, the sexual deviant does have a right to refuse the assessment and treatment. By refusing assessment and treatment the sexual deviant also gives up his/her right to be a full member of society because they pose a risk to the welfare of

others.

The sexual deviant also has the right to have the role of the clinician clearly defined prior to any evaluation or treatment. Part of the definition of this role should include the clinician's personal views of the sexual deviation and some statement regarding the potential results of the evaluation or treatment.

## Treatment of Sexual Deviancy

The primary goal of treatment for the sexual deviant is one of control: either the offender must develop internal control over his/her sexually deviant behavior or must be externally controlled so as to prevent sexual acting out (Groth, Hobson & Gary, 1982). This goal can be achieved in one or combination of five ways: chemotherapy, behavior modification, psychotherapy, psychosocial education, or surgery. Each of these treatment modalities involve unique ethical considerations and involve varying degrees of intrusiveness.

### Background Information

Chemotherapy, surgery and behavior modification are the most intrusive forms of treatment for sexual deviation. Currently surgery (castration or neurosurgery) is not considered a viable treatment alternative in the United States but has been used in other countries such as Denmark (Sturup, 1972) in recent years. Chemotherapy (Depro-Provera) is currently being used in some parts of the United States with moderate success. Behavior modification is currently being used extensively in many treatment programs throughout the country in the form of aversion therapy and saturation. Because these three treatment modalities rely on external control, the ethical use of them is easily questioned.

Psychotherapy and psychosocial education are the most commonly reported forms of treatment for the sexual deviant. Both of these treatment modalities rely on the client's participation and therefore are not very intrusive. The client has control over how intense and open he/she decides to get. In these forms of treatment, the client has the ability to maintain autonomy. Psychotherapy and psychosocial education have shown some promise in reducing recidivism (Whitford, 1987).

### Discussion of Issues

Most jurisdictions legislate that clients are to receive the least intrusive treatment and to be provided the least restrictive environment. In treating the sexual deviant, the legal system indicates that the client is to be

given the opportunity to use internal control systems rather than external control. This is supported by the ethical considerations of autonomy and nonmaleficence. If the client is considered dangerous to himself/herself or to others then the therapist has an obligation to recommend continued treatment in a secured setting in an effort to keep the client from further victimization. The clinician is also legally responsible for reporting most forms of sexual abuse to the legal authorities.

The issues surrounding whether the use of external forms of control are ethical are very similar to the issues surrounding the role of the clinician in determining the placement of the sexual deviant. If the clinician is viewed as working for society or the institution then the use of external forms of control are not only acceptable but also preferred. External forms of control are preferred from society's view because the sexual deviant is not given the opportunity to re-offend (the sexual deviant has lost the right to autonomy). Occasionally the client requests that external forms of control be exerted on them (this is a prerequisite for the use of castration in Denmark). Although this appears to contribute to the client's autonomy, one must approach this position with caution. If the client is faced with life imprisonment or accepting some form of intrusive treatment and being set free, does the client really have a free choice? Additionally, the research has shown mixed results in the use of these forms of treatment, offering primarily antidotal support for their use rather than presenting empirical support (raising strong questions as to whether they are actually doing good to either the client or society or are actually just being used as a form of punishment).

The use of psychotherapy and psychosocial education has been attacked because it makes the sexual deviant responsible for change and minimizes the role of society in ensuring that the sexually deviant will not hurt people. This position indicates that the sexual deviant has been shown to be irresponsible when he/she committed the sexually deviant act and the use of non-intrusive treatments only places the sexually deviant individual in a position in which he/she can act irresponsibly again. Proponents of non-intrusive treatments state that this loss of control by society is the price that must be paid to insure that people in general have a right to autonomy. They also support this argument with the fact that the non-intrusive treatment modalities have been shown, with most sexually deviant individuals, to be effective.

#### Balancing of Positions

The clinician has a responsibility to both society and the client. If the client poses a risk to the welfare of others, the clinician has a responsibility

(both legal and ethical) to report this risk to the legal authorities and to the potential victim. If the client is not eminently dangerous to himself/herself or to others, the clinician has a responsibility to provide the client the least intrusive form of treatment. For most sexual deviants, this means that the clinician needs to use psychotherapy and/or psychosocial education as opposed to behavioral modification, chemotherapy, or surgery.

In some cases, where psychotherapy or psychosocial education have failed to be effective, the use of more intrusive treatment modalities is indicated. The intrusive treatment modalities should be used in such a way as to provide the sexual deviant with the greatest amount of autonomy. The client should always be given the opportunity to refuse treatment (although this may be an artificial opportunity in that many sexually deviant individuals are faced with pressure to participate in programming because they are institutionalized and will remain institutionalized until they are deemed safe to return to society).

This position assumes a stance providing the client with the greatest amount of autonomy while providing society protection against those individuals who pose a substantial risk. The clinician's role is to provide the client with the most effective and least restrictive treatment while reducing the client's likelihood of re-offending.

## The Clinician's Values

Every clinician enters the counseling process with their personal values and beliefs. Corey, Corey and Callanan (1983) argue that these values and beliefs are intrinsically a part of the counseling process. They state "it is neither possible nor desirable for counselors to be scrupulously neutral with respect to values in the counseling relationship". Because most people have strong negative feelings regarding sexual deviancy, it is important for the clinician working with the sexually deviant individual to look at how their values and feelings affect the counseling relationship. An additional issue related to the clinician's values in working with sexually deviant individuals revolves around the definition of what is acceptable sexual behavior.

### Discussion

The professional community has had a good deal of difficulty in defining what is acceptable sexual behavior. Throughout history virtually every sexual behavior has been considered not only acceptable but also "normal". One example that has been debated in recent years has revolved around the acceptability of homosexuality. The Diagnostics and Statistical

Manual of Mental Disorders, second edition (1968), published by the American Psychiatric Association, stated that homosexuality was a mental disorder and implied that homosexuality must be "treated". The Diagnostics and Statistical Manual of Mental Disorders, third edition (1982) restated this position and indicated that homosexuality was only a disorder if the client had a problem accepting their homosexuality (ego-dystonic homosexuality).

In the most recent revision of the Diagnostics and Statistical Manual of Mental Disorders (1986), homosexuality is not considered a mental disorder. Some of the other sexual activities that have met with a good deal of debate as to their acceptability include: multiple sexual partners simultaneously (group sex), multiple sexual partners consecutively (promiscuity), cross dressing, and sex changes.

If the professional community can not decide on what is acceptable sexual behavior, it is very difficult for the clinician to determine whether a particular behavior is acceptable. Does the clinician base the acceptability of a particular sexual behavior on his/her personal position, on his/her perception of what society finds acceptable, on the client's perception of acceptability, or on some other source? Because the clinician is unable to completely separate his/her personal values from the therapeutic relationship he/she must make some determination of what is acceptable behavior before entering the therapeutic relationship.

#### Balancing of Positions

With the lack of guidance from the professional community regarding the acceptability of many sexual behaviors, the therapist is forced to rely on personal values as the bases for many clinical decisions. Because the effects of many sexual behaviors have not been determined completely, the ethical concepts of nonmaleficence and beneficence do not provide much aid to the clinician. It is rather apparent that the clinician should be primarily concerned with reducing the likelihood of personal suffrage, however this is a very difficult judgement to make because of the lack of research. A sound position would appear to be: if the act is not directly hurting someone then the client's interests and desires should be of primary importance in the therapeutic relationship. If this position is to be taken, the therapist has a responsibility to inform the client of their personal values regarding the behavior so that the client can be aware that the clinician's values may covertly effect the therapeutic relationship. In this way the burden of maintaining autonomy is placed on the client and the client can decide if the therapeutic relationship should continue.

#### Summary

Counseling the sexually deviant client raises many unique ethical dilemmas. Most of these dilemmas are not clearly addressed by the ethical guidelines provided by professional organizations. Some of these dilemmas can be addressed by looking at the general ethical principles described by Kitchener (1984) but others must be based on a mutual agreement between the clinician and the client.

Recent developments in the treatment of sexual deviancy and improved detection of sexual deviancy have brought about many new ethical considerations for the clinician. It is readily apparent that professional organizations will need to develop ethical guidelines to guide the clinician working with the sexually deviant client. Until this occurs, the clinician will need to continue seeking the assistance of peers and reviewing current literature to help define acceptable therapeutic practices with this population.

## **SEX EDUCATION/ADDICTION GROUP**

Most sexually deviant individuals have many questions with regard to human sexuality and why they are sexually deviant. Many of these individuals have received little or no information with regard to sex education. As a result of this lack of information or having received misinformation, many sex offenders have had difficulty developing appropriate sexual outlets. By providing the sexual deviant with accurate information and a general understanding of sexual deviancy, the individual is likely to feel more confident and be more capable of developing appropriate sexual relationships and will be able to use their understanding of the deviancy process to develop a systematic solution for their acting out behavior.

The following is a brief outline of a group that attempts to meet these needs. The psycho-educational group is designed to be run for approximately sixteen weeks with each session lasting 1½ hours. The ideal group should be no more than fifteen participants--all of whom have admitted to their sexual deviancy. The group employs a moderately structured educational format. The sessions generally begin with the facilitator reviewing information from previous sessions, followed by the presentation of new information, and concluding with the discussion of the new information emphasizing applications of the new material in daily living situations. A pre-test is available to assess the base knowledge of the group so that the material can be tailored to the group's needs. The test can also be used as a post-test to determine the cognitive progress of the group participants.

## **SEX EDUCATION/ADDICTION Group Outline**

The following is a general outline for conducting the S.E.A. group. This outline is simply a model and may require modification to accommodate the general educational level and interest level of the group participants.

### **Week 1**

- Present ground rules (see handout)
- Describe program content
- Conduct introductions
- Administer Sexual Knowledge Pre-Test

### **Week 2**

- Review ground rules (quiz)
- Introduction to 12 step concept (see 12 step handout)
- Introduce 1st step of the 12 steps
- Review results of Sexual Knowledge Pre-Test, answer any questions and respond to challenges

### **Week 3**

- Quiz - list 5 things learned last week
  - recite 1st step
- Introduce 2nd step of the 12 steps
- Discuss/Describe Male Sexual Physiology (see handout)

### **Week 4**

- Quiz - label all male sexual parts
  - recite 1st two steps of 12 steps
- Introduce 3rd step of the 12 steps
- Discuss/Describe Female Sexual Physiology

### **Week 5**

- Quiz - label all male and female sexual parts
  - recite 1st three steps of 12 steps
- Introduce 4th step of the 12 steps
- Assign autobiography - having participants complete one section per week and writing at least 1/2 page per question.

View movie "The Miracle of Life"

## **Week 6**

Quiz - label all male and female sexual parts  
- recite 1st four steps of 12 steps

Introduce 5th step of 12 steps

Collect section A of autobiography

Discuss Sexual Response Cycle

Discuss Contraception, Sterilization, and Sexually Transmitted Diseases

## **Week 7**

Quiz - label phases of sexual response cycle  
- list forms of contraception in order of reliability  
- general questions regarding STD's  
- list steps 2 - 5

Introduce 6th step of 12 steps

Return section A of autobiography with comments and collect section B

Discuss Sexual Dysfunctions and Paraphilias (Definitions and causes)

Discuss definition of normalcy

Discuss addiction

## **Week 8**

Quiz - define Sexual Dysfunctions and Paraphilias  
- define normalcy (statistical definition)  
- define addiction  
- list steps 3 - 6

Introduce 7th step of 12 steps

Return section B of autobiography with comments and collect corrected section A and new section C

Discuss Love Cycle (handout)

## **Week 9**

Quiz - label Love Cycle  
- list steps 4 - 7

Introduce 8th step of 12 steps

Return sections A and C of autobiography with corrections and collectcorrected section B and new section D

Discuss conflict resolution (handout)

## **Week 10**

Quiz - label Love Cycle and Conflict Resolution  
- list steps 5 - 8

Introduce 9th step of 12 steps

Return sections B and D of autobiography with comments and collect corrected section c and new section E

Introduce Etiology Model (handout)

Discuss Biological Factors (physical appearance, hormonal levels, structural abnormalities)

## **Week 11**

Quiz - identify Biological Factors  
- label Etiology Model  
- list steps 6 - 9

Introduce step 10 of 12 steps

Return sections C and E of autobiography with comments and collect corrected section D and new section F

Discuss Circumplex Model (handout)

Discuss role of early childhood in sexual abuse

## **Week 12**

Quiz - label Circumplex Model  
- list steps 7 - 10

Introduce step 11 of 12 steps

Return sections D and F of autobiography with comments and collect corrected section E and questions 1 and 2 of "Why Did I Do It?" work sheet

Discuss Addiction Cycle (handout)

Discuss other personality characteristics related to sexual deviancy (ie. socialization and aggression)

## **Week 13**

Quiz - label the Addiction Cycle  
- list steps 8 - 11  
Introduce step 12 of 12 steps  
Return question 1 and 2 of "Why Did I Do It?" work sheet with  
comments and collect corrected section F of autobiography  
and question 3 of "Why Did I Do It?" work sheet  
Discuss "current living conditions" role in sexual deviancy  
Discuss Pre-conditions

### **Week 14**

Quiz - Identify significant living conditions contributing to sexual  
deviancy  
- label Pre-conditions  
- list steps 1-12  
Return section F of autobiography and question 3 of "Why Did I Do  
It?"  
work sheet with comments collect questions 4 and 5 of work  
sheet  
Discuss "SAFE" formula (handout)  
Discuss Relapse Syndrome

### **Week 15**

Quiz - list all 12 steps  
- label "SAFE" formula  
- identify steps in relapse syndrome  
Return questions 4 and 5 of "Why Did I Do It?" work sheet with  
comments  
Discuss Relapse Prevention Model and Relapse Prevention  
Planning

### **Week 16**

Collect all autobiography sections  
Collect "Why Did I Do It?" questions  
Close group  
Administer Post-Sexual Knowledge Test

## PRE/POST SEX INFORMATION TEST

Some of the following statements about human sexuality are true; some are false. On the answer sheet circle "T" to indicate a true statement or "F" to indicate a false statement.

1. A girl as young as 5 years and a woman as old as 57 years has given birth to a child.
2. For a certain period of time (refractory period) after an orgasm, women are not able to reach orgasm.
3. Taking birth-control pills will delay a women's menopause.
4. Men who are impotent are usually sterile.
5. In the majority of rapes, the victim is promiscuous or has a "bad" reputation.
6. There must be two acts of sexual intercourse to produce twins, three for triplets, and so on.
7. If a girl reaches puberty at an earlier than average age, she will also be likely to reach her change of life (menopause) at an earlier age than average.
8. During sexual intercourse, a woman may suffer from vaginal spasms that trap her partner's penis and prevent his withdrawing it.
9. It is common for a person to become homosexual because of a hormonal imbalance.
10. The penis inserted in the vagina (sexual intercourse) is not the only normal method of sexual relations.
11. Sexual molesters of children are usually over 65 years of age.
12. Some homosexual behavior is a normal part of growing up.

13. Women are not usually capable of multiple orgasms, but men are.
14. Any female can get raped.
15. Male transvestites (men who like to dress in women's clothes) usually are homosexuals.
16. A person who has a large number of sexual partners in premarital or extramarital experiences usually possesses a sex drive that is stronger than average.
17. Menstrual (monthly period) cramps and pain usually have a psychological basis.
18. A large majority of parents want their children to be given sex education in school.
19. Eggs from one ovary produce males, and from the other females.
20. The cause of impotence (the inability to get an erection) is almost always psychological in nature.
21. Abortions performed under sensible medical conditions are less dangerous for a woman than normal births.
22. Most victims of rape are "sexy" people.
23. A women's orgasm produced by vaginal penetration is more physically satisfying but requires more maturity than orgasm resulting from direct stimulation of the clitoris.
24. Men and women are homosexuals because they were "born that way."
25. Oral-genital sex (mouth to sex organ) between a man and a woman often indicates homosexual tendencies.
26. Humans and lower animals cannot crossbreed.
27. A child that has been sexually molested often may have cooperated fully in the act or may have provoked it.

28. A mother cannot become pregnant as long as she is nursing her baby.
29. Men who molest or commit other sex offenses against children are frequently friends of the family or relatives.
30. AIDS can be caught through hugging an AIDS Victim.
31. Douching is one of the adequate and satisfactory methods of contraception.
32. When women reach menopause, they often begin to have a more satisfying sex life.
33. Men convicted of serious sex crimes often started their road to crime by committing minor sex offenses.
34. Certain foods are valuable in increasing the sex drive.
35. Premature ejaculation (coming to climax too soon) is due to such physical factors as an abnormally sensitive penis and too strong a sex drive.
36. It is quite dangerous and potentially harmful for a woman to take part in sports, to take a bath, or to shampoo her hair during menstruation.
37. Most sex offender's act out on a sudden, uncontrollable impulse.
38. Exhibitionists are likely to progress to more serious sex crimes unless they are controlled or given psychological treatment.
39. Pictures of nude men are sexually exciting to most women.
40. The primary goal of sex offender treatment is to get the client to believe that he will never recommit.
41. In most states, it is illegal to have sex with someone who is drunk.
42. Alcohol is a failure as a physical sexual stimulant.
43. One man may have an erection without orgasm or ejaculation,

another man may have an orgasm without erection or ejaculation, and still another man may have an ejaculation with out orgasm or erection.

44. Most prostitutes are lesbians (female homosexuals).
45. The average teenage male has a stronger desire for sex than the average teenage female.
46. Women who have a strong sex drive, come easily to climax, and are capable of multiple orgasm are nymphomaniacs.
47. Even though a woman has had her uterus removed, she can still have orgasms.
48. A woman is safe from pregnancy if sexual intercourse occurs during menstruation.
49. Sperm from one testicle produces males and from the other, females.
50. More than one-third of all men have had at least one homosexual experience in their lives that resulted in orgasm.
51. Men and women who are middle-aged or older seldom masturbate.
52. A person is likely to contract a venereal disease if he/she uses a toilet seat that has been used by an infected person.
53. At least two-thirds of men between the ages of sixty-five and sixty-nine experience satisfactory sexual intercourse.
54. Most people have sexual fantasies.
55. If married persons masturbate, it is a sign that they have a poor sexual adjustment in their marriage.
56. Husbands of the upper socioeconomic-educational group who are in their twenties are as likely or more likely to have sexual relations outside their marriage as husbands of the same group who are in their forties.

57. The orgasm of a man or a woman may be speeded up or delayed because of anxiety.
58. Alcohol often causes temporary impotence.
59. Most people in society are true to their religious beliefs regarding sexuality.
60. A male and a female must experience orgasm at the same time in order for conception to occur.
61. While most males masturbate at one time or another during their lives, very few females do so.
62. There are more reported cases of incest in families of lower socioeconomic-educational group than in families in higher groups.
63. Men have fluctuating hormonal levels similar, but less severe than those experienced by women during their menstrual cycle.
64. The size of the penis is usually directed to the sexual pleasure experienced by a woman during sexual intercourse.
65. Masturbation causes certain types of blindness.
66. Despite the recent women's liberation movement, just as high a percentage of today's men expect their brides to be virgins as was the case in the past.
67. Sex offenders are usually lacking in religious training and background.
68. When a woman is sexually aroused, her clitoris becomes larger and firmer and filled with blood, just as the penis does in the case of a man.
69. If a woman has an orgasm during an act of sexual intercourse, she has a significantly better chance of becoming pregnant than if she does not have an orgasm.
70. At least one-fourth of all married women will have sexual intercourse

with someone other than their husbands during their marriage.

71. The women's reproductive system determines the sex of the child.
72. A 7 month-old fetus (unborn baby) has a better chance for survival than an 8-month-old fetus does.
73. Sexual desire decreases markedly in both men and women after the age of 40 to 50.
74. Illegitimate fathers are usually unconcerned about their responsibilities to the child and its mother.
75. At least half of all married men will have sexual intercourse with someone other than their wives during their marriage.
76. Women are just as capable as men of having strong and intense orgasms.
77. Seventy percent of all males have had at least 30 sexual partners in their life time.
78. When a man is castrated (has his testicles removed), he loses his sex drive and potency almost immediately.
79. Men and women reach the peak of their desire for sexual contact at about the same age (within a year).
80. The size of the penis is a fixed hereditary factor and in normal circumstances nothing can be done by the way of exercise, use of drugs, etc., to increase its size.
81. If a woman does not have a maidenhead (hymen), it is good proof that she is not a virgin.
82. The frequency of intercourse in a relationship is a good indication of a women's satisfaction with the relationship.
83. A large percentage of married couples have experienced oral-genital (mouth to sex organ) sex.

84. A man who is sterilized by having his tubes tied (vasectomy) will show a gradual loss of sex drive as a result of the operation.
85. On the average, mistresses of middle-aged men are not young, voluptuous women as ordinarily thought, but are near the age of the men involved and work to support themselves.
86. LSD and similar drugs are effective sexual stimulants.
87. Children will have their sexual attitudes warped by erotic literature if they encounter it frequently.
88. There are good physical reasons why sexual intercourse ordinarily should be avoided during menstruation.
89. A women's virginity at the time of the marriage is directly related to the success of her marriage.
90. College men have more premarital coital (sexual intercourse) experience than do those men of lower educational achievement.
91. Homosexuals can ordinarily be identified by certain distinctive mannerisms or physical characteristics.
92. If a child is molested and emotional problems develop, it is usually caused by the upsetting attitudes of the adults who deal with the child.
93. In sexual intercourse, the greatest erotic pleasure for both the man and the women is achieved when both partners experience orgasm at the same time.
94. A man usually produces more than 200 million sperm in each ejaculation.
95. Girls who live in warm climates, such as the tropics, usually begin menstruation earlier than girls living in cooler climates.
96. As soon as a young girl starts to menstruate she can become pregnant.

97. Fertilization of the egg (conception) occurs in the vagina when sperm are deposited there through sexual intercourse or by other means.
98. About 80% of women infected with gonorrhea have no clinical symptoms of the disease.
99. Despite what certain people claim, only a small percent (less than 10%) of men and women ever engage in sexual practices that are against the law.
100. On the average, murderers spend less time in prison than rapists.

PRE/POST SEX EDUCATION TEST

Name: \_\_\_\_\_ Date: \_\_\_\_\_

- |         |         |         |         |
|---------|---------|---------|---------|
| 1. T F  | 26. T F | 51. T F | 76. T F |
| 2. T F  | 27. T F | 52. T F | 77. T F |
| 3. T F  | 28. T F | 53. T F | 78. T F |
| 4. T F  | 29. T F | 54. T F | 79. T F |
| 5. T F  | 30. T F | 55. T F | 80. T F |
| 6. T F  | 31. T F | 56. T F | 81. T F |
| 7. T F  | 32. T F | 57. T F | 82. T F |
| 8. T F  | 33. T F | 58. T F | 83. T F |
| 9. T F  | 34. T F | 59. T F | 84. T F |
| 10. T F | 35. T F | 60. T F | 85. T F |
| 11. T F | 36. T F | 61. T F | 86. T F |
| 12. T F | 37. T F | 62. T F | 87. T F |
| 13. T F | 38. T F | 63. T F | 88. T F |
| 14. T F | 39. T F | 64. T F | 89. T F |
| 15. T F | 40. T F | 65. T F | 90. T F |
| 16. T F | 41. T F | 66. T F | 91. T F |
| 17. T F | 42. T F | 67. T F | 92. T F |
| 18. T F | 43. T F | 68. T F | 93. T F |
| 19. T F | 44. T F | 69. T F | 94. T F |
| 20. T F | 45. T F | 70. T F | 95. T F |

21. T F

46. T F

71. T F

96. T F

22. T F

47. T F

72. T F

97. T F

23. T F

48. T F

73. T F

98. T F

24. T F

49. T F

74. T F

99. T F

25. T F

50. T F

75. T F

100. T F

## SEA GROUP RULES

### Confidentiality

Anything said in group stays in group including the names of the other group members. It is permissible to share with others any handouts given by the group facilitator. Three exceptions to confidentiality are as follows:

- 1) If you say you are going to hurt yourself or someone else
- 2) If you say or do something that is a direct threat to the security of another person.
- 3) If you give specific information about a crime that has not been reported.

### Attendance

For the group to work, all group participants must be present for every session. You are expected to attend all sessions and you are expected to be present on time. There are no excused absences and it is not possible to "make up" for missed sessions. You will not be reminded to come to group; it will be your responsibility.

### Completion of Assignments

An important and essential component to your treatment will take place through homework assignments. If you do not complete the assignments and review the material presented in group, you will not get the full value of the group. Completion of all assignments is necessary to progress in the treatment program.

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Group Facilitator

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Group Participant

## MALE SEXUAL PHYSIOLOGY

### Penis

An external organ that consists of three parallel cylinders of spongy tissue bound in thick membrane sheaths. When erect (engorged with blood during sexual contact) most penises are of equal size.

### Urethra

A tube that runs through the middle of the penis that carries urine or semen.

### Glans (Head)

The tip of the penis that has a high concentration of sensory nerve endings. Other areas of the penis with high concentrations of nerve endings are the tissue that separate the glans from the shaft (close to the base of the head) known as the *coronal ridge* and the underside of the penis where a thin strip of skin attaches to the glans known as the *frenulum*.

### Foreskin

Skin that covers the penis and is freely moveable. This area is routinely removed by circumcision to prevent infection of the penis.

### Scrotum

A thin, loose sack of skin under the penis that is sparsely covered with hair and contains the testes. The scrotum has a layer of muscle fibers that contract involuntarily as a result of sexual stimulation, exercise, or exposure to cold (or expand with heat). This is done to protect the testes and sperm.

### Testes (Male Gonads)

Highly sensitive to pressure and touch, the testes are often an area of sexual arousal for males. The testes produce hormones and sperm.

### Epididymis

Highly coiled tubing network folded against the back of the testes. Sperm travels through this network as they reach full maturation.

### Vas Deferens

Long tubes that leave the scrotum to carry mature sperm to the prostate gland. These tubes are cut as a form of sterilization when a vasectomy is performed.

### Prostate Gland

Located directly below the bladder, the prostate produces a clear fluid that makes up about 30% of the seminal fluid (ejaculate).

### Seminal Vesicles

Located directly next to the prostate gland, the seminal vesicles produce about 70% of the seminal fluid (ejaculate).

## FEMALE SEXUAL PHYSIOLOGY

### Vulva

External covering and protection.

### Mons

The area over the pubic bone that consists of a cushion of fatty tissue covered by skin and pubic hair. This area has many nerve endings and pressure may lead to sexual excitement.

### Labia Majora (Outer Lips)

Folds of skin covering a large amount of fat tissue and a thin layer of smooth muscle. When unstimulated, the lips are usually folded together to provide a mechanical protection for the urethral and vaginal entrance.

### Labia Minora (Inner Lips)

Spongy tissue rich in small blood vessels and has many sensory nerve endings. The flaps meet just above the *clitoris* and form the *clitoral hood*.

### Clitoris

The most sensitive area of the female genitals. Richly endowed with nerve endings, the clitoris is highly sensitive to touch, pressure, and temperature. It can easily be agitated to the point of pain by direct stimulation.

### Perineum

The hairless area between the labia and the anus. This region is usually quite sensitive to touch, pressure, and temperature and may be a source of sexual pleasure.

### Hymen

Thin tissue membrane covering the vagina. Has no known function. Is not an indication of virginity and is not necessarily "popped" upon intercourse.

## Vagina

Muscular organ that tilts upward to a 45° angle, diagonally pointed toward the small of the back. It can contract and expand to accommodate the passage of a baby at birth or adjust to the size of a finger. Following childbirth, the vagina is likely to lose some elasticity and to enlarge moderately. The vagina is lined with *mucosa*, similar to the mouth, that produces lubrication that facilitates intercourse. The vagina does not have a large number of sensory nerve endings.

## Uterus

The bottom part of the uterus (the *cervix*) protrudes into the vagina. The uterus (*womb*) is a hollow muscular organ shaped like an inverted pear. The inner lining changes during the menstrual cycle and is where a fertilized egg implants at the beginning of pregnancy after the egg has passed through the *fallopian tubes*.

## Fallopian Tubes

Connect the *uterus* with the *ovaries* and carry the egg from the ovaries to the uterus. Can be surgically blocked to prevent pregnancy. Fertilization takes place in the fallopian tubes.

## Ovaries

Two structures located on each side of the uterus. The ovaries produce hormones (estrogen and progesterone) and store eggs. About 400,000 immature eggs are present in a newborn girl and no new eggs are formed after birth.

## Breasts

Modified sweat glands that produce a milky substance during and immediately after childbirth. The sexual sensitivity of the breast, *areola* (area immediately surrounding the *nipple*), and the nipple do not depend on breast size or shape, but rather, on the learned habit, personal preference, and biology of the individual.

## AUTOBIOGRAPHY

The following is an outline for an autobiography. This autobiography was designed to help you gain insight into your behavior and to help identify problem areas in your life. Respond to each question as completely as possible. Each numbered item should require at least one half a page.

### A. Early Childhood

1. Where did you live? (Type of Community, what city, etc.) What kind of work did your mother and father or parent figure to do? How did they feel about their work?
2. What was the religious and ethnic background of your family?
3. Who named you? Why was that name chosen?
4. What is your earliest memory? What are the feelings connected to it? At what age was it?
5. What was it like being a young child in your home? Who was special to you, who cared the most about you? Who supervised you?
6. Give the names and birth dates of other children in the family in which you grew up:
  - a. How did you get along with them?
  - b. What was your Place in the family?
  - c. How did the Parents treat each of the children?
7. Who disciplined you?
  - a. How did they do it?
  - b. Why did they do it?
  - c. How did you feel about the discipline you received?
8. Where there any health problems in your family? Any deaths? Any traumatic events?
9. Did your family attend church or Sunday school? How often? Did parents attend? What type of church? How important was religion in the family?
10. How did your family show these feelings towards each other?
  - a. Anger?
  - b. Love?
  - c. Closeness?
  - d. Fear?
11. How did your parents get along with each other?

What did they enjoy together?  
What did they fight about?  
How did they fight?  
What effect did their relationship have on you then and now?

12. Which of the above events had the greatest impact on you?  
Why? How? Include all that seem important to you.

#### B. SCHOOL ACTIVITIES (6-19 years)

1. How did you feel when you started school? What was good about school? What was bad about it?
2. Who were your friends at school?  
What did you do with them?  
What games or hobbies did you enjoy with other children during grade school?
3. How did the teachers treat you?
4. Did you enjoy schoolwork?  
Was any of it hard for you?  
What subjects?
5. What did your Parents expect from you in school? Did they want you to do well in Sports? School-work? Religion?
6. Were there changes in your living arrangements or family during high school years? Financial changes? Deaths? Moves?
7. Did your feelings about school or achievements in school change in your high school years?
8. What friends and/or activities were you involved with during high school years?
9. What kind of future job dreams or plans did you think about in your high school years?  
What were your goals?
10. What kind of things were important to you?
11. Which of the above events had the greatest impact on you?  
Why? How? Include all that seem important to you.

#### C. SEXUAL DEVELOPMENT

1. When you were very young, what did your parents teach you about sex?
2. When did you start to masturbate? What did your parents tell you about it?  
What were your feelings about masturbating?
3. Did you have sexual contact with other family members?  
Who? When?
4. Did you have sexual contact with any adults?  
Did you have any exposure to adult sexual behavior?
5. What was your first sexual experience you remember as a child?  
What were your feelings then?
6. How did you feel about the changes in your body as you became a teenager?
7. How often did you have sexual feelings and thoughts about sex as a teenager?
8. When did you start to date?  
Describe this experience.
9. When did you start to have sexual contact with others? (Male or Female)
10. What did you think was expected sexual behavior of men during your teenage years?
11. What did you think was the expected sexual behavior of women during your teenage years?
12. Who scared or humiliated you sexually? How? When?
13. What was your father's sexual behavior like?  
How did you feel about it?
14. What was your mother's sexual behavior like?  
How did you feel about it?
15. What has your sexual behavior been as an adult?  
When and why have you been involved in sexual relations with other people?
16. How often do you masturbate now?  
To what thoughts or fantasies do you usually masturbate?
17. Do you sometimes have different kinds of fantasies that you masturbate to?  
When and what kinds of thoughts or fantasies?
18. Do you use pornography to masturbate to?  
Does this pornography depict violent acts?
19. About how many sexual partners have you had?  
How did you meet these people?

20. Which of the above events had the greatest impact on you?  
Why? How? Include all that seem important to you.

#### D. ADULTHOOD

1. What schooling or training were you involved in beyond high school?  
How did you like it and how did you do in it?
2. What kinds of jobs have you had?  
For how long?  
How did you like them?
3. When did you get romantically involved with some-one for the first time?  
How did you meet?  
What was attractive about the person to you?  
How long did it last?  
When and how did it end?
4. How many serious relationships did you have before you married or established a live-in relationship?  
How long did they last?  
When did they break up?
5. What first attracted you to your mate?  
Why did you decide to marry?  
How did the relationship change after you lived together?
6. What were the good parts of living together?  
What were the troubles in the relationship?
7. When did you have children?  
How many? (names and ages)?  
How did they effect the relationship?
8. Did you or your mate have other sexual relationships? Why?  
When?
9. Did the Primary relationship end? When? Why?

REPEAT 5,6,7,8, and 9 FOR ANY OTHER MARRIAGES YOU MAY HAVE HAD.

10. Which of the above events had the greatest impact on you?  
Why? How? Include all that seem important to you.

#### E. BEHAVIOR THAT BROUGHT YOU INTO TROUBLE WITH THE LAW

1. When and how did you first get involved with the law? What

- happened?
2. What other things have you been arrested for? When? What happened?
  3. Have you served time in other institutions? How long? When? For what?
  4. What was the situation leading up to your most recent sex offense?  
What was going on in your life?  
How were you feeling?
  5. What was the specific incident that seemed to trigger your sexually assaultive behavior?
  6. What did you say and do to your victim?  
How did you feel about him/her at the time?
  7. What did you feel about the victim and yourself after the crime?  
What did you say to them?
  8. What other similar crimes have you been involved with and for how long?
  9. Which drugs or chemicals have you abused? For how long?  
Do you still use or plan on using?
  10. Which of the above events had the greatest impact on you?  
Why? How? Include all that seem important to you.

## F. TREATMENT

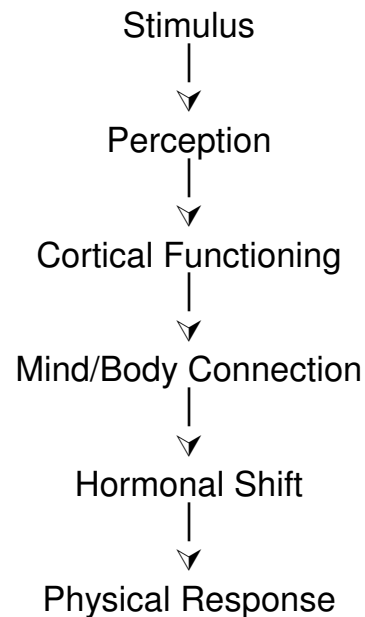
1. What other treatment have you or your family been involved in?  
Where and with whom?  
For what kinds of problems?
2. What helped you the most in treatment?
3. What do you wish you had done differently? How could you have gotten more from the treatment?
4. What is the most important thing you need now in this treatment? How can we help you get it?
5. Which of the above events had the greatest impact on you?  
Why? How? Include all that seem important to you.

List on a separate piece of paper a minimum of four (4) specific goals that you want to work on in treatment. Consider which parts of yourself that you need to change that caused your crime. Consider your own goals for

the future.

Adapted from a number of sources--Most of this autobiography form was developed at the Chillicothe Correctional Institution by Mr. Earl Stump and his staff

## FANTASY RESPONSE SYSTEM



### **Fantasy**

To imagine, visualize, or create a story line which fulfills a wish or desire. Fantasies usually occur in the visual (sight) or auditory (story line) modes. They can be very elaborate including much detail or can be simple passing thoughts. Fantasy extends reality in that elements are added to or removed from the real situation.

### **Stimulus**

Any condition or event which causes or motivates a response. Fantasy begins as a cortical response to a stimuli and is reinforced through physiological changes (physical responses such as the release of tension). All living people who have cortical functioning have fantasies. For some people, fantasies have developed into a problem because they have either: 1) become too self reinforcing or 2) resulted in unacceptable physical responses. Stimuli, in and of themselves, do not have intentions or motivation, they simply exist. Stimuli can be positioned or manipulated in such a way as to produce a predictable outcome.

## **Perception**

The sensory intake of stimuli. Perception occurs at two levels. The first level involves the 5 sensory mechanisms (sight, sound, taste, touch, and smell) and includes the encoding of the environmental stimuli into a format that the brain can understand. The sensory organs are influenced by the biological (hormonal) balance of the person. The second level of perception involves the interpretation of stimuli in terms of its meaning (placing a label on the stimuli). This level of perception is highly influenced by environmental cues (other stimuli which create the context of the situation) and prior knowledge/beliefs (cortical functioning).

## **Cortical Functioning**

Involves interpreting, categorizing, retrieving prior knowledge, and drawing association between prior knowledge and the perceived stimuli. Cortical functioning includes what we usually think of as "thinking," "memory," and "feeling." These processes occur in the part of the brain referred to as the cerebral cortex.

## **Mind/Body Connection**

Links the mind and body such that changes in one creates changes which are parallel in the other. That is, because of the mind/body connection, changes in the "mind" (cortical functioning) result in corresponding changes in the "body" (hormonal shifts) and changes in the "body" result in corresponding changes in the "mind." This mind/body connection is physically located in parts of the brain commonly referred to as the mid-brain and brain stem. These two parts of the brain create the mind/body connection by translating information from the brain to the body and from the body to the brain, (the mind and the body "speak" different languages).

## **Hormonal Shifts**

In response to the signals from the mind/body connection, the chemical balance (hormones) begin to change resulting in biological changes in the body. That is, hormonal shifts serve as signals to organs in the body to change their state. These hormones are created in a variety of glands distributed throughout the body (ie. adrenaline comes from the adrenal medulla located on top of the kidneys). Alterations of the chemical/hormonal balance of the

system will result in a miscommunication between the organs in the body and the brain. Hormonal shifts also alter the organisms that are responsible for perception, cortical functioning, and the mind/body connection.

### **Physical Response**

Measurable changes in the activity of internal organs. Physical responses occur at body structures known as "end organs" which include the heart, liver, arteries, lungs, skeletal muscles, and intestines. These structures perform the work of the body. Changes in "end organs" produce changes in the hormonal balance in the system, thus sending a signal through the mind/body connection back to the cortex for interpretation and other types of processing.

## **RELAPSE PREVENTION WORKBOOK**

Revised 2/92

Relapse prevention was originally developed as a method of enhancing maintenance of change by clients who have been in treatment for compulsive behavioral disorders. Relapse prevention was designed to strengthen self-control by providing clients with methods for identifying problematic situations, analyzing decisions that precipitated situations enabling return to the compulsive behavior, and developing strategies to avoid, or cope more effectively with, these dangerous circumstances.

The overall goal of relapse prevention is to increase your awareness and range of choices concerning your behavior, to develop specific coping skills and self-control abilities, and to create a general sense of manageability to your life. To achieve these goals, you will be asked to take a thorough look at your offense, explore further your personal characteristics, and develop specific plans for alternative behavior. Your relapse prevention plan should become an evolving recovery maintenance plan that you update on a continual basis. It is not a document that you complete once and file.

This workbook will attempt to help you develop your first relapse prevention plan. The first task in developing a relapse prevention plan is to identify past deviant behavioral patterns and the apparently irrelevant decisions (AID's) that made it possible to carry out these behaviors. The next step will be to identify coping resources that may be used in high risk situations. The final step will be the establishment of an ongoing evaluation of the relapse prevention process. You are encouraged to involve your therapist, your friends, your family, and anyone you know in the development of this plan. The more people you involve in the plan the more complete the plan will be.

Much of the material that you will be asked to write about will not be easy to remember. If, after sincerely trying to remember, and after asking the people who you were around at the time of the deviant behavior for information, you can not remember feelings or events, attempt to identify what would logically have happened. It is important for you to respond to every item thoroughly and honestly. The purpose of the relapse prevention plan is to help you stay out of prison once you have been released: the more you invest in this plan the better your chances are of staying out of

prison.

## Section A

### Identification of Deviancy

To create a relapse prevention plan, we must first identify what behavior we are trying to keep from going back to (it is assumed that you have already stopped the deviant behavior). Usually, the deviant behavior includes the behavior that brought you to prison and other, similar behavior. For most people in prison, the incarcerating offense was not the only time abusive behavior occurred. In responding to the following items, explore all behavior that was abusive.

When you respond to the items, use the format outlined in Appendix A. That is, respond to the items in the following manner: A1a, A2a, A2b, A2c, A2d, A3a, A3b, and repeat this for each behavior that brought you into contact with the law. When you have completed this go to A1b and continue responding as follows: A1b, A2a, A2b, A2c, A2d, A3a, A3b, etc.

1. The first step to developing a relapse plan is to identify the specific behavior that you hope to change. For the following items, list each response on a separate sheet of paper.
  - a. Describe the behavior that brought you in contact with the legal system. Provide dates, ages, who you were with, and a brief description of what took place.
  - b. Describe your behavior that, if discovered, would have brought you into contact with the legal system. Describe the events but do not give exact names, dates and places (if you are concerned about being arrested for these offenses).
  - c. Describe the behavior that negatively affected your relationships with significant others. Describe how this behavior negatively affected the relationships.
  - d. Describe the behavior that negatively affected your financial situation (ie. job, income, expenses). Describe how the behavior negatively affected the relationships.

- e. Describe all addictive/compulsive behavior that you have participated in (ie. gambling, smoking, eating, etc.). Describe these addictions using the addictive system (appendix D).
2. In order to be able to stop any type of behavior you must identify every aspect of the behavior. That is, you must provide specific information concerning the events, feelings and inner experiences that are associated with the behavior.
    - a. Describe the life situation that you were experiencing when you participated in the behaviors you wish to change. In particular, describe any major changes that were occurring in your life at the time you were participating in the behaviors listed in item 1. Also describe anything about your living arrangements that would be considered out of the ordinary.
    - b. List five feelings that you experienced just before you participated in the behaviors that you wish to change. Define these feelings in your own terms. Be specific.
    - c. List the specific events that led up to the behaviors you wish to change. That is, what exactly did you do and what was going on just before the deviant behavior.
    - d. List five feelings that you experienced when you participated in each of the behaviors that you wish to change. Define these feelings in your own words.
  3. Typically, we do not just act. We usually make a series of decisions that enable us to participate in a behavior. For example, we do not just eat. We must first recognize that we are hungry, decide what we want to eat, decide how to get what we want to eat, get what we want to eat, and finally eat. Addictive behavior works the same way.
    - a. Identify at least 10 specific decisions that you had to make before you could participate in the each of the behaviors listed in item 1. A decision is defined as a cognitive process that results in action. You may find it helpful to start the statement with the statement "I decided to....".

- b. Identify what you told yourself about each of your decisions that allowed you to make them. (Describe your rationalizations and impaired thinking.) A rationalization is something that you tell yourself to justify, or somehow make OK a decision. Rationalizations do not involve action. You may find it helpful to start the statement with the statement "I told myself that...".

## Section B

### Modifying Behavior

Once you have identified your abusive behavior, you can begin to change it. As much as you might want to, you can not simply stop the behavior. Addiction does not work that way (see appendix B). In order to stop abusive behavior, you must first identify when you are in a deviant behavioral pattern and then develop alternative behavior. If you attempt to simply stop a behavior but do not have an alternative behavior, you will likely experience a lapse (see appendix C).

Therapy has focused on altering your core beliefs, however, you will find situations that will resurrect your old belief system on occasion. When your old beliefs do return, you must be prepared to alter your thinking before your behavior results in a relapse. In most cases, you will find it easiest to alter your addictive behavior at the "impaired thinking" and "ritualization" points on the addiction system (see appendix D). The following questions will help you to identify when you are in a lapse situation and help you to be prepared to cope with lapses using adaptive responses.

1. Before you can prevent a lapse situation, you must become aware that you are approaching one. That is, you must know the symptoms of a lapse situation.
  - a. Review the feelings generated in section A and list ten "theme feelings" that are consistent with most of your abusive behavior. To do this, list all of the feelings identified in sections A2b and A2d on a sheet of paper. Then, "cluster" these feelings into ten clusters. Do this by counting how many times each feeling appears. Attempt to associate the feelings that have low frequencies with those feelings that have high frequencies and form a cluster. Once you have done this, attempt to describe/define each of the ten clusters in terms of what the feelings mean to you.
  - b. Describe how you and those people who are close to you will know when you are experiencing each of these feelings. How do you express these feelings behaviorally?

- c. For each "theme feeling", identify at least three adaptive ways of releasing or coping with the feeling. Be specific in describing how you can carry out these coping mechanisms.
2. For many people with clear behavioral patterns, we create thoughts to help explain or cope with our feelings. These thoughts often take the form of self-talk.
    - a. Drawing from the thoughts and decisions identified in sections A3a and A3b, list ten "theme thoughts". Do this in the same way that you completed section B1a. You will probably find it easiest and most useful to focus primarily on the rationalizations that you made (A3b).
    - b. For each "theme thought", identify at least three adaptive self-talk statements. That is, what can you tell yourself about each of the "theme thought" that will challenge or get rid of your "stinking thinking"?
  3. Once we have given ourselves permission to participate in abusive behavior, we often perform rituals that facilitate and/or enhance the abusive behavior.
    - a. Identify at least five ritualistic behaviors that you participated in. Be specific in describing each of these rituals. Identify each of the steps in the ritual.
    - b. Identify how each of these rituals enhanced and/or facilitated the abusive behavior. That is, how did this ritual help with your abusive behavior?
    - c. Develop at least three adaptive responses for altering each of the ritual behaviors. Be specific as to how you can carry out the adaptive responses.

## Section C

### Maintaining Adaptive Behavior

In section A we focused on identifying dysfunctional behavior and in section B we focused on identifying alternative behavior. In this section, you will attempt to develop methods for maintaining the alternative behavior. Whenever we gain new behavior that is more efficient and/or more adaptive, we become excited and try to use it as often as we can. When these new behaviors do not seem to be working too well, we usually go back to the behavior that we know best. For the person with a clearly defined behavioral pattern, this usually means a lapse. In this section we will focus on two methods of preventing this return to familiar (and dysfunctional) behavior.

1. The easiest way to keep from returning to old behavior is to "over learn" the new behavior. That is, if we practice a behavior until it becomes automatic, we will have to think about other behaviors before we do them. If we make healthy behavior our automatic behavior, we will need to think about participating in our old behaviors before we can do them. It is during this thinking process that we can catch ourselves before lapsing. During this thinking process, we always perform a cost/benefit analysis to determine what behavior we should participate in.
  - a. Review the life situations that led up to your dysfunctional behavior and the environment that you were in at the time you participated in the dysfunctional behavior outlined in Section A. Identify at least 10 "at risk" situations/behaviors.
  - b. For each of these "at risk" situations/behaviors construct a cost/benefit matrix (see appendix E for instructions).
  
2. The second step of the "Twelve Steps" states "Came to believe that a power greater than ourselves could restore us to sanity". This "greater power" is often interpreted to mean those people with whom you associate. The people you associate with affect you whether you want them to or not. Often times, people want to help you but lack the skills or knowledge to be of real assistance. Occasionally, people do things in the name of helping that, in fact, enable your dysfunctional behavior. In order to maintain

adaptive behavior, you will need to identify how people can be truly supportive and how people become enablers for dysfunctional behavior.

- a. List 15 people with whom you will be having weekly contact. Describe how you plan on having contact with each of these people.
  - b. Rank these people in order of supportfulness. Identify how each of these people can best support you in your recovery. Be specific!
  - c. Rank each of these people in order of enabling behavior (behavior that will get you into trouble). For each of these people, identify how they will most likely enable you to return to your dysfunctional behavior. Be specific!
  - d. With each of these people, communicate through a letter, phone call, or personal contact, how they can be supportive of your recovery and how you think they might enable your relapse.
3. Review the decision matrices on a daily basis. Make revisions and additions as appropriate.
  4. Review the enabler/supporter list on a daily basis. Make revisions and additions as appropriate.

**(APPENDIX A)**  
**RELAPSE PREVENTION QUESTIONS**  
**SUMMARY FOR SECTION A**

Repeat each of these questions for as many as apply.

- 1A. Describe the behavior that brought you in contact with the legal system.
  - 2a. Describe the life situation that you were experiencing when you participated in this behavior. In particular, describe any major changes that were occurring in your life at the time you were participating this behavior Also describe anything about your living arrangements that would be considered out of the ordinary.
  - 2b. List five feelings that you experienced just before you participated in this behavior.
  - 2c. List the specific events that led up to this behavior.
  - 2d. List five feelings that you experienced when you participated in this behavior.
  - 3a. Identify at least 10 specific decisions that you had to make before you could participate in this behavior.
  - 3b. Identify what you told yourself about each of your decisions that allowed you to make them. (Describe your rationalizations and impaired thinking.)
- 1b. Describe your behavior that, if discovered, would have brought you into contact with the legal system.
  - 2a. Describe the life situation that you were experiencing when you participated in this behavior. In particular, describe any major changes that were occurring in your life at the time you were participating in this behavior Also describe anything about your living arrangements that would be considered out of the ordinary.
  - 2b. List five feelings that you experienced just before you

- participated in this behavior.
- 2c. List the specific events that led up to this behavior.
  - 2d. List five feelings that you experienced when you participated in this behavior.
  - 3a. Identify at least 10 specific decisions that you had to make before you could participate in this behavior.
  - 3b. Identify what you told yourself about each of your decisions that allowed you to make them. (Describe your rationalizations and impaired thinking.)
- 1c. Describe the behavior that negatively affected your relationships with significant others.
    - 2a. Describe the life situation that you were experiencing when you participated in this behavior. In particular, describe any major changes that were occurring in your life at the time you were participating in this behavior Also describe anything about your living arrangements that would be considered out of the ordinary.
    - 2b. List five feelings that you experienced just before you participated in this behavior.
    - 2c. List the specific events that led up to this behavior.
    - 2d. List five feelings that you experienced when you participated in this behavior.
    - 3a. Identify at least 10 specific decisions that you had to make before you could participate in this behavior.
    - 3b. Identify what you told yourself about each of your decisions that allowed you to make them. (Describe your rationalizations and impaired thinking.)
  - 1d. Describe the behavior that negatively affected your financial situation (ie. job, income, expenses).

- 2a. Describe the life situation that you were experiencing when you participated in this behavior. In particular, describe any major changes that were occurring in your life at the time you were participating in this behavior Also describe anything about your living arrangements that would be considered out of the ordinary.
- 2b. List five feelings that you experienced just before you participated in this behavior.
- 2c. List the specific events that led up to this behavior.
- 2d. List five feelings that you experienced when you participated in this behavior.
- 3a. Identify at least 10 specific decisions that you had to make before you could participate in this behavior.
- 3b. Identify what you told yourself about each of your decisions that allowed you to make them. (Describe your rationalizations and impaired thinking.)
- 1e. Describe all addictive/compulsive behavior that you have participated in (ie. gambling, smoking, eating, etc.).
  - 2a. Describe the life situation that you were experiencing when you participated in this behavior. In particular, describe any major changes that were occurring in your life at the time you were participating in this behavior Also describe anything about your living arrangements that would be considered out of the ordinary.
  - 2b. List five feelings that you experienced just before you participated in this behavior.
  - 2c. List the specific events that led up to this behavior.
  - 2d. List five feelings that you experienced when you participated in this behavior.

- 3a. Identify at least 10 specific decisions that you had to make before you could participate in this behavior.
- 3b. Identify what you told yourself about each of your decisions that allowed you to make them. (Describe your rationalizations and impaired thinking.)

## (APPENDIX B) THE RELAPSE SYNDROME

When we attempt to stop an addictive behavior, we often try to just stop the behavior. Unfortunately, this does not usually work. Relapse generally follows a predictable and readily identifiable pattern. If you are able to identify this pattern for your own behavior, you will be better prepared to prevent relapse. This pattern usually takes the following steps:

### 1. Return of denial.

#### Problem:

As the addict progresses in his program, he is likely to begin to feel that he has his problem under control. When asked how he is doing he is likely to say "fine, no problems" when, in fact, we all have problems that need to be dealt with regularly. This return of denial is often supported by those persons who strongly want you to be "cured".

#### Solution:

- 1) Teach support people about recovery and relapse. Encourage them to probe you about problems.
- 2) Write down your problems on a daily basis and share this list with someone.

### 2. Avoidance of defensive behavior.

#### Problem:

As the addict begins to deny the potential for relapse, he drops his defensive behavior. He often will focus more energy on fixing others than on working on himself. He will begin placing himself in "at risk" situations and will stop doing his relapse prevention exercises.

#### Solution:

- 1) Surround yourself with support people who will encourage you to continue working on your relapse prevention program.
- 2) Maintain a "negative image" reminder of the price your

paid for your addictive behavior.

- 3) Develop and review a cost/benefit analysis of your coping behavior.

### 3. Crisis building.

#### Problem:

As a result of avoiding defensive behavior, problems begin to pile up and it becomes more and more difficult to see options. The addict develops tunnel vision and loses the ability to perform constructive planning. Plans that were developed earlier often begin to fall apart.

#### Solution:

- 1) Remind yourself to take one day at a time.
- 2) Return to coping behavior.
- 3) Accept your personal limits.
- 4) Review the concepts of RET (RET states that it is your thoughts about an event and not the event that is "bad" or "good").

### 4. Immobilization.

#### Problem:

When a crisis build up, the addict becomes crushed and trapped by the problems. The addict becomes totally incapable of initiating action and is trapped by his own lies and problems. Often times, the addict develops an unrealistic optimism wishing that things would "just go away". A sense that nothing can be solved may develop.

#### Solution:

- 1) Use the Serenity Prayer.
- 2) Use the support people that you have developed.
- 3) Review the concept of lapse as opposed to relapse (accept the reality that you may make some small mistakes but this does not mean that you have failed).

### 5. Confusion and overreaction.

Problem:

While the problems continue to grow and the addict feels stuck, he often becomes confused and angry. During this phase of the relapse syndrome, the addict may become irritable with those around him, develop a general sense of tension, and view others as out to get him.

Solution:

- 1) Identify the source of the feelings.
- 2) Accept responsibility for problems.
- 3) Review RET concepts.
- 4) Possible professional intervention.

6. Depression.

Problem:

As the anger begins to build, the addict begins to develop a sense of hopelessness and begins to turn the anger inward in the form of depression. Symptoms may include irregular eating habits, lack of desire to take action, irregular sleeping habits, loss of daily structure, and suicidal ideation.

Solution:

- Professional intervention.

7. Behavioral loss of control.

Problem:

During this phase, the addict becomes unable to control or regulate personal behavior and a daily schedule. There is heavy denial and no full awareness of being out of control. Life becomes chaotic and many problems are created in all areas of life and recovery as indicated by irregular support meeting attendance, open rejection of help, and feelings of powerlessness and helplessness.

Solution:

- Professional intervention.

8. Recognition of loss of control.

Problem:

The addict's denial breaks and suddenly he recognizes how severe the problems are and panics. As a result of this panic, the addict may begin self-pity, return to deviant fantasies, consciously lie, and lose self-confidence.

Solution:

- 1) Professional intervention.
- 2) Return to self-help program (ie. SLAA, AA, etc.).

9. Option reduction.

Problem:

During this phase the addict feels trapped by the pain and inability to manage life. Only three options seem possible-- insanity, suicide, or relapse. The addict believes that nobody can help. Common symptoms include: unreasonable resentment, discontinuance of all treatment, and overwhelming loneliness, frustration, anger, and tension.

Solution:

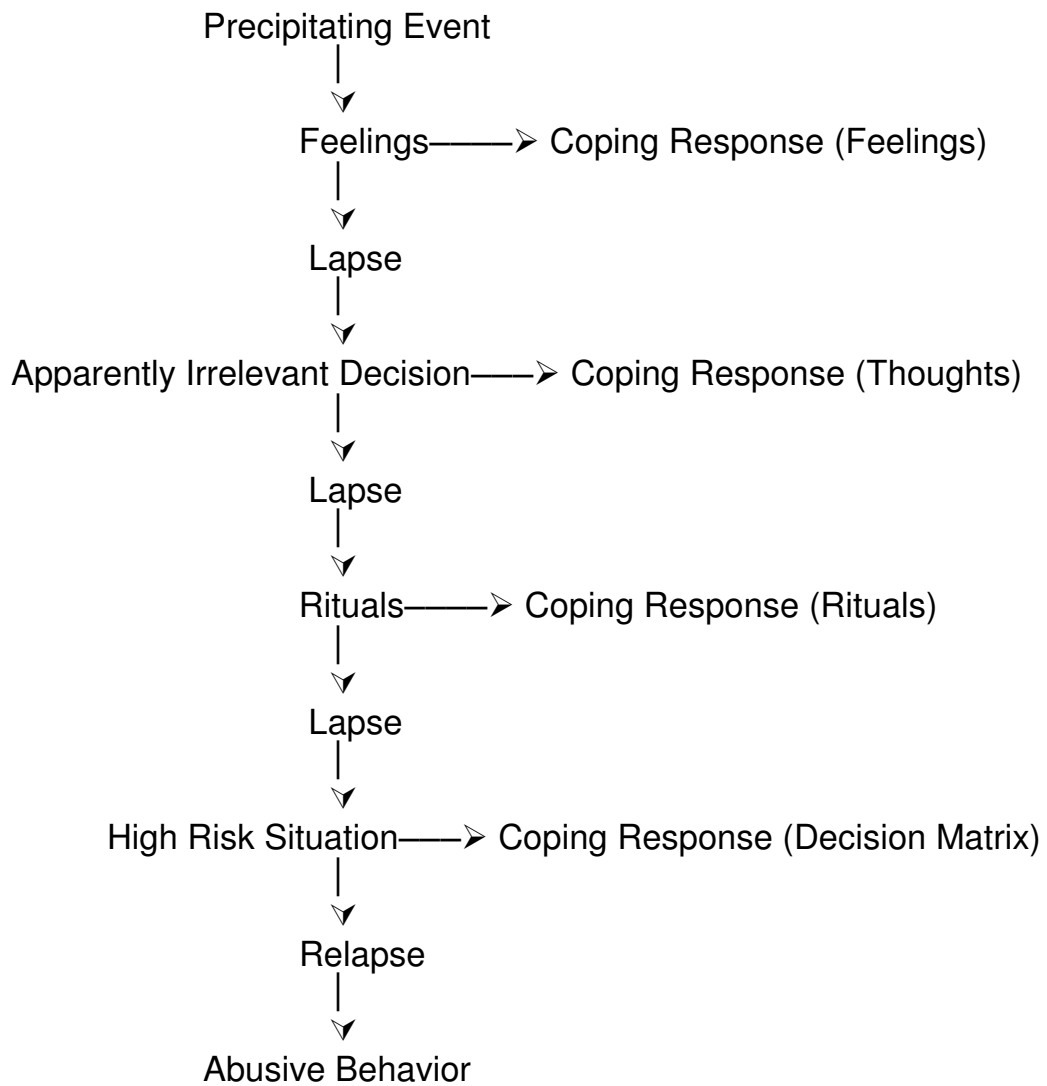
- 1) Forced treatment.
- 2) Revocation.

10. Acute relapse episode.

Problem:

Return to the abusive behavior.

**(APPENDIX C)  
THE RELAPSE PROCESS**



**(APPENDIX D)  
THE ADDICTIVE SYSTEM**

CORE BELIEF'S

UNMANAGEABILITY

IMPAIRED  
THINKING

ADDICTION CYCLE

PREOCCUPATION

SHAME

RITUALIZATION

GUILT

BEHAVIORAL ACTING OUT

---

Core Belief's--the accumulation of all life's experiences from the beginning of your life until the present.

Impaired Thinking--distorted view of self, others, and life. This impaired thinking develops in response to/and based on Core Belief's.

Addiction Cycle--an ongoing process that feeds on the Impaired Thinking and contributes to the Unmanageability.

Preoccupation--compulsive fantasizing or intense focus on the addictive behavior. This often includes intrusive thoughts.

Ritualization--routines or rituals that enhance the preoccupation and facilitate the acting out behavior.

Behavioral Acting Out--acting out the addictive behavior.

Shame--the part of the despair cycle that includes feeling hopeless about self.

Guilt--the part of the despair cycle that includes feeling bad about specific actions.

Unmanageability--the result of the addictive cycle that usually results in the impairment of one or more areas of the individual's life, (ie., social, occupational, marital, or spiritual).

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Adapted From: Carnes, P. (1983). Out of the shadows: Understanding sexual addiction. Minneapolis, MN: CompCare.

## (APPENDIX E) DECISION MATRIX

In developing a decision matrix, we are actually exploring the "response strength" between a stimuli (an event or internal experience) and a behavioral/emotional response. In the past when you encountered a high risk situation (stimulus), you responded with deviant acting out behavior. After participating in programming, it is assumed that you no longer see the old stimulus response connection the way you use to. When we develop the decision matrix, we will be exploring the way you used to see the stimulus response connection of you old behavior, the way you now see the stimulus response connection of you old behavior, and the stimulus response connection of your new, adaptive behavior.

Additionally, all experiences have a cost and a benefit. That is, all experiences have positive attributes and negative attributes. In your past, the deviant acting out behaviors had things that you did not like (costs like waking up with a hangover) and things you did like (benefits like getting high). We hope you do not see these costs and benefits the same way you did in the past! As a result, you should have a new set of cost and benefits for your past behavior. Your new behavior also has costs and benefits that may or may not be related to the old costs and benefits.

On the attached form fill in the appropriate boxes as follows:

- 1) At the top of the form spell out in detail the high risk situation that you will be discussing in this matrix. Define the old response pattern to this situation and define your new response pattern
- 2) Cost of old response pattern as seen in the past. Imagine your self as you were in the past and explore the negative attributes of being in this position. That is, what was bad or what did you have to give up to be in this position? List at least three of these costs.
- 3) Benefit of old response pattern as seen in the past. Imagine yourself as you were in the past and explore the attributes of being in this position. That is, what did you get out of being in this situation. List at least three of these benefits.

- 4) Cost of old response as viewed today. Given how you view the world today, look back at how you used to deal with this situation and identify at least three negative things associated with this.
- 5) Benefit of old response as viewed today. Given how you view the world today, look back at how you use to deal with this situation and identify at least three positive things associated with this.
- 6) Cost of new response. Given that you have developed a new response pattern when you are faced with this situation, what price will you be paying if you carry it out. List at least three of these costs.
- 7) Benefit of new response. Given that you have developed a new response pattern when you are faced with this situation, what is the benefit? List at least three of these benefits.
- 8) Assign the relative value of each of these costs and benefits. That is, assign a number between 1 and 10 to each of these costs and benefits indicating how important each of these are (1 being very unimportant and 10 being very important).
- 9) For each response subtract the cost from the benefit. This is the response strength of that response to the stimulus. The response strength determines which decision you are most likely to make.

**COST BENEFIT MATRIX**

DEFINE HIGH RISK SITUATION:

	Cost	Benefit
Old Response:	1 2 3	1 2 3
Old Response as viewed today:	1 2 3	1 2 3
New Response:	1 2 3	1 2 3

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# **AN INTRODUCTION TO UNDERSTANDING AND TREATING SEXUAL DEVIANCY**

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