

VOLUME 29 NUMBER 1

SPECTS

R E P O R T

SEXUAL ABUSE

OCTOBER / NOVEMBER 2000

SIECUS

R E P O R T

VOL. 29, NO. 1 • OCTOBER/NOVEMBER 2000

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The *SIECUS Report* is published bimonthly and distributed to SIECUS members, professionals, organizations, government officials, libraries, the media, and the general public. The *SIECUS Report* publishes work from a variety of disciplines and perspectives about sexuality, including medicine, law, philosophy, business, and the social sciences.

Annual *SIECUS Report* subscription fees: individual, \$65; organization, \$135 (includes two subscriptions to the *SIECUS Report*); library, \$85. Outside the United States, add \$10 a year to these fees (in Canada and Mexico, add \$5). The *SIECUS Report* is available on microfilm from University Microfilms, 300 North Zeeb Road, Ann Arbor, MI 48106.

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Design and layout by Alan Barnett, Inc.

Proofreading by Sheilah James

Printing by Fulton Press

Library of Congress catalog card number 72-627361

ISSN: 0091-3995

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ANOTHER REASON FOR
COMPREHENSIVE SEXUALITY EDUCATION

Mac Edwards

A little over a year ago, I received a phone call from Dr. Steven Brown, a staff psychologist at the Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy in Connecticut. He wanted us to publish a *SIECUS Report* on the subject of sexual abuse with an emphasis on sexuality education as part of sexual healing.

Now, a year later, we are publishing the largest *SIECUS Report* ever. In one way or another, all our expert authors point to the need for comprehensive sexuality education to help people become sexually healthy.

I would like to thank Steve for making this *SIECUS Report* possible. He worked with me regularly over the past year in selecting topics, finding authors, and reviewing manuscripts. I think his help and dedication show in the results.

ARTICLES ON SEXUAL ABUSE

The articles in this issue are presented in a specific order. The first provides background on the issue of sexual abuse; the next articles discuss victims of sexual abuse; and the following two pieces discuss those accused of sexually abusing. The final article is a "View from the Field" about a new prevention program called "STOP IT NOW!"

Specifically, Dr. Suzanne Sgroi, a pioneer in the sexual abuse field and the cofounder of the Saint Joseph College Institute for Child Sexual Abuse Intervention provides background in her article "Discovery, Reporting, Investigation, and Prosecution of Child Sexual Abuse" and points to the continuing need for professional and public education as well as research on this subject.

Next, Dr. Christine Courtois, who is currently serving as the clinical and training director for the Posttraumatic Disorders Program at the Psychiatric Institute of Washington in Washington, DC, discusses the after-effects of sexual abuse on sexual development in her article "The Sexual After-Effects of Incest/Child Sexual Abuse."

Then Wendy Maltz, a noted sexual abuse counselor and author, explains in her article "Sexual Healing from Sexual Abuse" how she works with survivors to help them develop a new meaning for sexual relationships based on mutual consent, caring, respect, equality, safety, trust, choice, and emotional satisfaction.

In the same vein, Cordelia Anderson, the founder of Sensibilities, Inc., and the author of the play *Touch*, writes in her article "*The Touch Continuum: Part of a Risk-Reduction Curriculum*" about the role that touch plays in sexual health and abuse-prevention education.

Then Gail Ryan, director of the Perpetration Prevention Program at the Kempe Children's Center in Denver, CO, writes in her article "Perpetration Prevention: The Forgotten Frontier in Sexuality Education and Research" that the knowledge exists to reduce the risk of both generally abusive and sexually abusive behavior problems.

Next, Dr. Toni Cavanagh Johnson, noted sexual abuse expert and clinical psychologist, writes in her article, "Children with Sexual Behavior Problems," about the still unresolved problem of how to make sense of the wide array of sexual behaviors in children. In the process, she looks at the dangers of overpathologizing children based on their sexual behavior.

In his article, "Healthy Sexuality and the Treatment of Sexually Abusive Youth," Dr. Steven Brown writes that many treatment programs unfortunately focus on interventions that curtail abusers' sexuality rather than on interventions that promote healthy sexuality.

Joan Tabachnick, who is director of public education at STOP IT NOW!, called me several months ago and said that she wanted to write an article about the organization, which works to help offenders take responsibility for stopping their sexual abuse. Her article shows how a small group can make a big difference.

A NEW BIBLIOGRAPHY

And finally, we have a new *SIECUS Annotated Bibliography* on "Sexual Abuse" in this issue. It contains the latest information on general resources, professional resources, survivor resources, and children's resources as well as education curricula. It also includes contact information for organizations working in the field.

As a layman, I have learned a great deal over the past year about sexual abuse. This includes the importance of helping victims as well as perpetrators recover and regain their lives. I hope you will find this issue of the *SIECUS Report* both informative and interesting.

STOPPING THE CYCLE OF SEXUAL ABUSE

Tamara Kreinin, M.H.S.A.

It is particularly significant that I am writing my first column as president of SIECUS on the subject of sexual abuse. Nearly 20 years ago, I started and ran the NCJW/JCC SHIELD Project in New Orleans. We helped thousands of children learn to protect themselves from abuse, trained teachers and other professionals in prevention and intervention, and developed a system to bring together advocates in public, private, and parochial schools.

As I worked on the Project, many children told me they had been sexually abused. In some cases, I discovered that a perpetrator went on to abuse other children. In other instances, I found that abused children were inappropriately sexual with other children, creating a cycle of abuse. Time and again, I saw that our public systems were failing to protect children. These experiences made me passionate about changing those systems and advocating on behalf of youth.

HEALTHY SEXUALITY

While teaching children to trust their instincts and protect themselves from sexual abuse, I became acutely aware that they also needed an introduction to sexuality as a natural part of life.

I have a distinct memory of answering a hotline late one night at the New Orleans Police Department after a television program on sexual abuse. This was in the early 1980s. An elderly woman called to thank us for being there. She said a relative had sexually abused her when she was a child. She added that she had always felt—as many children do—that it was her fault. She said she had believed the abuse would stop if she could only be a “better” little girl. She never told anyone. The abuse continued for many years. This was her introduction to sex. Now she was talking about this experience for the first time with the hope that it would help other children.

There are many striking aspects to this story. Perhaps most poignant is that sexual abuse is not new. What is new is the revelation of widespread sexual abuse. It is no longer a dark secret. We now have a reporting system that clearly shows us the large number of abuse cases involving both girls and boys of all ages. Research also shows us that sexual abuse knows no class, no race, and no ethnic boundaries. It occurs in every neighborhood across the United States. We have

recently learned more about children abusing other children. We now know that many perpetrators begin to abuse other children in their teen years. Very possibly they themselves were abused and did not receive the help they needed.

It is tragic that the first lesson many children learn about sexuality is one of abuse rather than one of a positive, healthy sense of their own bodies and their sexuality.

POSITIVE MESSAGES

Recognizing the prevalence of sexual abuse is particularly critical in this new era of sexuality education where federal funds are used to teach “abstinence-only-until-marriage.” The messages in many of these programs can prove harmful to children who are being abused.

If young people are being sexually abused by someone they perceive to be in a position of power and are then told by yet another person in power (a teacher) that “sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects” (the language in the federal legislation), they are receiving messages that could have a doubly negative impact.

It is imperative that young people hear that sexual abuse occurs, often by people they know; that it is not their fault; and that they can tell someone and keep telling if they don’t get help. Comprehensive sexuality education can communicate this message while also teaching children to respect their bodies and build sexually healthy skills.

Sexual abuse does not occur in a vacuum. It is a part of cultural forces in a society that has not come to terms with sexuality as a natural part of life. We are just beginning to understand the depths to which it occurs and the reasons it occurs. In the process, we are starting to craft solutions.

NEW INSIGHTS

It is my hope that this issue of the *SIECUS Report* will provide new insights from sexual abuse experts. Our intent is to take a holistic approach addressing the subject of both victims and perpetrators.

It is critical that we work to protect children and those who are abused while also counseling perpetrators to change their behavior. In the process, we will also stop the cycle of sexual abuse.

DISCOVERY, REPORTING, INVESTIGATION, AND PROSECUTION OF CHILD SEXUAL ABUSE

Suzanne M. Sgroi, M.D.

Executive Director, New England Clinical Associates
West Hartford, CT

Just three decades ago, public and professional awareness of child sexual abuse was extremely low. My first experience with a case of child sexual abuse occurred in 1972 and involved a six-year-old boy with a painful penile discharge. This child had been sent by a pediatrician to the city-run venereal disease clinic with a note that said, "Suspect gonorrhea—please treat."

In this clinic, I had become accustomed to seeing teenagers with sexually transmitted diseases (STDs), but this boy was the first prepubertal child I had encountered. His mother reported that she had brought him to a local hospital emergency room with the same complaint one month earlier. A copy of the emergency room record revealed that, on that date, the doctor had diagnosed a gonorrhea infection and had prescribed penicillin injections that should have been curative. The only follow-up instruction given to the mother was an admonition to scrub her toilet seat every day.

Although I was unable to elicit any other relevant information from the child or his mother, it was obvious that this boy had been reinfected by someone who continued to have sexual access to him. Clearly, antibiotic treatment alone would be insufficient; reinfection was likely to occur as long as he was exposed to repeated sexual contact.

I filed a report of suspected child abuse, but Child Protective Services was disinclined to take action for several reasons: first, they were understaffed; second, they had no experience in working with sexual abuse cases (none had been reported in the city that year); third, the only indication that this boy had been sexually abused was the presence of an STD. The intake staffperson opined that transmission of gonorrhea to the child via a contaminated toilet seat was an acceptable explanation and commented that it was against agency regulations to send an employee into a household where someone had a communicable disease. Despite my firm assertions that the boy must have been sexually abused by an infected person and that staff would not be endangered by making a home visit, the statutory child protection agency refused to investigate this complaint.

What to do? As recounted elsewhere, I did not know how to question the child and his mother effectively and made most of the common interviewing errors (communicating my own anxiety, interviewing them together instead of separately, using medical jargon, and asking accusatory questions).¹

Fortunately, a savvy public health nurse took over and, in a nonthreatening fashion, persuaded everyone in the household (symptomatic or not) to be cultured for gonorrhea. In this way, she discovered two other infected family members (a four-year-old sister and a 14-year-old uncle of my patient). With discreet questioning, the nurse learned from the little girl that the adolescent uncle sometimes masturbated and then "played games" involving genital touching of the younger children with hands contaminated with his own genital secretions.

Thanks to her interventions, all of the infected minors received adequate medical treatment, and the younger children's mother was advised that the 14-year-old uncle was not a safe baby-sitter. He, of course, denied any sexual contact with his niece or nephew but was advised nevertheless to refrain from such contact in the future. To our knowledge, the younger children did not become reinfected thereafter. Although far from comprehensive, these interventions probably were "state of the art" for this type of case at that time.

THEN AND NOW

This case was so perplexing and frustrating that I decided to review the existing professional literature on management of child sexual abuse cases. Unfortunately, in 1972, I was able to find no references in the medical or behavioral sciences literature that addressed investigation or initial management of complaints. Most of the references were in the psychiatric literature and consisted of anecdotal reviews of treatment of incest cases, usually limited to a few case examples. However, I continued to search for relevant research and guidelines for case management as I collected cases from the emergency room of the hospital where I worked.

In early 1975, while attending the first national child abuse conference sponsored by the newly established National Center on Child Abuse and Neglect, I was disappointed to discover that there were no workshops on sexual abuse scheduled for the two-day program and no references to child sexual abuse in any of the presentations. It was as if the problem did not exist!

I asked everyone I met (including the speakers) how she or he handled sexual abuse cases and, with one exception, learned that none of them had any experience with this problem. The exception was Vincent DeFrancis,

then director of the Children's Division of the American Humane Association. Dr. DeFrancis, the author of an early monograph on child sexual abuse,² recommended contacting Dr. Henry Giarretto regarding his work with intrafamilial child sexual abuse cases in Santa Clara County, CA. No one else at the conference was able to assist me.

My persistent questions at this conference had an unexpected result. Many of the speakers and other professionals I had questioned began to refer subsequent queries to me. Soon I was receiving phone calls from professionals throughout the United States, all asking the same types of questions about investigation and case management. Within a month, I was invited to submit an article about child sexual abuse for a special issue on child maltreatment for *Children Today*, a child welfare publication sponsored by the Office for Children in the U.S. Department of Health, Education and Welfare. The editor candidly informed me that she had been unable to find anyone else to write the article and had been given my name by a colleague who had attended the national child maltreatment conference described above. Despite the gaps in my own knowledge, I submitted the article.³ Since this publication was widely distributed throughout the United States, I received even more letters and phone queries thereafter.

Not surprisingly, my early case experience focused on performing medical examinations of alleged child victims. I was dismayed to discover that, because I was a physician, my opinion about the validity of those cases tended to carry more weight than findings and conclusions made by police or Child Protective Services investigators (my initial experience with the six-year-old boy in the venereal disease clinic notwithstanding). In part, this was due to the belief described above that any bona fide victim would have medical evidence of forcible penetration. However, it also could be explained by a prevailing tendency at that time to regard physicians as authority figures who occupied the top of the health and human services hierarchy and were extremely knowledgeable about human sexuality.

There was also a widespread belief (then as now) that engaging in sexual interaction was a transforming experience that marked an individual's rite of passage to adulthood. A sexually experienced child was viewed as an anomaly by most of the general public, who believed that youthful victims of sexual abuse had "lost their innocence" and become contaminated in a way that made them seductive and dangerous. Thus, the misperception that physicians were vastly knowledgeable about human sexuality reinforced the belief that physicians were better qualified than other professionals to evaluate the credibility of child sexual abuse complaints.

In today's world, it is difficult to credit the feelings of embarrassment and discomfort that open discussion of

sexual behavior evoked for many professionals and laypeople three decades ago. One of the greatest barriers to effective discovery, reporting, and investigation of complaints of child sexual abuse was the stigma attached to the problem. Child sexual abuse was a taboo topic that rarely was addressed by the media and not covered in most graduate education programs. Many professionals felt too inhibited by embarrassment and shame to speak directly about adult-child sexual interactions and lacked the vocabulary to do so. Others feared that they would be viewed as prurient or abnormal if they verbalized their concerns that a child was being sexually abused by an adult. Avoidance and denial were often encountered by professionals who did speak up and attempt to report suspected child sexual abuse or facilitate protective interventions.

I learned about these social barriers firsthand in 1976, when I was invited along with Dr. Ann Wolbert Burgess, the author of pioneering research on sexual assault, to present a two-hour workshop on child sexual abuse in Boston sponsored by the Child Welfare League of America. Although we had been informed that many participants had registered for the workshop, the room was nearly empty when it was time to begin. People began to trickle in after we started, however, and soon all the seats were filled. Dr. Burgess and I had allocated ample time for questions and discussion but found that no one in the audience was willing to ask questions or participate in any dialogue about the subject.

Ten years later, at another conference in Boston, a woman approached me and said she had attended the 1976 workshop. This woman commented that she and some of her colleagues had wanted to attend but felt too embarrassed to reveal their interest in child sexual abuse. Since the conference sponsors had issued registration badges displaying participants' workshop choices, she and her friends had removed their badges to conceal that they had signed up for the child sexual abuse workshop. Most attendees had come late to the session for the same reason and remained silent during the question-and-answer period because they did not wish to call attention to their presence by asking questions or participating in a discussion. What a difference between then and now!

Meanwhile, beginning in 1975, I had the opportunity to work in a federally funded child abuse and neglect demonstration center from 1977 to 1979, which focused on child sexual abuse cases. During that period, I participated in many investigations and assisted the multidisciplinary staff of the demonstration center to develop more effective investigative and treatment approaches for sexual abuse cases. I also gained much experience in interviewing for sexual abuse complaints and eventually developed guidelines published in 1978 and 1982 for investigative interviewing of children.⁴ These publications led to many requests for

training. In 1979, a colleague, A. Nicholas Groth, Ph.D., and I founded the Saint Joseph College Institute for Child Sexual Abuse Intervention, located in West Hartford, CT. This educational institute, still in operation, has provided a continuing venue for developing training formats for investigation and treatment of child sexual abuse cases.

By now, of course, there is a vast professional literature about every aspect of child sexual abuse intervention, and today it is common knowledge that child sexual abuse frequently occurs. In 1995, a Gallup Poll of a thousand parents nationwide revealed that 23 percent reported that they had been sexually abused by an adult or an older child during their own childhood.⁵ These parents also were asked if (as far as they knew) their own children had been coerced to participate in interactive sexual behaviors with another child or adult. Based on the parents' reports about their children's victimization experiences, Gallup estimated that 1.3 million children in the United States had been sexually abused in 1995. By contrast, the National Center for Child Abuse and Neglect estimated there were 130,000 cases of child sexual abuse during the same period. The tenfold discrepancy in these estimates is not surprising, since it reflects the disparity between what parents were willing to disclose in an anonymous phone survey (the Gallup Poll) versus official reporting of suspected abuse to police or Child Protective Services.

It also is probable that the Gallup survey of parents reflected frequencies of sexual abuse for at least two generations of children in the United States that were higher than official estimates because people were talking much more openly about sexual topics by the mid 1990s.

The willingness of media executives to publish and broadcast information about child sexual abuse began around 1980, most notably with the broadcasting of *Something about Amelia*, a made-for-television film starring Glenn Close and Ted Danson that openly and sensitively portrayed father-daughter incest.

During the same period, there suddenly appeared a spate of reports on television and radio and in the popular press describing sexual abuse of young children in day care centers. Multiple prosecutions followed in California, Minnesota, North Carolina, Massachusetts, and New Jersey of day-care providers accused of sexual abuse of young children. Although many of the convictions in these cases subsequently were reversed because of errors in investigation and prosecution, these cases attracted enormous media coverage and captured public attention across the country.

As a result, sexual abuse prevention programs proliferated in the schools, and public and professional awareness of child sexual abuse increased dramatically. Publication of journal articles and professional and self-help books about child sexual abuse, previously a rarity, began to

accelerate exponentially in the late 1980s. And child sexual abuse, especially parent-child incest, now is a commonplace theme in popular literature and drama.

DISCOVERY AND REPORTING

Despite the discrepancy between estimates based on self-reports versus official estimates, annual documented reports of child sexual abuse now are vastly higher than in 1970. Since 1967, every state in the United States has had a child abuse reporting law mandating teachers, health and mental-health personnel, and many other types of human services professionals to report suspected sexual abuse of children to civil authorities or law enforcement.

Professional awareness of child sexual abuse cases and mandated reporting laws also is much higher than in the past. Consequences to professionals for failure to report suspected child abuse (job-related sanctions, civil suits, and occasional criminal prosecutions) have been widely publicized. Most jurisdictions now have 24-hour toll-free reporting numbers for reporting suspected child abuse and on-call staff to investigate high-priority and emergency complaints received after daytime working hours and on weekends and holidays.

All of these factors undoubtedly have influenced the increase in reported complaints of suspected sexual abuse in the past three decades.

CIVIL AND CRIMINAL COURT

In most jurisdictions, complaints of child sexual abuse by a nonfamily member are investigated by the police. If law enforcement finds probable cause to believe that a crime was committed, the suspected perpetrator may be arrested and prosecuted in criminal court.

Complaints of abuse by a family member generally are investigated by civil authorities (usually the Child Protective Services division of the city, county, or state child welfare agency). If the statutory child protection agency makes a finding that a child has been sexually abused by a family member (or a person given access to the child by a family member), a variety of protective interventions may occur. In some cases, petitions of alleged abuse or neglect may be filed in juvenile or family court, and temporary or permanent removal of the child from the home may result. Treatment for child victims and other family members also may be mandated.

Intrafamilial complaints often are also referred to law-enforcement authorities, especially when the statutory child protection agency has made a finding that child sexual abuse by a family member has occurred. If police investigators believe there is sufficient evidence, criminal prosecution of the alleged perpetrator may follow. In some intrafamilial cases, criminal prosecution of the alleged abuser as well as juvenile

or family court interventions involving placement and custody of the alleged victim occur simultaneously.

INVESTIGATION TECHNIQUES, PRACTICES

During the past two decades, many professionals have come to realize that the manner in which child sexual abuse investigations are conducted significantly influences the results. Information elicited during investigations forms the basis for interventions by Child Protective Services and law-enforcement personnel.

A finding of intrafamilial child sexual abuse, especially when a parent is the alleged perpetrator, can have a profound impact on a child's placement and custody and sometimes may result in termination of parental rights. Likewise, criminal prosecution for child sexual abuse in intrafamilial or extrafamilial cases can result in incarceration, court-mandated sexual offender treatment, and placement on a sexual offender registry for individuals who are convicted. Thus, it is impossible to overstate the importance of comprehensive and objective investigations by skilled and experienced investigators.

To date, there is no uniform protocol for investigating complaints of alleged child sexual abuse. Three decades ago, little was known about the motivations of sexual offenders against children and the types of sexual behaviors that took place during child sexual abuse scenarios. Physicians and law-enforcement personnel tended to assume that sexual abuse of children always involved penile penetration of vulvovaginal or anal openings and would likely cause physical injuries that could be detected by medical examination. Thus, it was considered necessary in most cases to document that forcible penetration of these openings had occurred in order to make a finding of child sexual abuse. Investigation of child sexual abuse complaints usually consisted of a medical examination of the alleged victim. If medical evidence was absent, the complaint was assumed to be false.

We now know that the sexual behavior most commonly reported in child sexual abuse cases is fondling (which is unlikely to cause physical injury) and that medical evidence often is absent even when abusers admit to engaging in sexual penetration of young victims. In a comprehensive review of the medical literature, Bays and Chadwick reported that up to 83 percent of girls and 82 percent of boys who are examined for sexual abuse have normal physical findings.⁶

Increased understanding that medical evidence may be lacking in most cases has led to an awareness that determining the validity of the complaint may hinge on verbal information elicited from the alleged victim. In the absence of published guidelines or standards, the focus of interviewing children for sexual abuse complaints during

the 1970s and early 1980s was on overcoming barriers to disclosure such as shame or fear of retaliation.

There was a prevailing perception that it was extremely difficult for children to tell investigators about incidents of sexual abuse, and little attention was paid to avoidance of leading or contaminating questioning techniques. In addition, there was a perception that a child who was knowledgeable about interactive sexual behaviors must have acquired this familiarity through victimization experiences.

However, since children today often are exposed to sexually explicit material in films, television programs, and commercial videotapes, even young children may be familiar with sexual behaviors in the absence of a victimization history.

As more proposed guidelines for investigative interviewing of children for sexual abuse complaints have emerged,⁷ greater attention has also been focused on child development issues and on research pertaining to children's abilities to remember and report life events. During the past decade, there has been a growing consensus among professionals that open-ended, nonleading interviewing approaches are the most effective method for eliciting accurate information when children are interviewed for alleged sexual abuse.⁸ To date, a limited amount of research has been performed to test this hypothesis.⁹ However, a large body of research has been published that demonstrates even preschoolers can provide reliable verbal reports of sexual abuse and may be resistant to leading or suggestive questioning, while older children are much less susceptible to leading interviewing techniques and are capable of providing remarkably detailed reports when questioned appropriately.¹⁰

Although many books and guidelines on case investigation now have been published, uniform standards of practice are still lacking. I believe that any complaint of suspected sexual abuse of a child should be investigated promptly by the police alone if the allegation involves an extrafamilial abuser and jointly by police and Child Protective Services in intrafamilial complaints. Investigations should include a collection of verbal and physical evidence. Medical examinations of alleged child victims always should be a part of investigations, although medical evidence should not be regarded as the gold standard for demonstrating that sexual abuse has occurred. Investigation of the complaint should be a methodical and objective fact-finding process that addresses the following questions:

- Can the alleged child victim articulate a clear and believable history of sexual behaviors initiated by a suspected abuser?
- Is there medical or other physical evidence (photographs, videotapes, audiotapes) that corroborates the verbal report?
- Are there witnesses to the alleged abuse or other information that corroborates any aspect of the complaint?

- Does the suspected abuser acknowledge any (or all) elements of the incident under investigation?¹¹

Investigators should be trained in investigative fact-finding and familiar with the behaviors of child molesters and rapists. They also should have training and experience in conducting open-ended and nonleading yet focused interviews with children.

When investigators are skilled and police and Child Protective Services personnel respond promptly to complaints, most child sexual abuse investigations can be completed in a week or less. Based on the facts elicited, police and prosecutors must decide if there is probable cause to believe that a crime has been committed and that a particular person is the perpetrator. Child protective services staff must decide if a child has been sexually abused and if protective interventions are required to ensure the child's safety. This means that validation of the complaint must occur as soon the fact-finding has been completed.

Validation of the complaint is the process by which it is determined if sexual abuse of the child did or did not occur. I believe that validation should involve weighing all of the facts elicited by a careful investigation that has included a search for evidence that does *and does not* appear to corroborate the complaint.

It is probable that the most reliable information will be elicited in the hours or days immediately after the complaint has been filed. The credibility of verbal information obtained from children is greater when the report is elicited by investigators who use objective and non-leading interviewing techniques. The best way to determine if children were questioned properly is to record the process by audio-taping or videotaping investigative interviews. These can be powerful tools to help avoid trials or lengthy arguments over the disposition of a case. Also, audiotaping or videotaping can reduce the number of child interviews required for appropriate interventions.

During the 1980s, some professionals believed that, since many child victims of sexual abuse display symptoms of distress, behavioral symptomatology alone could be used to validate complaints in some cases. It also is true, however, that many other child victims of sexual abuse do not display symptoms of distress or engage in any type of characteristic or diagnostic behaviors. Research now has demonstrated that there is no single symptom or complex of symptoms that can be detected in a majority of children who are known to have a history of sexual abuse.¹²

On the contrary, there are no empirical data to support the existence of a diagnostic child sexual abuse syndrome, that is, a pattern of psychological symptomatology, that proves a child has been sexually abused.¹³ Although certain behaviors (sexual acting out, for example) may arouse suspicion that a child may have been sexually abused,

behavioral indicators cannot be used to prove that sexual abuse has occurred and should not be used to bolster the credibility of a report.

Other attempts to validate complaints of child sexual abuse have included the use of psychological or physiological measures to prove or disprove that an individual is an abuser. However, there are no available measurements, tests, or scales that can differentiate reliably between abusers and nonabusers. Likewise, there are no psychological or physiological tests or assessment tools that can prove or disprove an allegation that a particular person sexually abused a particular child during an incident under investigation. Forensic specialists and clinicians should not be viewed as being more skilled than laypeople in determining when someone is lying or telling the truth.

Instead, I believe that allegations of child sexual abuse must be corroborated to be deemed valid. Corroboration can take different forms depending on case circumstances, and may include witness reports; admissions by the alleged abuser; reports by other alleged victims; photographs, videotapes, or films of child sexual abuse scenarios; or medical findings.

As the state of the art in child sexual abuse investigations has improved, a higher level of case-by-case intervention has been possible than ever before. Factors contributing to this improvement include joint investigation approaches, case review by multidisciplinary teams, and the establishment of child advocacy centers that allow investigative interviews and medical examinations of children to be performed by specially trained personnel in one location.

Most child advocacy centers and some hospitals offer culposcopic examinations of children involving the use of an instrument that provides a lighted, magnified view and high-quality photographs of the genital area. Although not required to document medical evidence of sexual abuse, the use of culposcopic examinations in younger children arguably has enhanced the credibility of medical findings in cases in which this methodology was utilized.

WHERE ARE WE GOING?

Where are we going in child sexual abuse intervention? Although many of the myths and taboos that prevented open discussion of this subject in the past have been eliminated, there is a continuing need for professional and public education as well as research.

There is an unacceptably high rate of burnout and staff turnover in Child Protective Services and law-enforcement agencies that must respond to reports. Statutory agencies must address this problem in two ways: first, by improving working conditions to make these jobs less stressful and more rewarding for employees; second, by paying constant attention to recruitment and training to improve the quality of investigative services. Since these are tax-supported

services, their quality is an issue for citizens and the community at large. Lastly, more and better resources are needed for treatment and long-term intervention for victims, abusers, and their families in this new millennium.

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—Editor

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THE SEXUAL AFTER-EFFECTS OF INCEST/CHILD SEXUAL ABUSE

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Negative attitudes about sex as well as many types of sexual dysfunction are common after-effects of child sexual abuse and incest. The traumatic sexualization and the aversive sexual conditioning resulting from childhood abuse have only rather recently been recognized. This article presents research findings and clinical observations regarding the impact of incest and other forms of sexual child abuse on an individual's sexuality, sexual attitudes, and sexual functioning.

Incest and other forms of child sexual abuse introduce a child to sexuality in ways that are psychologically and physically overstimulating. For the child victim, sexually abusive behaviors are age-inappropriate as well as developmentally and maturationally "out of sync." These behaviors are out of the child's control, involve emotional and/or physical coercion, and occur at the whim of someone else's needs and desires, usually someone older and more knowledgeable who is in a greater position of authority or strength than the child.

Yet it is not only the sexually abusive behaviors that are problematic and harmful. Since abuse occurs in the context of family life (in the case of incest) or in the context of a more extended social and relational sphere (in the case of acquaintance abuse), additional familial and caretaking variables come into play. The quality of a child's interpersonal attachment and security are learned and profoundly influenced in these settings. Additionally, incest/child sexual abuse often occurs in the context of other abuses (spousal violence and strife, physical abuse, emotional abuse, and abandonment and neglect). The resultant effects of child sexual abuse are thus confounded by other forms of abuse and relational problems.

Substantial data from research and clinical settings identify child sexual abuse as a major form of traumatic stress for the child victim with high potential for traumatic after-effects, including highly negative sexual consequences. It should be noted, however, that not all sexual abuse is traumatic and not all reactions severe. Each abuse circumstance is unique and must be carefully assessed in terms of its characteristics and its meaning to the individual. The abuse experience can vary quite dramatically according to the objective dimensions of its occurrence, such as severity,

intensity, duration, identity, and relationship of participants. It can also vary considerably in terms of its more subjective dimensions, such as the child victim's personality, genetic makeup, personal resiliency, age, developmental stage at the time of the abuse, attachment history, coping and support resources, and the occurrence of other trauma.

This said, in this article I refer to those cases in which after-effects and symptoms are severe and may meet criteria for the diagnosis of posttraumatic stress disorder (PTSD).¹ This diagnosis is characterized by a variety of quite disruptive symptoms that occur in alternating fashion: intrusive/reexperiencing symptoms by which the trauma is actively recalled and relived and denial/numbing symptoms by which the memories and reactions are blunted and cut off. In the best-case scenario, this alternation between reexperiencing and repudiating the trauma allows the individual to process his or her trauma reactions to a point of personal resolution, at which time symptoms lessen and remit.

In the more likely scenario for child sexual abuse (especially if it occurred at a young age, was chronic and entrapping, was perpetrated by an adult who was in close relation to the child, involved psychological coercion and/or physical force, and escalated in severity to the point of physical penetration), processing to resolution is impeded, and the child is profoundly affected. Posttraumatic reactions usually have three courses: acute, chronic, and/or delayed. All three patterns have been observed in victims of child sexual abuse. They may have acute reactions that then might become and remain chronic, or they may be asymptomatic in the initial aftermath of the abuse and suffer acute reactions in delayed fashion, reactions that might then become chronic and meet criteria for delayed onset of PTSD.

Studies of trauma, posttraumatic reactions, and posttraumatic disorders have documented the routine use of dissociation as a psychological defense against traumatization, especially in child victims and in cases of chronic abuse. Dissociation interferes with the normally integrated functions of consciousness, identity, and memory² and serves to interrupt and split away from the abuse experience. (A common description of this process is that of the child leaving her body during the abuse, floating above and watching "it" happen to "her.") In this way, aspects of the

trauma can become sequestered outside of conscious awareness in the interest of psychological defense and survival. Awareness often returns when the individual is triggered by something that is a reminder of the original trauma. Sexual behaviors have been found to be a major trigger for some abuse survivors who may only become symptomatic once they engage in sexual activity. For others, however, sexual behavior serves an opposite function. When sexual behavior is compulsive and out of the individual's control, it may be completely dissociated from early abuse and, in fact, may be a way to keep abuse out of conscious awareness.

Finkelhor and Browne, in reviewing the available literature on the after-effects of incest/child sexual abuse, described four main trauma-inducing dimensions of such abuse ("traumagenic dynamics"), each with its own dynamics, psychological impact, and behavioral manifestations:

1. Traumatic sexualization
2. Betrayal
3. Powerlessness
4. Stigmatization

In describing their conceptualization, they wrote:

These traumagenic dynamics are generalized dynamics not necessarily unique to sexual abuse; they also occur in other kinds of trauma. But the conjunction of these four dynamics in one set of circumstances is what makes the trauma of sexual abuse unique, different from such childhood traumas as the divorce of a child's parents or even being the victim of physical child abuse. These dynamics alter children's cognitive and emotional orientation to the world, and create trauma by distorting children's self-concept, world view, and affective capacities.³

Traumatic sexualization refers to a "process in which a child's sexuality (including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of the sexual abuse." *Betrayal* refers to "the dynamic by which children discover that someone on whom they were vitally dependent has caused them harm" (or has failed to protect or believe them). *Powerlessness* refers to "the process in which the child's will, desires, and sense of efficacy are continually contravened." *Stigmatization* refers to "the negative connotations—badness, shame, and guilt—that are communicated to the child around the experience and that then become incorporated into the child's self-image."⁴ These traumagenic dynamics are key concepts in understanding the effects of sexual abuse generally but more specifically as they relate to sexual after-effects.

SEXUAL AFTER-EFFECTS

Evidence of a connection between experiences of incest/child sexual abuse and sexual dysfunction have been available since some of the pioneer studies of human sexuality.⁵ In recent years, this connection has been identified by a number of clinicians and researchers,⁶ and, in fact, has been one of the most robust findings concerning the long-term aftermath of sexual abuse.

Although the association between sexual abuse and sexual impact is both logical and common, tragically, it has been long overlooked by the general therapeutic community and, quite ironically, by therapists who specialize in the treatment of sexual concerns and dysfunctions. It also has been largely unrecognized by the medical community. The reasons for not seeing or neglecting the connection no doubt have to do with the societal denial of incest, other forms of sexual child abuse, and family violence (to which therapists are not immune), and to the emphasis that was placed on the findings of some of the early researchers. For example, some sexologists emphasized the child's enjoyment of the sexual activity and put the child in the role of seducer due to having a "charming and pleasing personality," while some wrote of the neutral or even positive impact of child sexual abuse.

In contrast to this latter perspective, Finkelhor and Browne, after completing a comprehensive review of the available literature on the after-effects of child sexual abuse, recounted the many ways in which an individual could be affected. Concerning sexual effects, they wrote:

The sexual problems of adult victims of sexual abuse have been among the most researched and best established effects. Clinicians have reported that victimized clients often have an aversion to sex, flashbacks to the molestation experience, difficulty with arousal and orgasm, and vaginismus, as well as negative attitudes towards their sexuality and their bodies. The frequently demonstrated higher risk of sexual abuse victims to later sexual assault may also be related to traumatic sexualization, and some victims find themselves inappropriately sexualizing their children.... Such problems and behavior, as well as victims' self-reports, suggest the various psychological effects produced by traumatic sexualization. At its most basic level, sexual abuse heightens awareness of sexual issues.... Confusion often arises, especially about sexual identity.... Traumatic sexualization is also associated with confusion about sexual norms and standards.... Another impact...is in the negative connotations that come to be associated with sex...revulsion, fear, anger, a sense of powerlessness,

or other negative emotions can contaminate later sexual experiences. These feelings may become generalized as an aversion to all sex and intimacy, and very probably also account for the sexual dysfunctions reported by victims.⁷

Finkelhor and Browne's findings have been substantiated and extended by a number of studies, most of which involved only female subjects. The study of the general after-effects of child sexual abuse in males, including sexual effects, is more recent. In the next section, I will review major findings regarding sexual after-effects in women, many of which have been found to affect men as well. Obviously, specific sexual dysfunctions are gender-specific; however, many of the general findings about sexual reactions in women are also applicable to men.

In one of the earliest reviews of sexual effects of incest, Maltz and Holman reported that sexual effects following childhood incest were found within three main categories; such categorization has proven to be quite useful and encompassing (and applies to men as well as to women):

1. Sexual development/emergence in adolescence, at which time the victim becomes aware of being more sexually experienced and knowledgeable than his or her peers. This recognition typically leads to overwhelming shame, resulting in social and sexual withdrawal on the one hand, or patterns of compulsive and sometimes indiscriminate sexual activity on the other, or alternation between the two.
2. Sexual identity and gender-preference issues, including difficulty identifying as a sexual being with sexual feelings and difficulty determining gender preference and reasons for it.
3. Sexual dysfunction, ranging from total inability to be sexual at one extreme to patterns of sexual compulsivity and hyperarousal at the other.⁸

Jehu and colleagues reported on a sample of 51 college women who reported having been sexually abused in childhood. Of this sample, 95 percent had sexual dysfunction; 92 percent had a mood disturbance constituting emotions of shame, self-blame, guilt, and depression; and 90 percent had interpersonal problems with men, including discord, insecurity, mistrust, fear, and the splitting of sex and affection in relationships.

Sexual stress, including recapitulations of features of the abuse (such as revictimization of some sort or prostitution), emotional reactions, cognitive reactions, physiological reactions to patterns of arousal, and behavioral reactions, including aversions and compulsive and/or ritualized sexual activity, were observed.⁹

Frawley found incest to be correlated with 50 percent of the sexual dysfunction variables measured in 82 women who reported abuse perpetrated by their fathers. Compared to controls, the women reported a lower capacity for sexual arousal and orgasm, less sexual satisfaction, more dysfunction with intimate partners than with casual lovers, and more sexual guilt.¹⁰

Sprei and Courtois, in their review article on sexual dysfunction arising from sexual assault and abuse, reported that childhood molestation, especially incest, is more indicative of later sexual dysfunction than is rape in adulthood, although rape can certainly have a profound and negative impact. The following are categories of sexual distress and dysfunction that can occur alone or in combination:

- Desire disorder, including low desire due to fear and aversion to sex and phobias
- Arousal disorder
- Orgasmic disorder
- Coital pain, including vaginismus, dyspareunia, and genital pain
- General sexual dissatisfaction and/or frequency dissatisfaction
- Other problems, such as paraphilias, promiscuity and indiscriminate sexual activity, compulsive sex, ritualized sex, sexual abstinence, sadomasochistic practices, flashbacks, and chemical and/or relationship dependencies¹¹

Briere and Runtz, in comparing the effects of different types of abuse, found sexual abuse to have a higher correlation with later sexual dysfunction than either emotional or physical abuse.¹² Lundberg-Love reported that adult survivors exhibit difficulties in two main categories of sexual functioning:

1. Arousal problems, including aversion to particular sex acts, painful intercourse, flashbacks, dissociative symptoms, and the utilization of alcohol or drugs to reduce inhibition and to enable sexual arousal
2. Orgasmic problems, including painful intercourse, flashbacks, and dissociative symptoms.¹³

The author noted that:

Regardless of whether survivors felt pain, pleasure, or numbness during the incestuous abuse, the majority of them appear to associate sexual arousal with the feelings they experienced during the abuse. Indeed, the salience of early sexual experience appears to be particularly robust, such that the biological response to sexual stimulation becomes conditioned to the negative feelings surrounding the

abuse. Often these feelings include disgust, anger, fear, nausea, guilt, and powerlessness.¹⁴

Courtois found a “sleeper” effect (also noted by the other researchers) in which the sexual effects, although not present and/or disruptive at the time of the abuse, may emerge as the victim/survivor enters adolescence and adulthood and attempts sexual activity, a normal developmental task of these life stages.¹⁵ Difficulty maintaining sexual functioning within an intimate relationship has been repeatedly observed. In a common scenario, an adult with a sexual abuse history is able to function relatively well sexually until a relationship becomes serious and/or committed, at which time sexual feelings and functioning markedly deteriorate. This pattern is paradoxical until understood within the context of sexual abuse. Many abuse survivors describe how their fear and vulnerability increase rather than decrease when a relationship becomes more intimate. The lessons of the past—namely, love equals abuse; commitment connotes entrapment, powerlessness, and loss of control—contribute to the inhibition of sexual feelings and functioning.¹⁶

Several investigators (including Frawley, Lundberg-Love, Maltz and Holman, Meiselman, and Westerlund) have suggested a higher degree of exploring a lesbian lifestyle among their survivor samples.¹⁷ Loulan found that 38 percent of her sample of lesbian women reported having been sexually abused during childhood,¹⁸ a figure consistent with what Russell found in a random community-based sample.¹⁹ Loulan concluded that lesbians are not more likely to have suffered child sexual abuse than the general population, an association sometimes projected onto lesbians to “explain” their sexual preference. (However, by virtue of having female partners, they are more likely to be with someone who has an abuse history, a fact that might contribute to greater sexual and intimacy difficulties than found in heterosexual couples.) The gender of the victim, the gender of the perpetrator, the gender of the partner, and social conditioning may serve to affect or disrupt a survivor’s sexual orientation in adulthood.²⁰

Westerlund, in a questionnaire study, investigated 72 female volunteers who reported an abuse history. Concerning body perception and reproduction, 74 percent of the sample held negative and/or distorted body perceptions, including body hatred and estrangement (apparently related to anger and guilt about incest), “nonownership” of or alienation from their bodies, not feeling in control of their bodies, and not feeling attractive or making themselves unattractive through self-neglect, poor hygiene, poor posture, or other means.²¹

Reproductive capacity was an unwelcome developmental milestone for 58 percent of the sample who expressed their concern about being able to bear a normal child and fear of not being a good parent. Pregnancy was problematic, pre-

dominantly due to shame, confusion, and fear for 80 percent of the sample who had been pregnant. Birth experiences were difficult because “the body” was again “out of control and in pain.” All of the respondents reported that their incest experience influenced adult sexual functioning in several discrete areas, including sexual fantasies, sexual desire, sexual arousal, inhibition, orgasm, and the “split” between intimacy and sexual functioning. Westerlund concluded that difficulties with arousal appeared to be most common, followed by desire and orgasmic problems. Responses were very individualized, and some respondents reported sexual satisfaction and/or no problems with sexual functioning. Westerlund conducted follow-up interviews with 10 subjects who represented various sexual preferences (heterosexual, homosexual, celibate, undecided, and bisexual) and sexual “lifestyles” (aversion, inhibition, celibacy, compulsion, “promiscuity,” prostitution, and sadomasochism). Many of the respondents expressed concern that others might automatically attribute their sexual orientation to their incest experience, and some wondered about their “true” sexual identity in the absence of incest.

The following sexual “lifestyles” and percentages for the total sample were reported:

- Sexual aversion characterized by reclusiveness, fear, and avoidance, 14 percent
- Sexual inhibition characterized by shame, fear, anger, and mistrust, 63 percent
- Sexual compulsion characterized by sexual thought, feeling, behavior, and/or activity with a driven, unnatural quality or with power and anger, 23 percent
- A period of celibacy associated with avoidance of or freedom from feelings of guilt, anger, and shame, 49 percent
- A period of self-defined “promiscuity” and self-abuse, a means of or illusion of control, and anger, 21 percent
- A period of prostitution, 12 percent
- “The split” or nonintegration of emotional intimacy and sexual intimacy, 28 percent²²

In addition, a small percentage reported a masochistic or sadomasochistic orientation and some past sexual activity with children or animals. Maltz echoed the findings of each of these researchers in her list of the top 10 sexual symptoms of sexual abuse:

1. Avoidance, fear, or lack of interest in sex
2. Sex as an obligation
3. Negative feelings such as anger, disgust, or guilt associated with touch
4. Difficulty becoming aroused or feeling sensation
5. Feeling emotionally distant or not present during sex
6. Experiencing intrusive or disturbing sexual thoughts and images

7. Engaging in compulsive or inappropriate sexual behaviors
8. Having difficulty establishing or maintaining an intimate relationship
9. Experiencing vaginal pain or orgasmic difficulties
10. Having erectile or ejaculatory difficulties²³

Sexual difficulties and dysfunctions are no less common or pervasive in male survivors. Certainly, nine of the 10 sexual symptoms in this listing by Maltz pertain to males as well as females, and all of the other types of sexual dysfunction and sexual distress found in the various research studies listed above can be adapted to male survivors. Additionally, Gartner has described how sexual abuse has a profound impact on a boy's masculinity, an impact that can vary by gender of the perpetrator and how the abuse was perpetrated that, in turn, affects his view of sexuality and his ability to function sexually. For example, males much more than females experience same-sex sexual abuse, which they usually mistake as homosexual, and that causes them conflict as to their own gender identity and sexual orientation. Additionally, males might experience gender shame. They "dis-identity" with other males and abusive male behavior and compensate by disowning any feelings of anger and by becoming "good guys." This may play out in their sexual functioning and in their ability to be intimate with a partner.²⁴

OTHER RELATED ISSUES

A number of researchers and clinicians have noted the overlap between child sexual abuse and chemical, relational, and sexual addictions and/or coaddiction in both men and women.²⁵

Sexual abuse in combination with physical and emotional abuse can result in many dependent and addictive-type patterns of relating and being sexual. Emotions and conflicts are best managed sexually in ways that avoid true intimacy or satisfaction. Many behaviors described as addictive, coaddictive, or codependent originate as mechanisms used to survive or accommodate abuse. It is helpful to identify these behaviors as once useful (and even essential and life-saving) coping mechanisms that have outlived their usefulness and become problematic.

The relationship between incest/sexual abuse-related trauma and posttraumatic reactions and sexual dysfunction is increasingly understood. Ogden identified the following as posttraumatic reactions to sexual distress:

- They are learned
- They often begin early as survival mechanisms
- They may generate positive as well as negative patterns
- They invalidate the individual's sense of self
- They tend to remain long after the situation changes
- They may create phobic avoidance of stress
- They may create compulsive dependencies or more stress²⁶

The traumatic reactions may be acute, be chronic, and/or appear in delayed or alternating patterns. Triggers in the environment (such as smells, sounds, body sensations, specific emotions, events, and locations) may cause the individual to experience flashbacks during sexual activity or when sexual thoughts or feelings are evoked. Flashbacks can involve a complete reexperiencing of a traumatic event or partial, isolated sensory fragments (pain, smell, sound, emotion) reminiscent of the abuse. Triggers also may cause numbing or distancing responses, quite the opposite of flashback phenomena. Flashback and shutdown processes can occur in alternating patterns and thus fit the posttraumatic, dissociative process described at the beginning of this article. Understanding sexual reactions as posttraumatic adaptations provides the clinician with a specific conceptual model within which to conduct treatment.

One last sexual pattern deserves mention, that of revictimization. Many of the traumatic, emotional, cognitive, and sexual after-effects of incest may put adult survivors at particular risk for additional sexual abuse and victimization throughout their lifespan.²⁷ This is not to imply that survivors wish to be revictimized but rather that they are rendered vulnerable due to their past experiences and many of the negative cognitions and dysfunctional behaviors learned within the context of abuse. Of course, revictimization serves to compound both the original traumatization as well as its consequences.

SUMMARY

Although the research cited here has limitations concerning its generalizability, enough consistency between studies supports the conclusion that incest/child sexual abuse adversely affects sexual development and sexuality for a sizeable proportion of male and female victims. It should be noted, however, that not all survivors suffer adverse sexual effects, and, therefore, the therapist should not assume such a response but rather should carefully assess sexual impact.

The effects of incest/child sexual abuse trauma on sexuality and sexual functioning can be quite pronounced. Survivors may have distorted or negatively influenced body responses and perceptions such that they are literally alienated from themselves. This alienation may extend to reproductive issues, sexual orientation, sexual response, and sexual functioning. Therapists need to be aware of the various ways in which sexual abuse affects sexuality, sexual identity, sexual response, and reproduction to be able to address these issues in treatment. Hopefully, this short contribution serves as an introduction to the topic and sensitizes therapists to the various ways in which these issues may manifest in adult survivors.

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This article is adapted from "Treating the Sexual Concerns of Adult Incest Survivors and Their Partners" (in the *Journal of Aggression, Maltreatment & Trauma*, and in the book *Violence and Sexual Abuse at Home: Current Issues in Spousal Battering and Child Maltreatment*). —**Editor**

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SEXUAL HEALING FROM SEXUAL ABUSE

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"I hate sex. It feels like an invasion of myself and my body by someone else. Life would be great if no one ever expected me to be sexual again."

—*Tina, raped as a child by her father.*

"My penis and my heart are disconnected. I use sex as a way to blot out pain when I'm feeling down. Masturbation is a lot easier than having sex with my wife. She wants a lot of kissing and hugging, and I'm uncomfortable with all that closeness."

—*Jack, molested as a young teen by a neighbor.*¹

Like Tina and Jack, many survivors of sexual abuse suffer from a variety of sexual problems.² And it is no wonder. Sexual abuse is not only a betrayal of trust and affection, it is also, by definition, an attack on a person's sexuality.

Our sexuality is the most intimate, private aspect of who we are. Our sexuality has to do with how we feel about being male or female and how comfortable we are with our bodies, our genitals, and our sexual thoughts, orientation, expressions, and relationships.

Sexual abuse—whether it involves a gentle seduction by a loved relative or a violent rape by a stranger—can seriously harm the development, inner experience, and expression of a person's sexuality.

For the past 25 years, I have specialized in helping survivors and their intimate partners heal from the sexual repercussions of sexual abuse. It has been very creative and rewarding work, challenging my previous notions of sex therapy and providing me with a deeper understanding of, and appreciation for, healthy sexual intimacy.

When I first began this work in the late 1970s, I was a newly trained sex therapist convinced of the power of traditional sex therapy techniques such as sensate focus and sexual functioning exercises to cure sexual ills in a relatively short period of time.³ I soon discovered, however, that a substantial portion of my clients would not do the exercises, would do them incorrectly, or would obtain little benefit from them. In many of these cases, the common denominator was a history of incest, rape, molestation, or exposure to some other form of sexual abuse.

I also noticed that these clients presented initial symptoms differently than my nonsexually abused clients. Rather than lamenting the lack of sexual satisfaction in their lives, many of my survivor clients were ambivalent or

neutral about the sexual problems they were experiencing. Gone was the usual sense of frustration that could fuel a client's motivation to change. Survivors often entered counseling because of a partner's frustrations, and they seemed more disturbed by the possible consequences of the sexual problem than by its existence. Gina, an incest survivor, tearfully confided during her first session, "I'm afraid my partner will leave me if I don't become more interested in sex," and Joe, a survivor of molestation by a childhood baby-sitter said, "My obsession with pornography is ruining my ability to keep a girlfriend."

As time went on, it became apparent to me that survivors of sexual abuse require a different style and program of sex therapy because they have a different perspective on sex than clients who were not sexually abused. I have discovered⁴ and developed numerous clinical strategies that are very effective in working with this population.⁵ In this article, I will present a brief clinical overview of these interventions. I will look at treatment philosophy, assessment, strategy, and techniques, and will consider the impact of this work on the health practitioner. (More detailed descriptions of these interventions are in, *The Sexual Healing Journey: A Guide for Survivors of Sexual Abuse*, which is discussed on page 54.)

WHAT IS SEXUAL HEALING?

Sexual healing is an empowering process that enables survivors of sexual abuse to reclaim their sexuality as positive and pleasurable. It involves using special strategies and techniques to actively change sexual attitudes and behaviors that have resulted from the abuse. A program of sexual healing often includes gaining a deeper understanding of what happened and how it has influenced sexuality, increasing body- and self-awareness, developing a positive sense of sexuality, and learning new skills for experiencing touch and sexual sharing in safe, life-affirming ways. Clinicians who provide sexual healing interventions need skills to combine trauma-recovery work with modified versions of sex therapy.⁶

Sexual healing can take several months to several years or more to accomplish. It is considered advanced recovery work and, thus, is best undertaken only after a survivor has a stable and safe lifestyle and has addressed more general effects of sexual abuse such as depression, anger, self-blame,

self-destructive behaviors, and trust concerns.⁷

There are different levels of sexual healing work that a sexual abuse survivor can pursue, from simply reading about recovery to engaging in a series of progressive exercises called “relearning touch techniques.” These exercises provide opportunities to practice a new approach to intimate touch. While some survivors are able to progress in sexual healing on their own, others find it essential to enlist the guidance and support of a trained mental-health practitioner. Professional care is recommended because of the likely possibility that sexual healing will stir up traumatic memories and feelings.

Survivors do not need to be in a relationship to participate in sexual healing. Some exercises are designed for single survivors. However, if a survivor is in a committed, long-term, intimate relationship, the survivor’s partner needs to become educated about the sexual repercussions of abuse and learn strategies for participating actively and effectively in the healing process.

Sexual healing is a comprehensive process that addresses experiences on psychological, physical, spiritual, and interpersonal levels. It empowers clients and addresses their needs on an individual, case-by-case basis. It challenges therapists to engage a therapeutic style that is less authoritative and prescriptive than has been practiced in traditional sex therapy.

SEXUAL IMPACT OF SEXUAL ABUSE

Many survivors do not realize that their current sexual difficulties are normal and natural long-term consequences of sexual trauma. Thus, the first step in sexual healing often is to help people make a connection between their present sexual problems and their past abuse. For a detailed evaluation of sexual impact, I recommend clients take the “Sexual Effects Inventory” and discuss their responses in therapy.⁸ In addition, survivors may benefit from becoming familiar with these sexual symptoms that frequently result, either immediately or years later, from experiences of sexual abuse:⁹

- Avoiding, fearing, or lacking interest in sex
- Approaching sex as an obligation
- Experiencing negative feelings such as anger, disgust, or guilt with touch
- Having difficulty becoming aroused or feeling sensation
- Feeling emotionally distant or not present during sex
- Experiencing intrusive or disturbing sexual thoughts and images
- Engaging in compulsive or inappropriate sexual behaviors
- Experiencing difficulty establishing or maintaining an intimate relationship

- Experiencing vaginal pain or orgasmic difficulties (women)
- Experiencing erectile, orgasmic, or ejaculatory difficulties (men)

These sexual symptoms can also be viewed as trauma reactions of hypersensitivity, withdrawal, dissociation, and avoidance. Simply stated, survivors are either having an unpleasant reaction or trying to avoid having an unpleasant reaction to what happens during sex. For example, survivors may unconsciously numb physical sensations to avoid an automatic negative feeling such as disgust that surfaces during stimulation of the genitals. Similarly, survivors may decide to refrain from sex altogether to avoid disturbing sexual thoughts that surface unbidden during sexual arousal and response. They may even engage in compulsive sexual behaviors such as frequent masturbation or use of pornography as ways of experiencing “sexual functioning” and release while avoiding emotional stresses felt during love-making with a partner.

Since the majority of child sexual abuse is perpetrated by someone in a trusted relationship to the child (such as a parent, grandparent, sibling, or baby-sitter), survivors may feel far too vulnerable when they make themselves emotionally available and intimate during sex. They may unconsciously fear a repeat of emotional betrayal, abandonment, humiliation, or loss. Thus, sexual symptoms may arise to help keep survivors “checked out” in one form or another and thus protected from additional pain and disappointment.

DYSFUNCTIONS ARE “FUNCTIONAL”

When we view sexual problems from the perspective of trauma reactions, we are forced to challenge a basic tenet of traditional sex therapy in which all sexual dysfunctions are seen as bad and something to be cured as soon as possible. In my work with survivors, I quickly learned that, for many survivors, their sexual dysfunctions are, in fact, psychologically functional and important. At least for a while, some sexual problems—such as loss of sexual interest or orgasmic and erectile difficulties—may actually help survivors avoid negative feelings, flashbacks, and memories associated with past sexual abuse.

I will never forget my experience working with Tony, a 35-year-old single man who was raped by his father as a child. While Tony had had a string of abusive and demanding girlfriends over the years, he had more recently become involved with a nice woman. One day Tony told me that he had failed to achieve an erection when his new girlfriend was performing oral sex on him. I asked if he had wanted to have sex. He replied, “No, I really wasn’t interested then.” As we talked, it became obvious that his body had said “No” for him. I smiled, clapped my hands, and said, “Wow, do you

realize what's happening? You're becoming congruent! For all these years, your genitals have operated separately from your feelings. Now your head, heart, and genitals are lining up congruently. Good for you!" Strange as it may sound, there I was, a sex therapist congratulating a client on his sexual dysfunction.

Experiences such as Tony's have taught me that, in working with survivors to heal sexual hurts, the goal of treatment needs to shift from improving sexual functioning and performance to improving self-awareness, self-care, and trust as well as intimacy skills. Insight and authenticity are more important than behavioral functioning.

While healthy sexual functioning is a desirable long-term goal for survivors, we need to see their sexual problems in context and find out how they feel about symptoms before we attempt to treat them. Therapists must respect dysfunctions, learn from them, work with them, and resist the urge to automatically try to "fix" them.

ADJUSTING THERAPEUTIC STYLE

The therapist's style is extremely important in working with sexual abuse survivors. It may, in fact, be more important to a successful outcome than any particular technique. Because sex is a loaded topic for survivors, clients will likely transfer to the therapist the negative feelings they have toward the perpetrator and the past abuse. This process of negative transference is inevitable because of the psychodynamics of the therapeutic relationship. Sex therapists are interested in their clients' sexuality. They try to get their clients to desire and enjoy sex. They talk privately with their clients by using sexual language that is often sensually stimulating. They attempt to diminish defenses and influence personal thoughts, feelings, and intimate behaviors. Is that not what perpetrators do, too? In addition, the techniques that therapists encourage can sometimes overwhelm and upset clients. The sexuality focus can trigger negative feelings similar to what clients felt in the abusive situation(s). The very process of sex therapy can strain a survivor's sense of control and protection.

To minimize negative transference, I suggest therapists adopt the following premise: *Do the opposite of what happened in the abuse.* For instance, because the victim was dominated and denied control during the abuse, the therapist should focus on empowering the client and respecting his or her reactions. The therapist needs to explain techniques and interventions as well as encourage clients to exercise choice at all times. The therapist should make suggestions, not give directions or prescriptions. Rather than admonish the survivor for his or her resistances and relapses, the therapist should see them as inevitable, seek to understand reactions, and work with the client to overcome challenges.

In addition, it is critically important that sex therapists

maintain clear emotional and physical boundaries. Talking about sex can stir up sexual feelings. It is inappropriate and too confusing for the survivor to combine sex-focused sessions (in which there are explicit descriptions of sexual activity or techniques) with touch. Therapy needs to be a safe place—physically and psychologically—for everyone at all times.

SEX ATTITUDES AND SELF-CONCEPT

In the early stages of sexual recovery work I recommend working with survivors to help them develop new attitudes about sex. Successful treatment depends on survivors conceptualizing sex as positive and worth pursuing. Abusive sex is exploitative, impersonal, impulsive, irresponsible, overpowering, and humiliating. Due to the influence of abuse, survivors often view sex as something bad, dirty, dangerous, hurtful, and out of control. Unless they work to change their attitudes about sex, many survivors will continue to blur definitions and confuse all sex with sexual abuse. I work with survivors to help them develop a new meaning for sex in which sexual contact is predicated on mutual consent, caring, respect, equality, safety, trust, choice, and emotional satisfaction.

Therapists need to help survivors see how and when they speak of sex in the same terms as sexual abuse. If a rape victim says, "Sex sucks," a therapist might rephrase the statement as, "Yes, sex in which you have no choice about what's happening sucks." By identifying the specifics about a survivor's negative feelings regarding sex, therapists leave open the possibility that under the right conditions sex can be positive and enjoyable.

I often provide resources for survivors to learn more about healthy sexual intimacy and to understand how it differs from the type of sex in sexual abuse and sexual addiction.¹⁰ These resources include books, tapes, articles, and movies that discuss and depict sex in positive terms. In addition, I suggest exercises such as making collages from magazines of images associated with healthy sexuality or writing a letter to a partner describing qualities of healthy sex.

Survivors also need to make conscious efforts to undo negative "self-talk" concerning who they are as sexual people. Many sexual abuse victims come to the erroneous conclusion that sexually they are bad, that they are objects for another's pleasure, or that they are "damaged goods." Survivors must learn to feel good about their sexual energies, body parts, passions, and expressions *in spite of the abuse.* I often find myself saying to clients, "*You are not what was done to you,*" or, "*You are not to blame for what was done to you,*" or, "*Your body's reactions and responses were normal, and even necessary, under the circumstances.*" Gestalt dialogues and role-plays can help survivors develop compassion and reintegrate the parts of their bodies that they believe

participated in, or were responsible for, the abuse. Thus, a female survivor might create an imaginary dialogue with her breasts, telling them, “You are not to blame for having been touched in abuse.” Similarly, survivors may need help resolving confusions and false conclusions related to their sexual orientation.

I also recommend that clients spend time during sexual healing to improve body image, acceptance, and self-care. Practicing good nutrition, getting regular exercise, and developing relaxation skills are often essential to feeling sexually fit, attractive, and present in one’s own body.

CHANGING SEXUAL BEHAVIORS

Before new learning about touch and sex can occur on a physical level, survivors need to stop engaging in sexual behaviors that can undermine the healing process. These include extramarital affairs, compulsive sex, unsafe and risky sex, violent sex, and obligatory sex. Therapists can help survivors analyze questionable sexual behaviors by suggesting they ask the following questions:

- How does the behavior reflect, mimic, or reinforce sexual abuse?
- How does the behavior hurt me or others?
- How does the behavior interfere with my developing a healthy intimate relationship?
- Why is it important for me to stop?
- What do I fear will occur if I stop?

Obviously, as with curtailing any habitual or emotionally driven behavior, the client’s readiness and personal motivation are critical to success. For survivors caught up in compulsive and addictive sexual behaviors, participation in 12-step recovery programs is often essential.

Many survivors naturally shy away from sexual contact when they are involved in sexual abuse recovery work. This is understandable since thinking about past abuse and perpetrators can cause an increase in posttraumatic stress symptoms (such as mood swings, flashbacks, insomnia, and depression) and naturally dampen sexual interest. Many survivors find that a period of sexual abstinence is usually beneficial to their sexual healing. This “vacation from sex” enables them to more easily resolve posttraumatic stress symptoms because they are not stimulated by sexual touch and partner demands. In addition, it can provide a clean slate for beginning new touch and sexual learning.

REACTIONS TO TOUCH AND SEX

Many survivors experience automatic reactions to touch and sexual contact that hamper sensual enjoyment and sexual healing. They may benefit from identifying as many forms of stimulation that trigger these reactions as they can.

Once they identify them, they can avoid these “triggers.” For instance, if a past perpetrator’s mouth smelled of alcohol, the client can avoid sex with a partner who has been drinking alcohol. Or, if certain sexual positions remind a survivor of abuse, the client can deem them “off limits” in love-making.

Survivors can learn numerous techniques to cope with unpleasant automatic reactions to touch and sex.¹¹ I encourage my clients to develop compassion, understanding, and patience with regard to their own reactions. These reactions were originally protective mechanisms, common and unavoidable results of trauma. When a survivor encounters a reaction, he or she can learn to:

- **stop** and become aware of the reaction.
- **stay calm** and reduce physical reactions by using relaxation techniques.
- **affirm reality** and remind themselves of being in present time (they are older, bigger, and have choices).
- **alter activity** by either switching to a different behavior or adjusting the present behavior to create new associations. For example, if lightly stroking the arm is upsetting, they can try stroking more firmly or stroking another part of the body instead.

Automatic reactions often diminish significantly or disappear over time as survivors become more responsive to these reactions and become aware of when they surface and what they mean.

SEXUAL FANTASY CONCERNS

Sexual fantasies are often extremely problematic for survivors of sexual abuse.¹² Guilt, shame, and embarrassment about their most intimate thoughts often keep them from revealing sexual fantasy problems to their therapists. But addressing sexual fantasy concerns is often crucial to a client’s achieving a complete and lasting sexual recovery. When intrusive, unwanted sexual fantasies continue, they can function as an unresolved nightmare creating psychic stress, lowering self-esteem, harming trust and intimacy with a partner, and essentially keeping the dynamics of the original sexual abuse alive.

On a psychological level, unwanted fantasies often represent the sexualizing of some kind of unresolved conflict related to past emotional injury, abandonment, and betrayal. By analyzing sexual fantasies, much as one might analyze a dream or nightmare, survivors can help loosen the conflict’s hold. Survivors may benefit from techniques that increase present awareness, reduce stress, and improve stimulation and intimate communication. In addition, survivors can learn to create new sexual fantasies with which they feel comfortable and that inspire lasting sexual pleasure and intimacy.¹³

PARTNERS ARE VICTIMS, TOO

Sexual abuse creates a crisis in intimacy for couples. Even though an intimate partner was not present during abuse, he or she unwittingly becomes a secondary victim of it.¹⁴ Unresolved psychological and sexual issues from the original abuse can harm the development of emotional trust and a mutually satisfying sexual relationship.

The partner's understanding and involvement are essential to a positive outcome in sexual healing therapy. Partners need to learn about the impact of sexual abuse and the techniques available for sexual healing. Partners may benefit from attending some counseling sessions with the survivor or participating in individual or group therapy sessions on their own.

Unresolved sexual and emotional issues from the partner's past often arise and influence the course of treatment. When Jane, a lesbian and incest survivor, needed to stop sexual relations for a while as part of her healing work, her partner Serena became very depressed. Through therapy on her own, Serena realized that Jane's withdrawal from physical intimacy reminded her of how her mother had withdrawn affection to punish her when she was a child. Serena discussed her insights with Jane. Jane reassured Serena of her sexual attraction to her and developed new nonsexual ways of communicating continuing care and affection.

Double-survivor couples, in which both partners have histories of sexual abuse, present additional challenges in treatment. Sometimes these couples are more patient and understanding of the healing process. At other times, the increased sensitivity to touch and sex issues compounds the situation, slowing the couple's progress. In these instances, therapists need to pace treatment and modify exercises to meet both clients' sexual recovery needs.

RELEARNING TOUCH

Since standard sex therapy exercises are usually "too much, too soon," survivors may begin the experiential part of their sexual recovery work with a series of "relearning touch exercises."¹⁵ I developed these exercises in the 1980s to meet the special needs of survivors and their intimate partners. Unlike traditional sex therapy techniques, these exercises are extremely flexible. They can be carried out with varying amounts of clothing, in varying amounts of time, and with a variety of modifications. These exercises are designed to help survivors learn skills that are basic to enjoying physical contact, such as breathing comfortably, relaxing, staying present, and communicating.

Survivors usually get the most out of the relearning touch exercises when they are undertaken during a vacation

SEXUAL ATTITUDES

SEXUAL ABUSE MINDSET (Sex equals sexual abuse)

- Sex is uncontrollable energy.
- Sex is an obligation.
- Sex is addictive.
- Sex is hurtful.
- Sex is a condition for receiving love.
- Sex is "doing it" to someone.
- Sex is a commodity.
- Sex is void of communication.
- Sex is secretive.
- Sex is exploitative.
- Sex is deceitful.
- Sex benefits one person.
- Sex is emotionally distant.
- Sex is irresponsible.
- Sex is unsafe.
- Sex has no limits.
- Sex is power over someone.

HEALTHY SEXUAL ATTITUDES (Sex equals positive sexual energy)

- Sex is controllable energy.
- Sex is a choice.
- Sex is a natural drive.
- Sex is nurturing, healing.
- Sex is an expression of love.
- Sex is sharing with someone.
- Sex is part of who I am.
- Sex requires communication.
- Sex is private.
- Sex is respectful.
- Sex is honest.
- Sex is mutual.
- Sex is intimate.
- Sex is responsible.
- Sex is safe.
- Sex has boundaries.
- Sex is empowering.

This chart is excerpted from *The Sexual Healing Journey* by Wendy Maltz (HarperCollins, New York, 2001).

from sex. And knowing they are engaged in a progressive, ongoing program of active physical sharing helps intimate partners cope better with these necessary periods of sexual abstinence. Popular relearning touch exercises include “sensory basket,” “cleansing,” “hand-clapping,” “drawing on body,” “magic pen,” “red light/green light,” “hand-to-heart,” “safe nest,” “safe embrace,” and “sensual massage.” Some exercises can be done without a partner. A number of the relearning touch exercises initially can be learned and practiced in the counseling-office setting. A therapist might guide the couple, step by step, through an exercise, providing them with ideas and feedback to ensure success. Survivors are encouraged to rest when needed, to become actively aware of what they are experiencing, to communicate openly, and to find creative ways to bridge and shift from one exercise to another, depending on interest and readiness.

When survivors express an interest in overcoming specific sexual problems (such as difficulty with orgasm, painful intercourse, premature ejaculation, or impotence), therapists can incorporate traditional sex therapy as an extension of the relearning touch exercises. Modifying traditional techniques gives survivors a sense of control over what they do and when, helps them deal with automatic reactions and abuse-related issues as they arise, and teaches survivors how to maintain emotional intimacy as sexual stimulation intensifies.

PRACTITIONER SELF-CARE

Helping survivors address their touch and sexual concerns is extremely rewarding work. It is heart-warming to witness individuals face their fears, deal with abuse repercussions, and reclaim sexuality in new and healthy ways. But this is not easy work. It requires a great deal of skill, patience, and good self-care. Survivors and their intimate partners often feel powerless, helpless, and overwhelmed. Practitioners need to be steady and encouraging of even the smallest progress. We need to offer hope that recovery is possible and that sex can be healthy and enjoyable. This means maintaining our own positive attitudes, even in the face of setbacks and frustrations.

In addition, this work requires therapists to pay special attention to our own sexuality and make sure that doing this work is not harming our personal sense of well-being, our sense of sex, or our intimate relationships. In doing sexual healing work, we are frequently exposed to horrific stories of sexual exploitation, violence, and harmful sexual practices. Over time, this exposure can warp our own thinking about, and enjoyment of, sex. We can become burned out on sex through overexposure to negative sex.

In order to protect ourselves, it is important that we create activities, living spaces, and environments free of the influence of sexual abuse. For example, my husband Larry (also a therapist) and I have a rule that our bedroom is a

“sexual abuse free zone.” That means no television shows about, readings on, or discussions of sexual abuse are allowed. I also recommend that sexual abuse recovery specialists make an effort to increase their exposure to ideas and examples of healthy sexual intimacy. This principle was the motivation behind my compiling and editing two poetry anthologies focused on healthy sexual love. (They are *Passionate Hearts: The Poetry of Sexual Love* and *Intimate Kisses: The Poetry of Sexual Pleasure*.¹⁶)

Practicing good self-care also means not practicing alone. It is especially important to seek help from other therapists and advisors if you find yourself becoming preoccupied with sexual abuse images and thoughts from work. On an ongoing basis, peer consultation and supervision are helpful to maintaining perspective.

CONCLUSION

Healthy sexual intimacy is infinitely joyful and rewarding. It is something everyone deserves. The sexual health practitioner plays a vital role in providing support and guidance to help survivors and their intimate partners to heal. This work involves integrating various mental-health specialties such as trauma recovery, addictions recovery, sexual abuse recovery, relationship counseling, and sex therapy into a comprehensive program tailored to meet the individual needs of each client.

Sexual healing is an empowering process in which survivors make dramatic changes in sexual attitudes, behaviors, thoughts, and relationships. New sex therapy exercises known as *relearning touch techniques* provide crucial experiential opportunities for survivors to increase self-awareness and improve intimacy skills. Unlike the relatively brief therapy format of standard sex therapy, it can take months and even years before clients report significant improvement in their sex lives. When survivors are able to obtain therapeutic help to heal their sexuality and reclaim it as a positive life force, the results can be profound and rewarding for client and therapist alike. As one survivor said, “When you reclaim your sexuality, you reclaim yourself!”

Wendy Maltz is a therapist and lecturer on healthy sexuality and sexual healing. She is the author of The Sexual Healing Journey: A Guide for Survivors of Sexual Abuse, coauthor of Incest and Sexuality: A Guide to Understanding and Healing, coauthor of Private Thoughts: Exploring the Power of Women's Sexual Fantasies (forthcoming), and editor of two anthologies, Passionate Hearts: The Poetry of Sexual Love and Intimate Kisses: The Poetry of Sexual Pleasure (forthcoming). Her Web site is: www.HealthySex.com. Readers can reach her at P.O. Box 648, Eugene, OR 97401. E-mail: maltz@continent.com —Editor

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ADOLESCENTS: SEXUAL ABUSE LINKED TO RISK BEHAVIOR

Adolescents with a history of sexual abuse are more likely to engage in risky sexual behavior than their counterparts, according to a study in the September issue of the *American Journal of Psychiatry*, Reuters Health reports.

Dr. Larry Brown and colleagues at the Rhode Island Hospital in Providence assessed 116 sexually active adolescents undergoing intensive psychiatric treatment, among whom 61 had been sexually abused. Brown noted, "This study is unique in that the children were well matched, aside from the sexual abuse, in terms of psychopathology, disturbed families and extent of dysfunction."

Researchers found that among those teens with histories of abuse, inconsistent condom use was three times more likely than among those who had not been abused. Sexual abuse was also linked to "less impulse control" and higher STD rates, the study revealed.

"[S]exual events are such triggers for abused kids," Brown said, adding that even if sexually abused children learn the same coping skills as other teens at risk, "they are just flooded with anxiety around sexual situations." Researchers concluded that while "most therapy does not address current sexual behavior," children with histories of sexual abuse need "adequate counseling around abuse issues"

**THE TOUCH CONTINUUM:
PART OF A RISK-REDUCTION CURRICULUM**

Cordelia Anderson, M.A.

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One of the rewards of helping to educate children is to witness their simplicity and their “say it like they see it” honesty. I find their views help to keep me grounded.

I recently asked participants in a mixed-generational group to express their thoughts about differences in touch. The adults quickly became political and philosophical, while a four-year-old child responded by saying, “Some touches tickle and some touches cry, and some just are. I don’t know why.” She smiled when she said “tickle” because her tickles were positive touch. She frowned when she said “some touches cry” because her tears were negative touch. And she shrugged her tiny shoulders when she said “Some just are, I don’t know why.”

The lightness of her words was void of any of the burden of what I call “the awfulization of touch.” Her words also went a long way toward explaining the *continuum of touch* from positive to confusing to negative. An adult quipped, “It would be nice if life were so simple. But it is full of sickos. Some are perverts. Some are just out for a quick buck.” In response, a male teacher blithely pointed out, “Yes, there is *bad* touch in this world, but we cannot let our actions be driven simply by cultural paranoia. We are in a *people* profession. We must be allowed to act and feel as people.”

There is a *continuum of touch* that needs to be considered in tandem with the continuum of the response to touch and the perception of touch. The responses I hear at training sessions for educators are indicative of the range of reactions to the touch phenomenon. A college professor complained:

I’ve been a sexuality educator for over 15 years. I’ve always been a *touch* person, and I’ve never thought anything about it. Recently, I was confronted by a student’s father. His daughter had complained to him about my behavior. He was upset. She had previously been the victim of some sort of abuse, and she had a negative perception of my touching her. The situation was eventually resolved, but I’ll never touch another student for any reason. I especially keep my distance if I am aware that someone was a victim.

A female teacher pointed out that these issues are splitting faculties apart by stating, “I know children need touch, and my instinct is to touch, but we have a ‘no-touch policy.’ One of

my colleagues was accused of touching a student in a sexual way. It split our whole faculty apart. No one knew whom to believe. He’s been accused before, but he’s just a touch kind of person.... Anyway, I think it’s better to never touch because you just never know what a student might think or do.”

A male teacher responded that he was well aware of the controversy surrounding *touch* and *teachers* but he felt it was critical not to lump all behaviors together. He said:

I feel it is very unfortunate that several troubled teachers have created a stereotype for the rest of us. I enjoy hugging my kids. I enjoy making them laugh. I like making them feel good about themselves. If a student comes up to me crying because she fell off the swing, I really find it difficult not to hug her or to wipe away her tears. We are constantly reminded not to touch our kids. I have had to keep that in mind every day while not forgetting what we’re really here for...the kids.

The room was quiet for a while. It appeared that those who had grown paranoid of touch were dominant until another teacher said:

We are continually advised by our principal, ‘Just don’t touch.’ The reason behind this advice is fear—notably fear of litigation. Those not worrying about something as ominous as litigation may well worry about the discomfort associated with someone taking their touching in the wrong way. It would be a sad world if everyone walked around afraid to make physical contact. What kind of messages are we sending kids when all the school’s adult role models shy away from physical contact? Teaching just wouldn’t be the same without the ‘pat on the back’ or the ‘high five’ for a job well done, the hand on the shoulder to express concern for a student’s well-being, or the hug that expresses extreme elation or sadness. Teachers mustn’t become unfeeling robots.

Clearly, feelings run deep, not only among school staff but also across all professions in both public and private settings. We have lost our common sense concerning touch. Common sense helps, but people also need tools and

guidelines to understand the principles of touch. That is what the *Touch Continuum* is all about.

THE TOUCH CONTINUUM HISTORY

While working in the sexual assault services section of the Hennepin County (MN) Attorney's Office, I was responsible for developing a more accurate and comprehensive child sexual abuse prevention project to replace the existing "dangerous stranger" models.

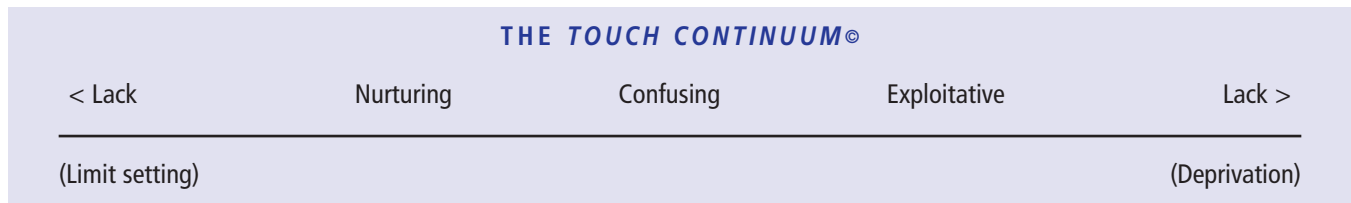
I was inspired by others who were talking about the need to understand normal child sexual development, positive methods of parenting, healthy sexuality, and the importance of touch.

I particularly wanted to increase awareness of child sexual abuse and its prevention while not playing into the commonly held fear of touch. I felt that people tended to fear touch because they equated it with sexual relations. I wanted people to know the benefits of caring touch and appropriate touch. I also wanted them to understand the

about child sexual abuse is going to damage them more than any potential 'abuser'?" His concern was that by talking about exploitative touch and sexual abuse we would play into the cultural paranoia about sex.

We had an up-hill battle to convince parents, professionals, and other people in the field that our approach was balanced and less scary than traditional "dangerous stranger" approaches. It was reassuring to some that we were doing our best to be "developmentally appropriate"—in other words, trying to develop programs that used words and concepts that made sense to children in different stages of development and in various age groups. Terms such as *nurturing* and *exploitative* did not make much sense to a seven-year-old child. Empowerment and power differentials are critical when analyzing the role of gender and sexism in sexual abuse, but they are not as pertinent as the concept of *bullying* to a child in elementary school.

The *Touch Continuum* is a tool to help children, young people, and adults identify what type of touch, "from their



damage caused by sexual abuse while not equating such abuse with touch.

I coined the concept of the *Touch Continuum* as a tool to help ensure that touch was talked about in a balanced manner within our broader child sexual abuse prevention curriculum. This concept became part of our collaboration with Illusion Theater, which eventually resulted in my coauthoring the play *Touch* with the theater's producing directors Bonnie Morris and Michael Robins. Since then, educators have widely used the *Touch Continuum* and the concepts in the *Touch* play in "personal body safety" programs throughout the country. In fact, I have toured nationwide with the subsequent *Touch* film as part of many educational efforts that have resulted in dialogue about sexual abuse and its prevention.

When this program was launched, there was little to no awareness of sexual abuse. I remember pleading with parents and educators to allow us to talk directly to their children. Those who were aware of sexual abuse were afraid that children would be damaged by the very information that might help reduce the likelihood of such abuse. Others were afraid of a rapid increase in false reports. I still remember a man with high credentials yelling at me, "You're just sexually repressed! What's wrong with a grandfather putting his hands on his grandchild's breast? Can't you see that talking to kids

own perspective," fits into each category. All need to develop skills to ask for the touch they want, to talk about the touch that confuses them, and to do what they can to refuse or set limits concerning the touch they do not like.

Nurturing touch refers to positive, caring types of touch. There are many different kinds of positive touch. Instead of telling children what type of touch is *good* or *bad*, we asked them for their own examples. We began using the terms *good* and *bad* because those are the words that they used and that made sense to them. Children usually give examples of *good* touch such as petting animals, playing games (tag, leap frog, statue games), kissing, holding hands, and cuddling. Most say there is nothing wrong with such touch and that they do it with people about whom they care or with whom they feel safe.

When people are unclear about a type of touch or are unsure if it is okay, it is *confusing* touch. Touch can be confusing when:

- it is not clearly good or bad
- the intent of the giver is not clear
- the receiver does not understand or misinterprets the intent of the giver
- the receiver is not used to being touched in this particular way

- what the person is saying is different from what his or her hands are doing (for example, the verbal and physical messages are not the same)
- the giver or the receiver is used to equating all physical contact with sex
- it feels good but it is shrouded in secrecy or shame
- it is in conflict with the attitudes, values, or morals of the giver and/or the receiver
- it does not fit within the context of the relationship of the giver to the receiver (for example, it is either too intimate or too formal)
- the receiver does not like the contact or is uncomfortable with it even though it is okay or not a secret

One of the challenges of teaching children about sexual abuse is that some of the touch that is sexually abusive can feel good and some of the touch that is appropriate (such as a doctor's examination) can feel bad. Talking about such confusing touch can help children know they can speak up or ask questions when they are uncertain about a type of touch. Touch is often as confusing for adults as it is for children. We all need to understand that we should stop if we are touching someone in a way that he or she does not like or finds confusing. We all need to respect each other and get help when we need it.

Talking about common kinds of touch such as tickling or wrestling is useful in showing how any type of touch can change from positive to confusing to negative. Touch such as tickling or wrestling is fun when it is wanted, but it can change and is not okay if a person, when asked to stop, does not listen, or if someone is getting hurt.

Exploitative touch refers to touch that is manipulative or forced. Sexual violence is one of the most extreme examples of exploitative touch. Children tend to think of examples of physically exploitative or bad touch more easily than nurturing or positive touch. They give such examples as hitting, bullying, slapping, and kicking. It is also easier for both adults and children to discuss physically assaultive touch than sexually exploitative touch.

Lack of touch is on both ends of the continuum. It is positive when it puts limits on the type of touch we want to receive. Not all of us want to touch or be touched. It is negative when it results in severe deprivation. This deprivation, called somatosensory deprivation, can lead to some of the same negative ramifications as abusive touch.

USING THE TOUCH CONTINUUM

The *Touch Continuum* is misused when it is considered a prevention program in and of itself or when it is used as a quick way to identify victims. It is particularly misused when it is over-simplified into good touch and bad touch.

Some of the problems of this over-simplification include:

- omitting the crucial elements of confusing touch and lack of touch.
- making everything black or white when, in fact, a lot of touch is confusing. People need to learn how to ask questions, how to say “no,” and how to tell someone when they are uncertain about touch. They need to know how to talk about confusing touch without making a major issue out of all confusing touch and without dismissing all their hesitations.
- skipping over the reality of the range of touch. This means educators are not being comprehensive enough to effectively teach protection skills and recognition of the need for caring and nurturing.
- adding a right or wrong moral tone to the discussion. It is better to focus on the words that the children use to describe touch (and that make the most sense to them). This allows for differences.
- using touch as the sole way to define sexual abuse rather than as a tool to differentiate among different types of touch. Part of the problem is the subjectivity of relying too heavily on feelings. In addition, it is a fact that some types of sexual abuse occur without touch.
- avoiding a comprehensive sexual abuse program. Educational tools can help teach concepts and skill, but a lot of important information is missed when educators focus solely on touch.

In reality, the *Touch Continuum* is not free from ambiguity, and our society is uncomfortable with ambiguity—whether evidenced in our need for a code that rates movies and television shows, for a list of ingredients and nutrients in groceries, or for laws of such complicated wording that no one but a lawyer can understand them. We want a “one size fits all” book of rules that has the answer for every person and every situation. We want a videotape or a curriculum that can ensure safety for all—and in 25 minutes.

As Judith Deiro wrote in *Teaching with Heart*, tolerance for ambiguity means being able to deal comfortably with situations out of one's control. Such tolerance is not the same as avoiding or denying situations in one's control. Nor does it mean throwing thought and deliberation out the window. It simply means that we cannot control everything around us, we can only control how we respond. Tolerating ambiguity also means being able to keep our focus amidst chaos. When such a tolerance exists, not only is there comfort with ambiguity, but there is also adaptability, flexibility, and the understanding that being in control does not mean having your own way about everyone and everything. The growing fear of touch and touching has led to more rigid thinking that, in the name of preventing

abusive touch, eliminates the right of everyone to touch.

What happened to our ability to accept the simple cradling of a baby? Or finally connecting with a teenager by shutting up and extending an arm for a hug? Or placing a reassuring hand on a colleague's shoulder while sitting down for what promises to be a tense meeting? Why is it not allowed for two people of the same gender—friends, relatives, or partners—to kiss or hug in public without fear of violent retaliation? Why do assisted-care facilities not recognize the dignity of older people's sensual and sexual needs by giving them privacy?

While our feelings—especially our fears—can get in the way of common sense, recognizing, accepting, and understanding our feelings help us to act sensibly. We must be sensible about touching because, according to Dr. Tiffany Field of the Touch Research Institute, “touch is more than beneficial—we should consider touch as essential as diet and exercise to the growth and well-being of children.” And to the wholeness and emotional vigor of adults.

By using the *Touch Continuum*, educators can help reinforce seven important points about touch:

1. It is a wonderful gift that people can learn to safely and respectfully give and receive
2. It helps people develop skills in such areas as communication, conflict resolution, empathy, respect for others, responsibility for actions, and the recognition of the impact of actions on others. It also helps people become aware of their own wants and needs as well as clear up confusion, set limits, and get their touch needs met.
3. No one has the right to use touch to harm others or to force, manipulate, pressure, or trick others into touch or sexual contact.
4. Everyone has the right to say “no” to touch when that is unwanted and to tell someone when he or she does not feel safe or when an abuser won't listen.
5. Everyone has the right to question touch that they regard as confusing. Everyone has the right to say, “I'm confused.... I want you to stop. I need space/time/a pause until I clear my head.”
6. Everyone has the right to say “yes” when he or she wants touch or to make it clear when he or she wants to touch.
7. Adults should do all they can to protect children and youth. That involves, among other things, understanding the *continuum of touch* and doing all they can to promote sexual health.

Regardless of debates, talking about touch is an important part of sexual health and abuse-prevention education. The issue is not *whether* to talk about touch but *how* to talk about it. Touching is a basic human need, and it is important to talk about touch from a balanced perspective. It will not help protect children or society if our young people are taught that all touching is dangerous and suspect. Just as teaching children to beware of strangers leaves them with a warped idea of who perpetrators are, the deprivation of accurate, balanced information about touch leaves children without the skills they need to reach out for help when they need it.

Cordelia Anderson is the founder of the Minneapolis-based training and consulting company, Sensibilities, Inc. Prior to forming Sensibilities, she spent 15 years working with Illusion Theater, where she coauthored Touch. She is also a consulting therapist with both survivors and sex offenders. This article is adapted from a book, Touchy Issues, which she is currently writing. —Editor

EXCUSES TO TOUCH

The “domino theory” of touch—“If I touch you, it means I want to hold your hand, then hug you, then kiss you, then jump into bed with you, and have sexual intercourse”—has kept many people from touching. Instead, they have developed socially acceptable excuses, rules, or ways to touch. This menagerie includes techniques for all ages: contact sports, New Year's Eve kisses, “under the mistletoe” kisses, pass-the-lifesaver-on-the-toothpick-from-mouth-to-mouth or apple-from-neck-to-neck games, tag, “Kiss me, I'm Irish” buttons, and Twister board games.

Some people have used alcohol and other drugs as an excuse to touch. This includes “use rituals” such as winding through each other's arms to sip a glass of champagne. People “under the influence” will also often hug, kiss, or fondle each other much more than they would if they were sober. Sexual decision-making often becomes blurred and tainted under these circumstances.

Excuses to touch also set the stage for more abusive touch. When communication is indirect, sideways, or dishonest, abuse is more likely. The idea that romance and passion are felt rather than discussed is a component in everything from disappointing consensual encounters to acquaintance rape. All people have their own excuses to touch. In many cases, excuses to touch appear easier or more natural than a conscious, direct statement about our touch needs and desires.

—Cordelia Anderson

PERPETRATION PREVENTION: THE FORGOTTEN FRONTIER IN SEXUALITY EDUCATION AND RESEARCH

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Adults have many legitimate concerns regarding children's sexuality. Despite the diversity expressed in the beliefs, attitudes, and lifestyles of different individuals, most adults in most cultures have some shared values and concerns regarding the development, protection, manifestation, and exploitation of children's sexuality.

Tremendous resources have been directed toward education to protect children and youth from disease, unwanted or ill-conceived pregnancies, promiscuity, exploitation, and child sexual abuse. Many of these efforts have focused on self-protection: victim prevention. The risk of the child becoming the perpetrator has predominately been addressed with regard to the sexual interactions of older male youth as discussed in programs targeting safer sex practices, responsible fatherhood, sexual harassment, and acquaintance rape. The risk of a child sexually abusing other children has been largely ignored in sexuality education and sexual abuse prevention programs.

Yet it became apparent as early as 1983 that juveniles are responsible for an alarming portion of the sexual abuse of children.¹ Research has shown that more than 50 percent of the sexual abuse of boys and 25 to 30 percent of the sexual abuse of girls is perpetrated by older juveniles, for an overall rate estimated at 30 to 40 percent.²

Since then, the Kempe Center's Perpetration Prevention Program has sought to discover and disseminate primary, secondary, and tertiary prevention interventions to reduce this risk. Beginning by contacting the 20 programs providing specialized treatment for youth who have committed sexual offenses and by building the National Adolescent Perpetration Network to facilitate communication among the more than 1,000 programs currently treating sexually abusive adolescents and the more than 400 programs treating preadolescents. From the start, this author's focus has been to learn from the identified abusive youth how we might prevent other children from becoming sexually abusive.

Primary perpetration prevention targets the general population of children. *Secondary perpetration prevention* identifies "risk" factors that help identify groups of children who may be at "increased risk" as compared with the general population. It was suggested early on that all forms of "victim

prevention" efforts are secondary prevention and that primary prevention must reduce the risk of attempted perpetration.³ Perpetration prevention is defined as "reducing the risk of children being abusive across their life span."⁴

THE SEARCH FOR KNOWLEDGE

Whereas in 1983, the literature specific to the problem of sexually abusive children and adolescents was small,⁵ there is now a glut of publications.⁶ During the same time span, we have learned much about the incidence and prevalence, identification and investigation, and treatment and management of child sexual abuse, as well as its immediate and long-term sequelae. This has created a similarly unmanageable quantity of publications.⁷

Descriptive studies of abusive youth, child victims, adult survivors, and adult sex offenders, along with theories and treatment models abound, but empirical knowledge is more limited. Gleaned from these piles of publications, some particularly important and interesting hypotheses and dilemmas relevant to the question of children becoming the perpetrators of sexual abuse emerge.⁸

PRIMARY PERPETRATION PREVENTION

"Cut that out, and don't let me catch you doing it again!"

—Typical adult response to child's sexual behavior⁹

Myths and misinformation regarding childhood sexuality and sexual deviance are prevalent.¹⁰ Denial, discomfort, and repression often cause adults to respond to children's sexual behaviors without differentiating among normative, problematic, abusive, and illegal behaviors. For generations, adult responses have perpetuated denial and secrecy regarding children's sexuality, and the taboo against both childhood sexual behavior and the sexual exploitation of children has effectively prohibited discussion without impacting the behavior. The secrecy surrounding sexuality has likely contributed to the risk of children being exploited, as well as precluding the validation and correction of sexual learning.

Today's children live in a culture surrounded by explicit sexual messages, and children are entering puberty

earlier with each generation. Yet the majority of child-serving professionals have had little or no academic training on the development of childhood sexuality or normative childhood sexual behaviors.¹¹ It was not until training for mandatory child-abuse reporting characterized children's sexual behavior as a possible sign of victimization that adults were forced to acknowledge the sexuality of prepubescent children.

The sexual abuse of children is defined by law. Yet therapists quickly realized as they worked with sexually abusive youth that it was not the sexual behavior that defined "sexual abuse," but rather it was the abusive nature of the relationship and interaction (such as lack of consent, lack of equality/abuse of power, and/or coercion¹²). Identifying sexual behaviors as signs of victimization without imparting any comprehensive understanding of normal childhood sexual development pathologized all childhood sexual behavior. Even then, the denial that children might sexually abuse other children continued. Only when child-serving organizations were sued for not preventing the sexual abuse of children by other children in their care did administrators acknowledge a need for training and policies relevant to children's sexual behavior.¹³

In training developed by a multiagency work group at the Kempe Center, the range of sexual behaviors was described along a continuum from what was clearly expected among children and adolescents to what seemed reflective of problems or abuse-supportive attitudes to what was clearly unusual and of most concern. The training stressed that the behavior alone did not define the problem but that therapists must evaluate interactions in terms of consent, equality, and/or coercion to define (or rule out) sexually abusive behavior. Yet adults were still tempted to use the range of behaviors as a checklist, without further evaluation. This was of concern because children might exhibit any of these behaviors as they imitate or explore the wide range of sexual information to which they are exposed in this culture.

A more thoughtful model evolved, which simply asks: *Is the behavior a problem? And if so, what kind of problem is it?* Defining the reasons why the behavior might be a problem for the child, for others, or that it is abusive or illegal, served to inform levels of concern and intervention. This model has proved most helpful to parents and professionals alike.¹⁴ It also became apparent, however, that adults tend to talk more specifically to other adults about children's sexual behaviors than they do to the children involved. Since children rely on the adults around them to both validate and correct what they are learning and doing, it was thought that adults should learn to provide short, immediate responses to behaviors. Many professionals were, however hypersensitive about proactive sexuality education in the schools and were afraid to do more than simply prohibit all sexual behaviors without discussion.

Arriving at teachable responses required that adults agree on a definition of "universal goals" that would bridge their personal beliefs or values. All adults seem to agree that children should be encouraged to (1) talk to adults rather than using behavior to figure things out; (2) recognize and respond to discomfort or distress (of self and others); and (3) be responsible for their own behavior. These "universal goals" parallel the three of the most common deficits noted in all types of abusive persons (poor communication, lack of empathy, and misattributions of responsibility).¹⁵ Training adults to (1) label behaviors specifically and accurately with words; (2) express their own feelings regarding the behavior that was occurring; and (3) make accurate attributions of responsibility without blaming, shaming, or assuming culpability, became the goal of training.

Those conducting the pilot workshops soon realized that adults tend to intellectualize issues that make them uncomfortable and have a hard time speaking directly to children about anything sexual. For this reason, the workshops required the adults to practice articulating responses aloud. Administrators accepted the training more as they became aware of liability issues. The resistance that had plagued the introduction of a sexuality education curriculum (and even a sexual abuse victim-prevention curriculum) into the schools was avoided because it was not directed at children but was designed simply to train professionals to respond to what children were actually doing. The training of trainers in 12 states and in the United Kingdom to replicate the Kempe Center workshops has resulted in hundreds of training sessions that are helping thousands of professional and paraprofessional caregivers increase their ability to understand and respond to the sexual behaviors of children in their care.¹⁶ Such training has contributed to earlier identification of sexually abusive children and adolescents and has increased opportunities for primary, secondary, and tertiary interventions.

SECONDARY PERPETRATION PREVENTION

"Victim to Victimizer: A repetition compulsion."

—Simplistic explanations for sexually abusive behavior¹⁷

The work with sexually abused children has recognized the uniquely personal violation of sexuality and the risk of subsequent dysfunction. Sexual "acting out" is widely reported in the literature describing them.

Work with adults who molest children has assumed the behavior is a reflection of personal sexually deviant interests associated with arousal. A review of a ten-year course of study aimed at identifying the risk factors specific to the development of sexually abusive behaviors is described in a recent publication.¹⁸ In summary, it points to a constellation of risk factors that seem to be associated with the risk of a

child becoming abusive. Some hypotheses emerge regarding the reasons that abusive behavior might be sexual (in contrast to physical, verbal, or psychological) and regarding why abusive behavior might be directed at self, others, or property.¹⁹

It is clear that single or collective risk factors are not causal and that although sexual victimization does increase risk it is not the most predictive factor.²⁰ In fact, prospective studies have shown that children who have been neglected become sexually abusive more often (and physically abused, just as often) than those who were sexually abused.²¹ Witnessing domestic violence, parental losses/disruptions in care, and acute or chronic trauma continue to emerge as critical variables in all types of risk for children.

A parallel course of study has sought to identify “protective factors,” or assets, that seem to moderate the risk of children doing poorly following adverse experiences. It appears that assets in the developmental competence of the child, the family and early life experience, and the child’s community and peers may explain the outcomes for children more clearly than the bad things that happen to children. As stated by Ryan and Associates²²: “Sexual abuse is an event, not a diagnosis.... It is not the bad things that happen to a person that determine outcomes; it is one’s ability to cope with the bad things that happen.”

A developmental-contextual-ecological approach²³ allows us to recognize a broad range of risk factors that suggest that some groups of children may be at greater risk for dysfunction (in general) and at risk to become abusive and/or sexually deviant, specifically, as compared with their peers. Children known to have experienced neglect, deprivation, victimization, or trauma; clinical populations; children in foster care and special-education settings; and children identified in domestic violence cases, are clearly “at risk.” Professionals and caregivers of at-risk children can be trained to recognize dysfunctional patterns (specifically, the “high-risk cycle”)²⁴ and to intervene directly to decrease habituation. They can also work to increase more functional assets, including effective coping strategies and empathic, prosocial relationship skills. Secondary perpetration prevention strategies are being integrated into existing services for at-risk groups of children, such as special education, victim services, and foster care.

TERTIARY PERPETRATION PREVENTION

“I knew I’d be in trouble because I was always in trouble for sexual behavior, but I never knew it was illegal, and I still don’t know why they call it abuse.”

—12 year old referred for treatment²⁵

The early work with juveniles who perpetrate sexual offenses was largely informed by the adult sex offender field. The prevailing belief was that these perpetrators were destined to be (without intervention) the same as the adults

who had begun committing sexual offenses as juveniles and continued to be abusive into adulthood. Research describing adult sex offenders has consistently indicated that more than half began their offending prior to age 18, that many engage in a range of deviant sexual behaviors, and that even paternal incest perpetrators will offend outside the family when access and opportunity change.²⁶ Adult treatment models, based on a “no cure” assumption, have come to rely on external containment and monitoring as a part of a lifelong relapse prevention strategy.²⁷

Now, much has been learned and implemented with regard to the definition, identification, investigation, assessment, treatment, and management of youth who commit sexual offenses, including those who molest younger children.²⁸ It is now possible to describe this population in terms of the range and mode of their offending, as well as the characteristics of the youth.²⁹ Although the modal age of youth being referred for offense specific treatment is 14, it is apparent that many of the adolescents being arrested for sexual offenses began engaging in abusive sexual behaviors prior to puberty.

Even though it is widely heard that rape and sexual assault are crimes of “power” (that is, that the behavior serves to compensate or retaliate for feelings of helplessness or loss of control³⁰), it has been apparent in the research with all types of adult sexual offenders that sexual interests and arousal patterns were of significance in understanding and addressing assessment, treatment, and risk management. Therefore, specialized “offense specific” treatment methods and programs developed that focused attention on the assumption of deviant sexual fantasy and arousal, issues of power and control, and cognitive processes (thinking errors or irrational thinking) that support the behavior.³¹

However, as the dynamics associated with abusive patterns of behavior and interventions to interrupt those patterns have been described,³² it has become apparent that the dynamic pattern of situations, thoughts, feelings, and behaviors associated with sexually abusive behaviors represents a common human coping style and applies to many types of behaviors that are used to compensate and defend against overwhelming emotions or stress.

Many juveniles’ sexually abusive behaviors are initially much more about being *abusive* than being *sexually deviant*. Only a small portion appear to have a primary sexual interest (and arousal) fixated on deviant behaviors.³³ While those youth who are primarily aroused by significantly younger children or by violent and aggressive scenarios may be quite similar to their adult counterparts, most juveniles who commit sexual offenses have more normative interests and arousal.³⁴ This is very good news and explains why juvenile recidivism is significantly lower than that of adults (even without treatment) and is very low after treatment.³⁵

Just as most juveniles who commit delinquent acts do not go on to adult criminality, a majority of juveniles who commit sexual offenses will not continue to sexually offend or be sexually deviant as adults. In fact, juveniles are more at risk for nonsexual recidivism following treatment than for sexual recidivism. Many exhibit a wide range of abusive behaviors that pose a risk to self, others, and/or property, and the powerful physiological reinforcements of some behaviors encourage habituation.

Especially with sexual behavior, the fantasy, arousal, and orgasm, combined with intimacy and tension reduction, suggest a risk of habituation that may increase the pairing of deviant interests with arousal over time. Many youth who are referred following multiple sexual offenses recognize that they might have continued to offend indefinitely if they had not been stopped, simply because the behavior served a temporary function and produced immediate pleasure in spite of any misgivings or feelings of anxiety they may have experienced following the behavior.

The motivation for earlier identification and intervention with children and adolescents was fueled by a belief that children are more changeable than adults because they are still growing and developing. Nonetheless, most early intervention did not focus on growth and development as much as on the deviant/problematic history.

Most recently, actuarial risk assessment and the definition of dynamic and protective factors are being refined.³⁶ Actuarial risk prediction relies on known factors from the past (such as deviant exposure and rates or characteristics of past offenses) to predict future reoffense. However, because actuarial risk factors can never be changed, reliance on historical factors in assessment of risk leads clinicians to overestimate future risk. In contrast, dynamic risk factors (events, responses, and functioning in the present) can change, and protective factors can be increased.

As research continues to illuminate the work, treatment is becoming more goal-oriented, and outcome measures that focus on changes in the developmental, contextual, and ecological conditions are increasing.³⁷ The consensus regarding what constitutes “offense-specific” treatment for juveniles who commit sexual offenses is beginning to shift to accommodate new information regarding more individualized, differential treatment plans aimed at reducing the risk of all types of abusive behaviors and increasing successful, prosocial functioning.³⁸

DILEMMAS

Whereas system and community denial was paramount in 1983, today adults are hypersensitive to all sexual offenses, including sexual harassment of peers and the molestation and exploitation of younger children.

Unfortunately, adult understanding of children’s

sexuality remains minimal, while adult fear of juvenile crime is enormous. The community believes that “sex offenders” cannot be cured and that they pose a constant, unchangeable risk to community safety.

At the same time, many of the laws governing the sexual behaviors of children and adolescents are products of values and beliefs that deny and repress sexuality until adulthood or, at least, the late teen years. There continue to be “status offenses” prohibited by law (behaviors that would not be considered a problem for adults, that would not be considered deviant, unusual, or abusive from a clinical standpoint) that may result in charges of a “sexual offense.” In some states, any consensual sexual contact with same-age peers is illegal. Such laws confuse the distinction between rule breaking, other legitimate concerns, and abuse.

At the same time, laws and sanctions associated with the sexual abuse of women and children have been strengthened but now allow much less judicial or clinical discretion in evaluation and intervention. Due to the (ill-conceived) inclusion of juveniles on many states’ “sex offender registries,” the loss of confidentiality regarding juvenile misbehavior (which has been a cornerstone of juvenile justice’s belief in and commitment to rehabilitation) has made it possible for communities to directly target this population of youth with stigma and sanctions in a way that is rarely tolerated in light of civil rights.

As is often the case, the pendulum of concern regarding juvenile sexual offending has swung too far, and some youth are being harmed by overzealous responses.³⁹ Registration and public notification, restrictive zoning ordinances, and labeling and stigmatizing of youth are counterproductive to the goal of these youth becoming able to live successfully in a prosocial environment.

Ironically, the knowledge to inform reasonable responses to the sexual behaviors of children has never been greater. Translating that knowledge into practice takes time and must overcome even professional resistance to change. Because sexual abuse evokes an emotional response, many decisions are made in haste, and community members, legislators, and policymakers do not always hear, or use, reliable facts to inform decisions.

PROACTIVE PREVENTION STRATEGIES

There are some key steps that people can take to stop the perpetration of sexual abuse.

In the development of tertiary prevention strategies, numerous practitioners are articulating outcome measures based on current observable functioning that is thought to be indicative of decreased risk and improved health.⁴⁰ Although not yet empirically validated, the measures of health are congruent with and supported by the research on

successful functioning of normal youth. Likewise, the measures of decreased risk are informed by what has been learned about the deficits and dynamic processes associated with abusive behaviors.

Many professional interventions that help to disrupt the dynamic patterns of abusive behavior teach young people to substitute more functional coping strategies, define and reject abusive thoughts, and accept the responsibility for making the choice to use nonabusive solutions. They teach that avoiding abuse is dependent upon defining abuse as abuse and feeling responsible for causing distress.⁴¹ Developing the same skills, preventively, in all children, and especially in “at risk” groups, is a reasonable goal.

An important educational intervention involves making people conscious of both the definition of abuse and the laws defining sexual offenses. It is reasonable that children learn the meaning of the law before they are arrested for breaking it. Unfortunately, this means that parents and educators in many states will need to learn to describe to young people sexual behaviors that are illegal even before the schools allow sexuality education. Ironically, sexuality education is first taught in the fifth grade in many states—despite the fact that many girls are already menstruating before the class is taught and that children in many jurisdictions are held legally culpable for sexual behavior at age 10 or younger.

Communities can begin primary perpetration prevention by assuring that babies are: (1) born healthy (prenatal care and protection); (2) in favorable circumstances (welcomed by the family and community); (3) with empathic families (sensitive, responsive, and consistent caregiving); and (4) protected from disruption and trauma.⁴² This will help them experience and acquire: (1) effective communication; (2) empathic recognition and responses; (3) accurate attributions of responsibility and control; and (4) positive models for relationships.⁴³

Children need to be given permission to talk about sexuality positively and to learn to define all types of abusive behaviors. Adults need to understand and respond to what they see and hear; define abuse of power and coercion, confront abusive attitudes; model nonabusive relationships; convey messages of privacy and respect for sexuality and personal boundaries; and especially, expect children to change their behavior when it causes others distress.

It was particularly alarming when we began training early childhood professionals about the importance of empathy to hear from many that they did not expect young children to be empathic because that required abstract thought. Understanding the difference between “sympathetic” responses (role-taking and perspective-taking accompanied by experiencing the corresponding feeling of another)⁴⁴ and “empathic” responses (noticing cues of distress or need in self and others, interpreting the need, and responding to

meet the need)⁴⁵ is of critical importance in perpetration prevention.⁴⁶ Children who are cared for empathically (that is, provided care in response to cues) begin to demonstrate empathic recognition and responses toward others prior to age two,⁴⁷ whereas the ability to imagine the experience of another by projection and perspective-taking requires abstract thinking which is a much later developmental acquisition.

Identifying groups of children “at risk” for abuse carries with it a burden of responsibility to avoid labeling and stigmatization, but it also provides the opportunity for secondary perpetration prevention. Whereas it would be ill advised to assume a need and to dictate “treatment” for every child who has been exposed to risk factors that might increase the likelihood of future abusive behavior, it is only prudent to train the professionals who have contact with at risk groups of children to provide preventive guidance to those children and their caregivers. As stated in relation to primary prevention, secondary perpetration prevention can also be accomplished by increasing those assets associated with successful nonabusive functioning and increased health without fear of creating iatrogenic harm.⁴⁸

Professionals and caregivers also need to take note of early patterns of dysfunctional or abusive behaviors and should be prepared to interrupt (the potential habituation of) such patterns even before chronic behavior problems trigger referrals for treatment. Just as parents with a family history of medical or psychiatric disorders learn to notice and intervene when they see early manifestations of problems in their child, caregivers and child-serving professionals should learn to notice and intervene when they observe early manifestations of the dynamic pattern associated with abusive behaviors.

Perpetration prevention should be a constant and parallel goal along with all the other goals that adults have for children’s healthy development and well-being. Even so, some adults continue to resist the notion that children can be “sexual” while others resist the notion that children can be “abusive.” It is clear that children can be both. And the knowledge exists to reduce the risk of both sexual and sexually abusive behavior problems.

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ADVOCATES FOR YOUTH "TEEN SCENE" SECTION

Readers can directly access the "Teen Scene" section of the Advocates for Youth Web site at <http://www.advocatesfor-youth.org/CORNER.HTM>. The article "Web Sites for Adolescents on Sexuality-Related Issues" in the June/July *SIECUS Report* published an incorrect "Teen Scene" address.

The Advocates for Youth "Teen Scene" section provides age-appropriate, unbiased sexuality information through a chat area, articles, a link to the national nonprofit "Do Something," and a link to the Peer Education Web ring.

SEXUALIZED CHILDREN AND CHILDREN WHO MOLEST

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The first treatment program for children who molest started in 1985 at Children's Institute International in Los Angeles. The program accepted children between the ages of five and 12 for treatment of their abusive sexual behaviors.*

It became apparent that there were a considerable number of issues that needed to be carefully studied about this population of children. Some of the questions raised were:

- What is natural and healthy sexual behavior in children?
- How can we distinguish between what is natural and healthy and what is not?
- What criteria should we use to differentiate between children who molest other children and those who have developmentally inappropriate sexual behavior but do not molest?
- How can we define molesting behavior in children?
- Are there differences among children who molest and adults and adolescents who sexually offend?
- Are the criteria used to define sexually abusive behavior in adults and adolescents relevant to children?

These and many other questions plagued the early years of this treatment program and continue to plague professionals working with these children today.

This article will address the still unresolved problem of how to make sense of the wide array of sexual behaviors in children. It will also look at the dangers of overpathologiz-

ing children based on their sexual behavior and at the dangers of not addressing problem behaviors.

CHILDREN WHO MOLEST

In the mid 1980s, several articles were written about a small group of children who sexually molest.¹ Johnson² used the term "children who molest" while Friedrich³ used the term "sexually-aggressive children."

These children who molest were described as 12 years of age and younger. Fifty to 75 percent of the boys had been sexually abused while all of the girls had been sexually abused. A large percentage of these children had been physically abused and virtually all had been emotionally abused. The abusive sexual acts committed by these children involved coercion of vulnerable children, with an average of two to three victims.

All of the children lived in chaotic homes, primarily with single mothers who had a series of men in their lives, and the children had witnessed their mothers being physically and emotionally abused by these men. Some children had witnessed their mothers being sexually abused. Most of the children were of average-to-low-average intelligence and attended school, sometimes erratically. Most had learning problems, and a significant proportion were in special education. This group of children had poor relationships with their peers and had few, if any, good friends. Antagonism, fear, uncertainty, and disagreements generally characterized their relationships with other children and adults. These children had few social skills, and they had a very limited ability to control their impulses. Frustration tolerance was very poor. These children had virtually no problem-solving or positive coping skills.⁴

A CONTINUUM OF SEXUAL BEHAVIORS

After these children who molest were discovered and treatment programs began, practitioners soon learned that there was a wide range of children who had problematic sexual behaviors but who were not engaging in sexually abusive behaviors or molesting other children. Unfortunately, some of these children were labeled as offenders.

Such mislabeling can have serious and extensive consequences for children, including:

- removal from their homes
- not being allowed to be alone with other children

*While this article talks about the sexual behaviors of children, this may be a misnomer and could be misleading about children and sexual behaviors. The behaviors that most of these children engage in are behaviors that are related to sex and sexuality but are not "sexual" behaviors in the same way we conceive of adult sexual behaviors. The behaviors of young children often mimic the behaviors of adults as they touch their own and others genitals, explore gender roles and the pairing behaviors of adults ("dating," "marrying," "playing house," "playing doctor," "dirty dancing," "humping"). Unlike adults, children are generally not seeking emotional connections and intimate relationships in their "sexual" behaviors but are experimenting with adult roles and coupling behaviors. Most of the "sexual" behaviors engaged in by young children are not driven by the desire for sexual arousal, physical gratification, and orgasm. Yet, children's bodies are equipped from birth for arousal and pleasure and infants can experience orgasms even in utero. Generally, children experience pleasurable sensations from genital touching. Some children experience sexual arousal while others experience orgasm. Sexual arousal and orgasm are more frequently found in older children entering puberty. Therefore, the term "sexual behavior" is used for the sake of brevity; otherwise the phrase that is more apt is "behaviors related to sex and sexuality."

- not being allowed to attend regular classes in school
- not being able to play freely in their neighborhood
- being placed in therapy as an “offender”
- not being allowed visits with the “victim” for an extended period of time

The term “sexual offender” is among the most highly charged labels in our culture. It can define a child’s future employment and devastate his or her sexual development. Many children who are mislabeled also struggle to comprehend how their sexual behavior can fit the heinous crime of sexual offending.

In 1988, T. C. Johnson defined a continuum of sexual behaviors in children. Along this continuum, she identified four groups. One group consists of children who engage in “natural and healthy sexual behaviors.” The other three groups consist of “children with sexual behavior problems.” These three groups are defined as: “sexually-reactive children,” “children who engage in extensive, mutual sexual behaviors,” and “children who molest other children.” Johnson believed it was essential to differentiate among the three groups because the treatment needs and the “systems” interventions are different. This differentiation is also essential in making certain that children with less serious sexual behaviors are not misidentified as children who molest.⁵

Natural and healthy sexual behaviors. Natural and healthy sexual exploration during childhood is an information-gathering process in which young people explore each other’s bodies by looking and touching (“playing doctor”) as well as by exploring gender roles and behaviors (“playing house”). Children involved in healthy sexual play are of similar age, size, and developmental status and participate on a voluntary basis.

While siblings engage in mutual sexual exploration, most sexual play is between children who have an ongoing, mutually enjoyable play and/or school friendship. Their sexual behaviors are limited in type and frequency and occur at several periods of their young lives. Children’s interests in sex and sexuality is balanced by their curiosity about other aspects of their lives. Healthy sexual exploration may result in embarrassment but does not usually result in deep feelings of anger, shame, fear, or anxiety. If children are discovered in sexual exploration and instructed to stop, the behavior generally diminishes, at least in the view of adults. Children’s feelings regarding their sexual behavior are generally light-hearted and spontaneous. Children usually experience pleasurable sensations from genital touching. Some children experience sexual arousal while some children experience orgasm. Sexual arousal and orgasm are reported more frequently in older children entering puberty.

“Sexually-reactive children.” These children may engage in self-stimulating behaviors and/or sexual behaviors with

other children and, sometimes, with adults. This type of sexual behavior is generally in response to environmental cues that are overly stimulating or reminiscent of previous abuse or to feelings that reawaken other traumatic or painful memories.

Many of these children have lived in sexually overwhelming environments in which they have not been shielded from adult or adolescent sexuality. Hiding the sexual behaviors or finding friends to engage in the behaviors in private may be less possible for these children as the sexual behavior is a way of coping with overwhelming feelings of which they cannot make sense. This type of sexual behavior is often not within the full conscious control of the child. In some situations, children are trying to make sense of something sexual done to them by doing it to someone else. They do not coerce others into sexual behaviors but act out their confusion on others in an attempt to reduce anxiety and confused sensations and feelings. Many do not understand their own or others’ rights to privacy or physical space integrity. While there is no intent to hurt others, receiving sexual behaviors can be confusing for the other child and feel like a violation or abuse.

“Children who engage in extensive, mutual sexual behaviors.” Often distrustful, chronically hurt, and abandoned by adults, this group of children relates best to other children. In the absence of close, supportive relationships with adults, they use their sexual behaviors to connect with other children. Children who engage in extensive, mutual sexual behaviors use sex as a way to cope with their feelings of abandonment, hurt, sadness, anxiety, and often despair. They do not coerce other children into sexual behaviors but find other similarly lonely children who will engage in sexual behaviors with them. Almost all of these children have been sexually and emotionally abused and neglected and look to other children to help meet their emotional needs and their need for physical contact.

Children in this group were previously “sexually-reactive children.” Children do not go from natural and healthy sexual behaviors to extensive, mutual sexual behaviors. First they become confused and overwhelmed by the overt and covert sexuality to which they are exposed. Then some come to use sex as a coping mechanism against their pain, despair, disillusionment, and lack of adult attachment figures.

“Children who molest.” The sexual behaviors of children in this category are frequent and pervasive. A growing pattern of sexual behavior problems is evident in their histories and intense sexual confusion is a hallmark of their thinking and behavior. Sexuality and aggression are closely linked in the thoughts and actions of these children. Unless the other child is too young to understand, children who molest use some type of coercion to get other children to participate in sexual behaviors. Bribery, trickery, manipulation, or emotional or physical coercion is generally

used. Physical force is neither commonplace nor necessary as the children's victims are selected due to vulnerabilities, including developmental delays, social isolation, and emotional neediness. The victims may be older, younger, or the same age as the child who molests.

There is an impulsive and aggressive quality to many of the behaviors—including sexual behaviors—of children who molest. Generally, these children have problems in all areas of their lives. There is a progression for these children from healthy sexuality to sexually-reactive behaviors to molesting behaviors. Some of these children progress through all three groups prior to molesting.

Confusing terms. Other authors writing about “children with sexual behavior problems” use the term in a similar manner to Johnson. D. K. Hall, in a complex statistical analysis of the records of sexually abused children, describes five groups of sexually abused children with sexual behavior problems, two of which are children who molest other children.⁶ J. Burton uses the term “sexually abusive behavior problems” for children who molest and the term “children with sexual behavior problems” as an umbrella term for those with less serious sexual problems and for abusive children.⁷

The term “children with sexual behavior problems” is not used consistently in research and publications. Berliner intentionally used the term “children with sexual behavior problems” to encompass the whole range of sexually related behaviors observed in children without regard to etiology and without imposing an interpretation of legal culpability.⁸ Bonner described subjects in a treatment-outcome study funded by the National Center on Child Abuse and Neglect as “children with sexual behavior problems.” The subjects in this study were divided into three groups: “sexually inappropriate” (hands off or masturbation), “sexually intrusive” (hands on, noncoercive), and “sexually aggressive.” Although the subjects were divided for purposes of description, the results of the study discussed one large group.

Bonner used the term “recidivism” to describe children who engaged in further sexual behaviors after treatment. This term is used when referring to adolescent and adult offenders who relapse and engage in further sexually abusive behaviors after being treated. Bonner also stated that the therapists working in the treatment groups were surprised that the children “were less willing than adolescent sex offenders to say what they had done.” Bonner uses the term “children with sexual behavior problems” to describe the wide range of children in her study. The language she uses to describe the children, referring to recidivism rates and adolescent sex offenders, appears to mean the children are involved in “sexually abusive behavior.”⁹

This lack of differentiation between the subsets of children with sexual behavior problems also occurred in the

parallel grant awarded to Pithers by the National Center on Child Abuse and Neglect. In this study, a complex statistical procedure was used to define five subtypes of children with sexual behavior problems who were the subjects of the study: sexually aggressive, asymptomatic, highly traumatized, rule breakers, and abuse-reactive.¹⁰

Children were admitted into the study if their problematic sexual behaviors met at least one of the following criteria: (1) repetitive; (2) unresponsive to adult intervention and supervision; (3) equivalent to adult criminal violations; (4) pervasive, occurring across time and in a variety of situations; or (5) highly diverse, consisting of a wide array of developmentally unexpected sexual acts. As can be noted, any one or more of the criteria needs to be met for the child to be part of the study. None of the criteria indicate that force or coercion was used or that the other child or children were vulnerable to the child due to size, age, developmental status, attachment disorders, or emotional problems.

In the Pithers studies¹¹ and in studies by Gray¹² from the same grant, the term “victim” was used consistently to describe all of the children with whom the study subjects engaged in sexual behaviors. If a child becomes a victim as a result of another child's sexual behavior toward them then, by definition, the other child must be sexually offending. The sexual behaviors of all the children in the study are then labeled as “abusive.” Thus, for this study, the term “children with sexual behavior problems” seems to refer to children who sexually molest or act in sexually abusive ways.

This confusion in the use of the term “children with sexual behavior problems” does nothing to resolve the problem of over-identification of children with problematic sexual behaviors as offenders. In fact, this confusion in terms may blur the differences and lead people to see all children with problematic sexual behaviors as offenders.

The treatment developed for “children with sexual behavior problems” in the Bonner study uses a 12-week group treatment program with one-hour sessions once a week for both parents and children. There are two orientations offered. One is cognitive-behavioral, the other psychodynamic. The same treatment length and format is suggested for all children who are referred for “inappropriate behavior with other children such as fondling, oral and/or anal sex, intercourse, sexual behaviors involving the use of force or coercion or where a significant age discrepancy exists.”¹³ The treatment manual does not instruct the user to discriminate between the children in terms of their treatment needs. Parents are not informed about the level of seriousness of their child's behavior. There is no mention of any specific safety planning for children engaging in molesting behavior. This lack of differentiation between the needs of the children and parents and the community's need for safety is potentially dangerous.

Like Chaffin and Bonner,¹⁴ I am concerned “to see parents told that their seven-year-old child could never return home again after two incidents of genital fondling of a five-year-old sibling—all in the name of controlling sex offenders and all based on behavior involving single or very few incidents.” Yet, I believe it is necessary to make an accurate and thorough individualized assessment of each child in order for him or her to receive the proper interventions. We are hurting children by saying they are offenders when they do not meet the criteria. But we are potentially creating more victims when we don’t provide the proper treatment and structure when they do meet the criteria for offending.

CHILDREN WHO MOLEST

Children who molest meet all of the following criteria:

- the child engages in sexual behaviors that violate others’ emotional, physical, and/or sexual rights and
- the problematic sexual behaviors are a pervasive part of the child’s behavior and
- the problematic sexual behaviors have occurred across time and in different situations and
- force, fear, physical or emotional intimidation, bribery, and/or trickery are used when engaging with another person in the sexual behaviors.

While not necessarily part of the definition of children who molest, but an important aspect of the diagnosis, is that the child’s problematic sexual behavior has been unresponsive to adult intervention and supervision. A significant number of young children who engage in molesting behavior when living in chaotic homes in which sex and aggression are routinely part of the family environment will stop the behavior when placed in a healthy environment with firm emotional, physical, and sexual boundaries.

Many of the children who molest have no model for healthy sexuality. When given guidance, caring, consistency, understanding, and information, many of these children stop their molesting behavior. I believe that children removed from their homes and placed in care should have all of the necessary safety plans to keep themselves and others safe as well as treatment opportunities. Then, after a period of treatment and stabilization, the children should be reevaluated to determine if their thinking and behavior remain in the abusive range or if the behavior was an artifact of the environment in which they lived.

MEGAN’S LAW

The need to clarify the distinctions between the levels of sexual behavior problems in young children is of enormous importance in the current climate in the United States. Megan’s Law calls for the public notification of sex offenders. States handle this notification process idiosyncratically.

By 1997, 19 states had mandated public notification of adjudicated juveniles who have sexually offended.¹⁵ In Texas, there is a ten year old on the list of registered sex offenders. His name and address are listed on the Internet. In New Jersey, a 12 year old charged with a sexual offense must register for life as well as be subject to public notification. One of the criteria used to decide the level of risk of the registered offenders is: “Is the victim under 13?” A 12 year old soon to be on the list noted that he is under 13 and asked if that made a difference. The answer is “no.”

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QUESTIONS TO HELP YOU DETERMINE IF YOU WERE SEXUALLY ABUSED

If you answer "yes" to any of the following questions, you can distinguish your experience as sexual abuse.

1. Where you unable to give your full consent?

If you were harassed, intimidated, manipulated, or forced into the sexual activity, you were not able to give full consent. If you were under the influence of drugs, alcohol, or medication, you were not able to give full consent. If you were asleep, unconscious, or otherwise not mentally alert, you were not able to give full consent. As a result of age, size, and power differences, children are not informed or mature enough to give full consent.

2. Did the sexual activity involve the betrayal of a trusted relationship?

If persons who were supposed to be taking care of you or who were in an authority role used their position to force or encourage you to engage in sexual activity, you were sexually exploited and, thus, sexually abused. This can occur in situations in which a parent, relative, teacher, religious leader, or therapist compounds the trusted caretaking relationship with sexual involvement.

3. Was the sexual activity characterized by violence or control over your person?

Any sexual situation in which you were restrained or bound against your will, physically forced, or harmed constitutes sexual abuse. Humans need to be in control of what is happening to them physically. When this is denied by someone else in a sexual situation, it constitutes abuse.

4. Did you feel abused?

Finally, for purposes of sexual healing, what matters most is whether you feel you were sexually abused. Your feelings are genuine. They cannot be erased. You need to trust your own feelings about an experience. If it felt funny or exploitative to you, regardless of how others perceive it, it has had an impact on you. That is what counts.

These questions were excerpted from The Sexual Healing Journey by Wendy Maltz (HarperCollins, New York, 2001).

HEALTHY SEXUALITY AND THE TREATMENT OF SEXUALLY ABUSIVE YOUTH

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While working as a psychologist in a long-term residential treatment program for sexually abusive adolescent males, I had an exchange with a 17-year-old boy who was approaching discharge following two years of intensive treatment and, by all accounts, had made tremendous progress.

“What do you think it will be like ‘out there’ in the real world when you start to meet girls your age?” I asked.

“I’m looking forward to it,” he replied.

“What if you meet someone you really like, you’re attracted to her, and you guys really hit it off?” I continued.

“Well, nothing will happen. I’ll just use the urge control I’ve learned here,” he immediately interrupted.

“But, let’s say you really like her. You might like to ask her out on a date. You guys go out on a date and, at some point, you both might want to kiss, make out, or even go further?” I pressed him.

“Well, I’ll make sure I keep my relapse prevention plan with me and look at it as if I’m in a high-risk situation,” he said anxiously as he searched for the “right” answer.

“Well, what does your relapse prevention plan say?”

“It says to avoid situations where I might be with someone who fits my ‘victim profile.’”

“What’s your victim profile?”

“Little girls that are the same age as my victim.”

“So how’s that gonna help you with a girl your own age who you’re attracted to?”

Frustrated, he blurted, “I don’t know! I guess I’ll just use my urge control. Nothing will happen. Don’t worry. I’m not going to do anything. I’ve come too far to make that mistake again.”

I sighed and thought to myself, “What have we done?”

It was fairly common for me to hear these sentiments from young men in my former treatment work. I have heard numerous similar stories from those working with sexually abusive youth in other settings.

The more I heard, the more I became concerned about the negative messages treatment programs were sending young people about their sexuality and how rarely programs focused on interventions to help these youth develop into sexually healthy adults. Both concerns made me fear the potential long-term consequences, not only to these young people themselves, but to the community at large.

More specifically, I wondered whether this was an unfortunate but necessary part of the therapeutic process in working with troubled young people. What about our treatment practices and treatment culture contributed to these negative messages? Was it possible to conduct treatment in a more balanced way, challenging teens’ abusive sexuality without making them feel they needed to renounce their sexuality altogether? If so, what measures could treatment programs take to promote healthy sexual development?

TREATING THESE YOUTH

Beginning in the 1980s, there was a growing awareness that a substantial portion of sexual violence was perpetrated by adolescents. Current data suggest that juveniles under 18 years of age account for 20 percent of all rapes and from 30 to 50 percent of acts of child molestation committed in this country each year. Retrospective studies of adult sex offenders demonstrate that the majority self-report that they began their sexual offending before age 15 and often before age 12.¹ More recently, we have learned that a surprising number of children under age 12 engage in sexually abusive behavior.²

The predominant treatment approach used with sexually abusive youth is referred to as a “cognitive-behavioral relapse-prevention model.” This model teaches young people to understand the thoughts, feelings, and behaviors that occur before, during, and after their abusive behavior with the goal of interrupting their pattern or cycle of behavior.³

Relapse prevention, adopted from the field of substance-abuse treatment, is based on the premise that there is no cure for sexual deviancy and that, even after completing treatment, teens always have the potential for relapse. They learn how to recognize warning signs on the path toward relapse and ultimately learn how to escape this relapse chain.

Many programs employ techniques to reduce deviant sexual arousal, the ingrained patterns of deviant fantasy or attraction that are thought to lead to offending. What is often called “sex-offender specific” group therapy is the most common modality of treatment. Treatment often includes psychoeducational interventions focused on topics such as anger management, social skills, victim empathy, and (sometimes) human sexuality.⁴ In recent years, some have

advocated for a broader and more holistic approach to the treatment of sexually abusive youth by integrating ideas from the fields of object relations, attachment, trauma, and family systems.⁵

QUESTIONING TREATMENT MODELS

In recent years, researchers and practitioners in the juvenile-offender field have challenged the appropriateness of current treatment models, arguing that they are based on assumptions adopted from treatment work with adult sex offenders and pedophiles, usually in prison settings.

These assumptions include beliefs, for example, that sex offending is a compulsive behavior resulting in an extremely high recidivism rate; that sex offending is a lifelong disorder that cannot be cured, only managed; that denial must be broken and manipulation challenged via a highly confrontational stance; that offenders engage in carefully planned and highly ritualized grooming behaviors to set up their victims; and that an ingrained pattern of deviant arousal and deviant fantasies are essential features.⁶

Despite the wide acceptance of these assumptions and beliefs about sexually abusive youth, there is little empirical evidence to support them. Currently available treatment outcome research, for example, suggests that sexual relapse rates for sexually abusive youth who have been in treatment are generally low (10 to 15 percent). The logic of these assumptions also breaks down when applied to children and teenagers who, developmentally, have very little in common with adult sex offenders and pedophiles.⁷

Having worked closely with teenagers who were considered at the highest risk to sexually reoffend, I also find these assumptions highly questionable and applicable only to a minority of youth. As one therapist and trainer who has been practicing in the field for nearly 15 years put it, “We have developed theories and notions about juvenile offenders based on the worst, most dangerous 15 percent of the adult-offender population.”⁸

THE REALITY OF TREATMENT

At the same time, it is important to recognize that these young people are often quite damaged psychologically and are very difficult to treat. While most differ significantly from adult repeat offenders, some share similarities that pose challenges for treatment providers. These include denial, compulsive use of sex to cope with negative feelings, a high degree of manipulation and deceptiveness, patterns of deviant arousal, and highly sexualized thinking and behavior.

Furthermore, they have hurt others. Most of the teens with whom I worked in residential treatment had multiple victims against whom they committed multiple offenses ranging from flashing to fondling to anal rape. In such settings, it is not uncommon for clients to use extremely

devious means to sexually abuse or engage in consensual sexual behavior with other clients. One of my clients passed sexual notes to a peer through an empty pen tube. This led eventually to their fondling each other in a public area while staff members were not looking.

Such incidents are problematic because they cause other clients and staff members to feel unsafe, place agencies at risk for lawsuits, and have the potential, if the sexual incident is a common occurrence, to shut down facilities altogether.

HEALTHY SEXUALITY IMPLICATIONS

The physical and psychological safety of clients, treatment staff, and the community are—and must remain—of paramount concern. Without such safety, therapeutic progress cannot happen. At the same time, I believe that the goal of safety is often used to justify treatment practices that are motivated less by thoughtful reasoning and more by fear and anger.

Partly due to the assumptions noted above, sexually abusive youth are associated, in the minds of the general public, the child protection community, law enforcement, and treatment staff themselves, with the image of adult rapists and pedophiles, arguably the most frightening and reviled group of criminals. With this association often come fear, disgust, and anger. When fear drives treatment, control becomes a high priority. I believe this, in part, explains the often highly punitive and restrictive treatment practices common in programs as well as the tacit (and often unconscious) need to contain young peoples’ sexuality.

Our society fears talking about sexuality with teens, believing it will give them permission to engage in sex. With young people who have used sex abusively, the fear of how they will hear, internalize, and act upon messages about healthy sexuality is that much greater. The fear seems rooted in a number of questions. If treatment programs discuss healthy sexuality, will these young people become overstimulated and more likely to act out sexually? Are there risks to the community? How will referrers perceive practices that teach “these kinds of kids” adaptive sexual expression? And, most importantly, what are the risks to treatment staff themselves of talking about healthy sexuality with kids who have used sex abusively? The response to all these questions is usually, “Better to be safe than sorry” by focusing exclusively on interventions that aim at containment.

In residential treatment settings, containing sexuality is particularly compelling because of the fear of lawsuits stemming from teens engaging in abusive or consensual sexual behavior while in care. Any long-term goal of providing healthy sexual socialization or teaching healthy sexual expression gives way to the more immediate goal of containing sexual expression while in the program.

I also believe that treatment staff often harbor unacknowledged and unexpressed anger at these youth and

feel that, after what they have done, they do not deserve satisfying sexual lives. People feel that by committing these acts of violence against others, these young people have given up their right to learn about or experience sexuality as positive, growth enhancing, and pleasurable. Even for those who see them as deserving, it is understandably difficult to imagine them being in a romantic or sexual relationship in the future. Better they be asexual or, at least, wait a very long time before becoming sexually active.

DISCOURAGING HEALTHY SEXUALITY

Many treatment practices, rooted in dubious assumptions about sexually abusive youth and often motivated by fear, communicate highly negative messages about sexuality. These messages may account for the kinds of feelings and beliefs evident in the dialogue at the beginning of this article. I will highlight a few examples here.

Absence of interventions (such as sexuality education) or discussion about healthy sexuality. Entire treatment programs are organized around interventions that help young people avoid their sexually abusive patterns. They place little, if any, emphasis on helping youth develop positive, healthy feelings about their sexuality or develop sexually healthy alternatives to their abusive behavior.

This imbalance is also reflected in the broader juvenile sex offender field. In recent years, a rich body of literature and ongoing professional dialogue have blossomed about interventions to help young people interrupt abusive behavior. Yet there is still very little discussion about interventions to promote healthy sexuality. A recent search of “PSYCHINFO” (a database of journal articles in the field of mental health maintained by the American Psychological Association) on the topic of healthy sexuality/sexuality education and sex offenders yielded fewer than five articles on the subject and only a handful of articles on related subjects. In a recent brochure advertising the upcoming annual conference of the Association for the Treatment of Sexual Abusers (ATSA), there appeared to be no sessions addressing the promotion of healthy sexuality.⁹

Despite this lack of literature, the *National Task Force Report on Juvenile Sexual Offending*¹⁰ does stress treatment interventions related to healthy sexuality and recommends sexuality education based on the rationale that the development of healthy relationships and realistic information about sexuality reduces the risk of reoffending. In Massachusetts, most treatment programs claim they teach sexuality education.¹¹ Anecdotal evidence suggests, however, that few actually do. When they do, it is usually taught sporadically and by woefully unprepared staff, and focuses only on the dangers of sex.¹²

Teens, as a result, receive the very clear message that they are only permitted to talk about their abusive sexual

behavior. Not only must teens hide all of their sexual feelings, but they must also hide their curiosity and yearning to learn more about sexuality.

The sex offender introduction. A central part of many treatment programs is what is often referred to as the “sex offender introduction,” which requires clients to begin the disclosure of their sex offenses in group therapy by saying, “My name is _____, and I am a sex offender.” The rationale for this practice is to break offenders’ denial about their abusive behavior and make them take responsibility for their offenses. In their 1998 article in *Child Maltreatment*, Chaffin and Bonner cite the example of young teenagers, ages 13 to 15, being forced on a daily basis to recite phrases such as “I am a pedophile and am not fit to live in human society.... I can never be trusted.... Everything I say is a lie.... I can never be cured.”¹³ While the last of these examples is extreme, it is not difficult to imagine how young people, over time, come to adopt the identity of a sex offender and view all of their sexual feelings, fantasies, and actions as dangerous, anxiety-producing, and requiring repression or containment.

The concept of grooming. Treatment programs also frequently focus on “grooming” behaviors, a concept also directly imported from work with adult pedophiles. Grooming is the term used to describe the intentional behaviors sexual abusers use to prepare, train, or persuade a victim to comply with their sexually abusive behavior.¹⁴ In the program in which I worked, staff often viewed behaviors such as playful joking, holding a gaze for too long, or just acting friendly as grooming and reprimanded teens for them.

Clients were quick to accuse each other of grooming. While it is undoubtedly important to closely monitor sexualized behavior, and many would argue that grooming often takes the form of playful joking, I believe the pursuit of this goal easily creeps into the term being overused and misused to prohibit, shame, and prevent any and all expressions of young peoples’ personality and sexuality. Over time, teens in treatment learn that, in order to avoid charges of grooming and to succeed in the program, they need to put away any behavior that is an expression of their sexuality or could possibly be construed as sexual.

One 16-year-old young man with whom I worked was continually accused by staff of grooming because he had a flirtatious way of interacting. Though problematic at times, his behavior had nothing to do with intentionally setting up potential victims. Rather, it reflected a long, gruesome history of sexual abuse from which he had learned that acting in a sexualized manner with others was the only way he could get badly needed attention. This had become his primary way of relating. The frequent reprimands took a toll on his self-esteem, provoked shame about his sexuality, and appeared to reinforce many of the same messages he had learned about sexuality from the man who sexually abused him.

SO, WHAT IS THE PROBLEM?

Unbalanced, shame-based, sex-negative treatment practices reflect our culture's conflicted views of sexuality and adolescent sexual health. As is generally true in American culture, treatment providers are very clear about what they do not want sexually abusive youth to do with respect to their sexual behavior. These providers are much less clear about the healthy behaviors they want to take the place of sexually abusive behaviors.

This sole focus on stopping deviance violates a fundamental principal of therapeutic intervention—if you take away a maladaptive coping mechanism, you need to replace it with a more adaptive one. For example, these young people never learned through adult guidance and modeling how to recognize the difference between a healthy and an unhealthy romantic/sexual relationship; how to get to know someone on whom they have a crush; how to recognize cues from others that communicate “I like you back”; or what one does when things get sexual. I feel that treatment programs do these young people a grave disservice and a disservice to the safety of the community if treatment providers do not grapple with how to teach these kinds of skills.

Highly sex-negative treatment practices also parallel the family cultures of many of these young people, who already see sexuality as emotionally linked with danger and as fraught with anxiety, shame, and guilt. Therapist and author Toni Cavanagh Johnson states, “Children who molest are socialized to sex and aggression occurring in tandem.... Children's bodies are used as vehicles for the pleasure of adults.... Anxiety, tension, anger, rage, and cruelty become intimately associated with sex.... Relationships are based on sex and need, not love and caring.... The way to stop emotional emptiness and pain is through sex, which is often accompanied by hitting and violence and quick exits and loss....”¹⁵ In one study, clinicians rated 86 percent of the families of sexually abusive youth as “below average,” “inappropriate,” or “dysfunctional.” Another, studying the families of sexually abusive youth, found that 64 percent of family members had been physically or sexually abused as children.¹⁶

Excessive control in treatment runs the risk of merely reinforcing the message that sex is simply dangerous or disgusting, not something to be valued. The end result of too-rigid control is to discourage or squash any sexual thoughts, feelings, and fantasies—in short, any developmentally normal curiosity or behavior.¹⁷ Moreover, it seems likely, at a minimum, to promote lives with troubled relationships and sexual dysfunction, if not continued abusive behavior.

In the same vein, if young people are taking away from treatment programs that they should repress, deny, or avoid all their sexual feelings, their sexuality will express itself in other ways—ways that will likely prove similarly dangerous and destructive. As is true with anger, putting the lid on

tighter and tighter only works for so long and ultimately leads to disaster. Increased risk for reoffending is often linked to stress. I can hardly think of anything more stressful than trying to negotiate the world of dating, teen relationships, and physical intimacy with no skills and a feeling that your sexuality is bad and dangerous.

POSSIBLE ANSWERS

As therapist and author Eliana Gil states, the challenge for treatment is “how to support natural and expectable sexual development without overlooking problematic sexual behaviors that can result in an unsafe environment of sexual exploitation or abuse.... Sexual development cannot be put on the back burner during the treatment of adolescent male sex offenders....”¹⁸ Treatment providers must base treatment on sound reasoning, not fear. But meeting such challenges is not easy.

I think that success lies in treatment providers and treatment programs engaging the hard issues, attempting to strike a healthy balance, and avoiding what Gail Ryan calls “the pendulum effect.”

The pendulum effect is a term Gail Ryan uses to describe the move from one extreme solution to another that is so common in work with sex offenders. On a macrolevel, for example, she notes that, in the 1980s, total denial of abusive sexual behaviors by juveniles was the rule. Now, in stark contrast, sexually abusive youth are labeled as “sex offenders” for life and are placed on sex offender registries in some states.¹⁹ There is a parallel process that occurs on the microlevel of treatment when dealing with issues of sexuality. For example, as noted earlier, treatment staff in residential settings, when dealing with teens' flirtatious or sexualized behavior, tend either to punitively label all such behavior as grooming or, at the other extreme, ignore it altogether.

I believe that extreme all-or-nothing solutions serve to help people—whether they be lawmakers or sex offender therapists—avoid the anxiety, fear, and disgust common in work with sex offenders. In the example above, it is easier for treatment staff to treat all sexualized behavior as grooming rather than engage in the difficult and often anxiety-producing task of distinguishing between sexualized behaviors that are meant to set up victims and those that have another, more benign, meaning.

When I implement sexuality education groups for sexually abusive youth, I try to strike a balance by making the groups relevant and engaging for young people and, at the same time, taking reasonable steps to ensure safety. To do this, I establish and enforce clear ground rules from the very beginning. My standard four rules are: (1) do not put anyone down; (2) respect what others say; (3) it is okay to pass; and (4) there is no such thing as a stupid question. I aim for a tone that is frank, positive, and open yet not

inappropriately personal; that is fun yet serious; and that is humorous but not silly.²⁰ To safeguard against negative acting out, I brief staff in advance, carefully craft the makeup of groups, and directly address, through problem-solving activities, how members can manage sexual feelings they might have during group.

Treatment programs also need to provide time, appropriate forums, and encouragement to agency staff at all levels to voice their anxieties and fears about doing this work. Specific to healthy sexuality, staff members must have room to grapple with how to strike the difficult balance between a focus on abusive sexuality and healthy sexuality.

In my experience, such forums rarely exist, or, if they do, staff members feel inhibited from sharing their genuine feelings. They often believe it is not okay to have, and surely not okay to share, feelings of fear, anger, and disgust about these young people. Conversely, others refrain from advocating for healthy sexuality for fear they will appear “soft” on safety or unwilling to hold the teens strictly accountable.

If such forums were available, these feelings would be less likely to go underground and get acted out in treatment practices that are overly punitive (or overly permissive). And treatment practices would more likely be based on thoughtful reasoning rather than fear.

HEALTHY SEXUALITY EDUCATION

Having taught nearly 100 sexuality education groups for sexually abusive youth, I have learned that such groups, when taught well, can be immensely powerful and therapeutic.

Particularly because sexuality is usually discussed only in contexts associated with tremendous gravity, shame, and embarrassment, it is exciting to see initially wary young people come alive when permitted to talk openly about sexuality. There is a palpable energy, fascination, and engagement in the room that I have experienced at few other times in their treatment. For example, I often begin groups by answering members’ anonymous questions, and these questions stimulate so many other questions that there is often little time left for the planned lesson. Treatment staff, for whom burnout and vicarious traumatization²¹ are common, often remark at how refreshing and energizing it is to participate in the human sexuality groups.

When possible, the groups cover a comprehensive range of topics, including reproductive and sexual anatomy, sexual feelings, sexual decision-making, puberty, teen pregnancy, HIV/AIDS, safer sex, sexual orientation, sexual values, healthy relationships, and courtship and dating skills.²² I attempt to present positive models of sexuality, discussing both the dangers and pleasures of sexuality while also teaching about the power of intimacy and love within the context of mutually consensual relationships.

I try to set a tone that communicates that it is okay to talk openly, ask questions, and learn about sexuality; that sexuality, while serious, is also sometimes funny, light, and awkward; that there are adults on the staff who are willing to talk frankly about sex and sexuality; and that the teens can talk about sex without acting on it. For most of these teens, this group discussion offers them the first opportunity in their lives to talk with peers and adults in an open yet appropriately restricted manner about sexuality.

In contrast to the common fears of treatment staff, there is no evidence of increased sexualized behavior as a result of these groups. After initial discomfort, the teens, for the most part, are appropriate, respectful, and serious. Rather than leaving groups overstimulated, residential staff reported that appropriate discussions that began in group would sometimes continue on the residential units. Frequently, group would trigger important therapeutic issues that therapists would address in individual therapy. On occasion (though much less than expected), there is a need to remove teens from group because the sexual issues discussed in the group stimulate overwhelming feelings that they cannot manage.

While there is little empirical research on the impact of healthy sexuality education on sexually abusive youth, it is reasonable to suspect that it can impact young people in many important ways. Healthy sexuality education teaches that a person can talk about sexuality without acting on it. Or, as a colleague said, it “puts words between feelings, thoughts, and action.”²³ This form of education teaches youth about verbal boundaries related to sexuality as they talk openly about sexuality without making inappropriately personal disclosures. It also breaks down the barrier between teens and adults by sending the message that there are adults who are willing to talk with young people about sexuality in a frank and honest manner. Some have suggested it may also reduce dependency on pornography because it provides them with the information they crave.

SYSTEMIC INTERVENTIONS²⁴

It is unrealistic to expect, however, that sexuality education groups alone can facilitate healthy sexual development without the transformation of broader treatment cultures. At a recent workshop, I discussed a range of interventions that juvenile-offender treatment programs might implement to promote healthy sexuality.²⁵ Some of these measures apply only to residential settings, although most could be integrated into outpatient programs as well. The interventions span multiple levels of agency systems, from executive administration to front-line workers.

1. **Articulate agency mission, policy, and values related to the promotion of healthy sexuality.** This ensures that agency administrators grapple with the difficult issues involved in

doing this work and are committed to backing staff who are conducting interventions to address healthy sexuality.

2. **Provide in-service staff training related to the promotion of healthy sexuality.** The goals of such training are to clarify agency values and policies, provide staff guidance on how to respond to young people in ways that promote healthy sexuality, and increase staff comfort addressing issues of sexuality.
3. **Implement formal sexuality education groups.** In these groups, young people learn the information, attitudes, and skills necessary to make healthy choices about their sexuality.
4. **Develop and offer a support group(s) for gay, lesbian, bisexual, transgender, and questioning clients.** Because concerns related to sexual orientation are common among sexually abusive youth, it is critical that they have a safe space in which to learn about and explore these issues.
5. **Develop and offer psychoeducational groups for families to promote healthy sexuality.** The goal of such groups is to educate families about healthy sexual development and facilitate communication between parents/guardians and teens about sexual issues and concerns.
6. **Integrate healthy sexuality as part of the general psychoeducational curriculum.** Balancing workbooks commonly used in offender programs,²⁶ which focus primarily on abusive sexuality, with material about healthy sexuality would help facilitate healthy sexual development.
7. **Establish a zero-tolerance policy for anti-gay name-calling.** This atmosphere promotes exploration of sexual orientation issues and the development of self-esteem for the many teens dealing with these concerns as well as reinforcing respect for others.

CONCLUSION

Despite the obvious overlap between the work of sexuality educators and professionals working with sexually abusive youth, there is surprisingly little dialogue between the two disciplines. As someone who has a foot in both fields, I have attempted in this article to promote such dialogue.

Sexuality educators have much to offer the juvenile sex offender field and vice versa. Perhaps this article will increase dialogue with the goal of safeguarding potential victims in the future and helping troubled young people develop into emotionally healthy, and sexually healthy, adults.

Steve Brown is a psychologist, psychotherapist, and sexuality educator/trainer who specializes in work with youth—including sexually abusive youth—who have serious psychiatric, behavioral, and emotional problems. He is the author of Streetwise to Sex-Wise: Sexuality Education for High Risk Youth, a manual used

nationally by agencies and schools serving high-risk youth. SIECUS Report readers can reach him at steve.brown@tsicaap.com or by phone at 860/644 2541.

—Editor

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11. This statement is based on an examination of adolescent program listings in the *Massachusetts Directory of Sex Offender Assessment, Treatment and Residential Services* published by the Massachusetts Association for the Treatment of Sexual Abusers (MATSA) and the Massachusetts Adolescent Sexual Offender

Coalition (MASOC). Nearly all programs indicated that they offer sexuality education as a cognitive treatment approach.

12. This impression is based on conversations with practitioners at programs throughout the Northeast United States. Joann Schladale, M.S., who provides intensive training nationally for professionals who treat sexually abusive adolescents and their families, reported a similar impression based on her extensive experience.

13. Chaffin and Bonner, "Don't Shoot," p. 315.

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26. The two books most commonly used in adolescent sex offender treatment are T. Kahn, *Pathways: A Guided Workbook for Youth Beginning Treatment* (Orwell, VT: The Safer Society Press, 1996) and C. Steen, *Relapse Prevention: Workbook for Youth In Treatment* (Orwell, VT: The Safer Society Press, 1993).

SEXUAL ABUSE LINKED TO EATING DISORDERS IN TEEN GIRLS

Young girls who are sexually abused are more likely to develop eating disorders as adolescents, says a new report published in the October issue of the *Journal of the American Academy of Child and Adolescent Psychiatry*.

Investigators from the University of North Dakota School of Medicine and Health Sciences in Fargo assessed eating disordered behavior and concern with body image in 20 sexually abused girls and 20 girls who were not abused. All girls were between 10 and 15 years of age.

The study revealed that abused girls were more dissatisfied with their weight and more likely to diet and purge their food by vomiting or using laxatives and diuretics. They were also more likely to restrict their eating when they were bored or emotionally upset.

The report suggests that abused girls might experience higher levels of emotional distress, possibly linked to their abuse, and have trouble coping. Such eating disorder behaviors may reflect efforts to cope with such experiences.

STOP IT NOW! CHALLENGES
OUR THINKING ABOUT SEXUAL ABUSE

Joan Tabachnick

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STOP IT NOW!
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Eight years ago, I met Fran Henry just as she was incorporating STOP IT NOW! into a new national nonprofit organization. I was inspired by her simple statement as a survivor of sexual abuse: “I am founding STOP IT NOW! because I don’t know if the current good touch/bad touch programs for children would have reached me or worked in my family’s situation. I don’t think I could have stopped the sexual abuse or reported my father as a 12-year-old child. Instead, I needed him or another adult to take responsibility for stopping the abuse.”

I was also inspired by her idea of using public health thinking and social marketing tools to test this new initiative. For those who have not heard of social marketing, a classic explanation is, “Why can’t you sell brotherhood in the same way that you sell soap?”

SOCIAL MARKETING

In 1992, STOP IT NOW! suggested using this new field of social marketing to inspire sexual abusers and those who know sexual abusers to stop abusing children. I felt this would be the ultimate challenge. How could a small organization hope to encourage a society to talk about adults who sexually abuse children when that society can hardly talk about healthy sexuality between consenting adults? I started as a volunteer and eventually joined the organization full-time to help test this concept.

In both traditional and social marketing theory, the place to start is with the target audiences. We defined our three audiences as adult abusers, the friends and families of adult abusers, and the parents of children with sexual behavior problems. To learn more about these audiences, we talked with abusers in prison, family members in support groups, and parents in therapy programs with their children.

The mistake that most social service campaigns make is to focus on what they want to say. Our country’s biggest campaigns have used this heavy-handed approach to tell us what to do—“Just say no” or “Get off of drugs”—without looking at people’s motivations for change. As a mother of two children, I know exactly what I would want to tell an

abuser, but I know that would not motivate anyone. That is like someone telling me to “eat better” or “exercise more” without understanding why I, a working mother of two, might have a hard time changing my behaviors.

WHAT ABUSERS WANT TO HEAR

The first phase of our work involved sitting down with each of our target audiences and asking them what they wanted to hear. We asked traditional marketing questions such as “What would you want to hear in order to stop abusing?” “When would you have heard such a message?” “Who would you most likely listen to?”

My first interview with a sex offender was in a high-security prison in upstate New York. I was taken there by Fay Honey Knopp, a prisoner-rights activist and a mentor to our program. She had arranged for me to talk with a man who had sexually abused a number of children. I learned two important lessons that day.

The first lesson came from Honey herself. We had to go through metal detectors when we entered the prison. Honey was asked to go through the detector again and again. She took off jewelry, hair clips, belts, and other metal items. The guards finally had to use a hand-held detector to find the metal stays in her clothing that had continued to set off the alarm. As we headed into the prison, she whispered that it was getting “harder and harder to find bras with metal underwire to set off the metal detectors.” She had intentionally dressed to trigger the alarm to make the prison guards see her as a person and not as some number. It was an important lesson for me. It made me realize I was about to meet a *person*. It helped me not to think of him as “one of those sexual predators.”

My second lesson came from “Jon,” the inmate. When I met with him, I was struck by his openness and honesty. I was also struck by a statement he made: “All of the signs [of sexual abuse] were there, but no one bothered to ask me about them.” We asked him about those signs. He talked about “grooming” behaviors used by someone like himself who wants to gain the trust of children or family members

before they abuse them. He shared examples such as bringing young kids rather than someone his own age to family picnics or hanging out at video arcades and community fairs where children might be alone. He expressed surprise that not a single family member or friend ever asked him about these types of behaviors. He said that he did not blame anyone but that he felt they had many missed opportunities to offer him a chance at treatment before he abused and before he went to prison.

We interviewed and met with other sex offenders for a period of more than two years and learned that this population is very much like other traditional marketing audiences. They wanted to hear from people like themselves. They wanted to hear a message of hope from someone who had been there, done that, and learned how to control their destructive behaviors. And they wanted to hear the message directly—to have someone speak the unspeakable and to say out loud the words that no one, including themselves, was able to say until a child had reported them.

We also met with families of sexual abusers. They told of their desire for more information, to know what they could have done, and to know what they could do if they were faced with a similar situation. Most importantly, they asked for guidance to help family members when they finished treatment programs or prison sentences. They also talked about their fears of retaliation and ridicule from neighbors.

THE CAMPAIGN

When we do not take the keys from a drunken friend who is about to drive, we are risking the lives of the friend and everyone else on the road. When we do not question sexually suspect behaviors of our family or friends, we are risking the safety of our children and giving up on the family member or friend who may be abusive. But when we do not even talk about sexual boundaries in families, imagine how hard it is to talk about inappropriate sexual behaviors. This is the challenge for STOP IT NOW! We must inspire those who abuse to become a part of the solution that challenges adults who know a potential abuser to take action and that asks society to change the way it thinks about, talks about, and reacts to sexualized behaviors.

Based upon our research with our target audiences, STOP IT NOW! created our first campaign by targeting adults in Vermont. We chose Vermont because of the cooperation of numerous organizations, individuals, and public officials, and because of the availability of treatment programs for abusers. We could guarantee that anyone with the courage to step forward would get into an established treatment program. With a total population of 580,000 citizens, Vermont was also a state that was small enough for STOP IT NOW! to mount a media and community action campaign on an extremely limited budget.

In cooperation with The Safer Society Foundation, Inc., our sponsoring agency, we worked with a volunteer advisory group for nearly three years to plan the public launch of this program. We talked with over 100 Vermont stakeholders, surveyed clinicians working with sex offenders, and conducted a random-digit-dial phone survey of over 200 Vermont citizens to get their opinions, reservations, and suggestions about our plans.

Our key tasks were to establish a media campaign, to build relationships with other community-based organizations, and to create a help line for abusers and the people who know them.

With pro bono assistance, we created television and radio public service announcements (PSAs), planned media events and press conferences, and developed informational materials available at no charge in doctors' offices and community agencies across the state.

Our overall focus was to address the following issues:

- ***Put a human face on sexual abuse.*** Most of the cases presented by the media are the most horrendous situations. They do not help people understand that a person whom they love may be sexually abusing someone.
- ***Give hope to those affected by abuse.*** Most people we interviewed did not know that help was available, that abusers could learn to control their behaviors, or that abuse victims could heal from this trauma.
- ***Use the media to model how to talk about sexual abuse.*** All of our PSAs use specific words needed to describe sexualized behaviors. For example, we talked about “pants down” games between 12-year-old children and younger children who were 6 years old. We also described situations of sexual abuse such as an adult touching the genitals of a child for pleasure or an adult becoming sexually aroused by showing pornography to a child.

With seed grants from the local Vermont Community Foundation, an individual donor, and the W. K. Kellogg Foundation, we were able to launch this campaign. We also developed a comprehensive evaluation of the program in collaboration with Market Street Research, a Northampton, MA, research firm that donated the majority of its services.

WOULD ANYONE SEEK HELP?

Before we began our campaign, people asked us, “Will anyone call for help?” We responded that we expected someone to call and hang up, call again and ask a question, and then, after many calls, have the courage to talk with us about the abuse. Only then, we said, would someone ask for help and consider entering the legal system. When we launched STOP IT NOW! VERMONT, our first phone call was from a man who said, “Hello, my name is Joe. I am a child molester, and I need help.”

We continued our efforts to help in a variety of other ways. We held community speak-outs with recovering offenders and survivors talking together about the need for prevention. We also worked on a PSA with the mother of a son who had sexually abused her daughters. She reached out to other mothers in similar situations.

Last September, we conducted our four-year evaluation of the program. We again held interviews with key stakeholders, surveyed clinicians working with sex offenders, and conducted a random-digit-dial phone survey of Vermonters. We found that:

- **People will call for help.** Initially no one believed a sex offender would call for help. In our first four years, STOP IT NOW! VERMONT received 657 help-line calls. Fifteen percent were from people who identified themselves as abusers. Fifty percent were from people saying they knew an abuser—and often the victim, too.
- **Many adults have learned to talk about sexual abuse.** “Breaking the Silence” is a call to action that is generally endorsed by everyone working in the field of child sexual abuse prevention—from victim-based advocacy groups to sex offender treatment providers. We are proud to say that the number of Vermonters who can explain child sexual abuse has doubled in the past four years. Specifically, the number has increased from 44.5 percent to 84.8 percent.
- **Adults still need better skills to stop sexual abuse.** Although more Vermonters can explain sexual abuse, many still do not know what to do when faced with a specific abusive situation. Only 66 percent told us they would take direct action if they suspected sexual abuse. This percentage decreased by nearly half if the suspected abuser was a close family member.
- **Abusers themselves are taking preventative action.** Before our program, no one thought of a sexual abuser as a potential source for stopping abuse. STOP IT NOW! VERMONT has challenged this belief by encouraging abusers to step forward into the legal system for help. Over the past four years, 118 people (20 adults and 98 adolescents) have voluntarily sought help for their sexual behavior problems. These adults and adolescents, with support from their families, asked to enter treatment, fully knowing that this single act would trigger the mandatory reporting laws that require a clinician to notify the police that a crime was committed against a child.

WHERE DO WE GO FROM HERE?

In addition to continuing our work in Vermont, we are now testing the STOP IT NOW! program in a more urban and

culturally diverse area. With the help of the Joseph J. Peters Institute, our local sponsor, as well as a volunteer advisory committee, we are developing a culturally appropriate program in Philadelphia. Again with the pro bono assistance of many community-based organizations as well as professionals in advertising and media research (including, but not limited to, MEE Productions, Reimel Carter/EPB, and the Philadelphia Health Services), we have developed a national advertising campaign that will launch the program this fall.

In addition to this geographic testing of the campaign, STOP IT NOW! is also currently working with an advisory committee to grow our geographically based program into an online virtual site. As our world begins to move into this virtual space, we believe that the lack of shame engendered by this new media may also provide new opportunities for families to work together to break the silence surrounding sexual abuse and get the help they need to stop potentially abusive behaviors.

But program development is only one aspect of our work. Our social focus is to shift how people think, how people talk, and how people act with regard to all sexual abuse behaviors. Each of our activities provides an opportunity for us to see and feel where we are blocked by our societal norms.

One of our most moving activities in the past few years was a weekend dialogue between recovering sexual abusers and survivors of sexual abuse. One survivor talked passionately about “the courage it takes for each of us to disturb the surface, let go of appearances, and disrupt the social relations just to begin a conversation with a child or adult about the possibility of child sexual abuse.”

Twenty years ago, people would not have talked to someone who was drinking about not driving. Today, people have a new norm that makes it okay to offer a ride or to take keys from a friend. We have made similar shifts around the issues of HIV/AIDS, smoking in public places, and using bicycle safety helmets.

STOP IT NOW!’s vision is to make a similar dramatic and radical shift in the way we deal with sexual abuse of children.

Joan Tabachnick has worked for the past eight years educating the public about STOP IT NOW! and its programs. Readers can reach her at STOP IT NOW! at P.O. Box 495, Haydenville, MA 01060 or at 413/268-3096. The toll free STOP IT NOW! help line is 888-PREVENT (888/773-8368).

—Editor

A SIECUS Annotated Bibliography

Sexual relationships should be consensual between partners who are developmentally, physically, and emotionally capable of understanding the interaction. Coerced and exploitative sexual acts and behaviors such as rape, incest, sexual relations between adults and children, sexual abuse, and sexual harassment are always reprehensible. There should be information and education programs to prevent such acts, laws to punish those who perpetrate such acts, treatment programs to help survivors and offenders, and research to increase understanding of the causes and effects of sexual exploitation.

This annotated bibliography presents a cross section of available resources on sexual abuse. Readers are encouraged to seek additional resources in bookstores and libraries as well as by contacting the organizations listed at the end of this bibliography. In addition, readers can refer to the SIECUS bibliography *Child Sexual Abuse: Prevention, Education, and Treatment* (1995) on our Web site.

All of the books listed in this bibliography are available for use at the Mary S. Calderone Library. For those interested in purchasing any of the resource materials, each annotation contains contact and price information (not including shipping and handling). SIECUS sells and distributes only its own materials.

Copies of this bibliography are available at no charge on the SIECUS Web site and for purchase from the SIECUS Publications Department for \$3 each. SIECUS' address is 130 West 42nd Street, Suite 350, New York, NY 10036-7802. Phone: 212/819-9770. Fax: 212/819-9776. E-mail: siecus@siecus.org. Web site: <http://www.siecus.org>.

This bibliography was compiled by Amy Levine, M.A., SIECUS librarian; Darlene Torres, library assistant; and Dr. Mathieu Heemelaar.

GENERAL RESOURCES

Because There Is a Way to Prevent Child Sexual Abuse: Facts about Abuse and Those That Might Commit It

Joan Tabachnick, Editor

This booklet includes such topics as "Why Do We Need to Know About Sexual Abusers?," "What Exactly Is Child Sexual Abuse?," "What Can You Do?," "Community Notification and You," "Checklists: Warning Signs About Child Sexual Abuse." National resources are also included.

1998; \$0.50; *The Safer Society Press, P.O. Box 340, Brandon, VT 05733-0340; Phone: 802/247-3132; Fax: 802/247-4233; Web site: <http://www.safersociety.org>*

The Last Secret: Daughters Sexually Abused by Mothers

Bobbie Rosencrans, M.S.W.

This book presents data from 93 women who were sexually abused by their mothers and comparative data from a small sample of men who were abused by their mothers. Topics include "The Research: Concepts,

Assumptions, and Procedure," "The Survivors and Their Families," "Unspeakable Acts: The Nature of the Abuse," "The Effects of Sexual Abuse by Mothers," "Daughter's Response to the Abuse," and "Confrontation, Resolution, and Separation."

1997; \$20; ISBN 1884444369; *The Safer Society Press, P.O. Box 340, Brandon, VT 05733-0340; Phone: 802/247-3132; Fax: 802/247-4233; Web site: <http://www.safersociety.org>*

A Mother's Nightmare—Incest: A Practical Legal Guide for Parents and Professionals

John E. B. Myers

This book provides information about incest for parents of children who have been abused as well as for the professionals who work with them. Topics include "Essential Information About Child Sexual Abuse," "A Mother's Allies: The Legal System, A Good Lawyer, Mental Health Professionals," "Detailed Discussion of the Criminal Justice System, Family Court, Child Protective Services, and Juvenile Court," "Proving Child Sexual Abuse in Court: Overcoming Obstacles and Protecting Your Child," and "Summing It All Up: Plan for Victory, Prepare for Defeat."

This book is dedicated to protective parents. 1997; \$31; ISBN 0761910581; *SAGE Publications, 2455 Teller Road, Thousand Oaks, CA 91320; Phone: 805/499-0721; Fax: 805/499-0871; Web site: <http://www.sagepub.com>*

Rape of the Innocent: Understanding and Preventing Child Sexual Abuse

Juliann Whetsell-Mitchell, Ph.D.

This book is intended for anyone interested in child sexual abuse prevention. It provides research, information about child development, and guidelines that address prevention. Chapters include "Indicators of Child Sexual Abuse: Children At Risk," "Sexual Abuser Profiles," "The Hows and Whys of Victimization," "Development of the Child: Origins of the Self," "Prevention Programs for Preschoolers, Primary Graders, and Adolescents," "Child Sexual Abuse and Pornography," "Minority Children," and "Children with Special Needs."

1995; \$36.95; ISBN 1560323949; *Taylor & Francis, 7625 Empire Drive, Florence, KY 41042; Phone: 800/821-8312; Fax: 800/248-4724; Web site: <http://www.taylorandfrancis.com>*

**Sexual Abuse in America:
Epidemic of the 21st Century**

*Robert E. Freeman-Longo
and Gerald T. Blanchard*

This book addresses the problem of sexual abuse as a public-health epidemic and offers guidelines that can help Americans prevent child sexual abuse from recurring. Chapters include "Understanding Sexual Abuse and the Abusers," "The Politics of Sexual Abuse Prevention," "Experiencing and Overcoming Sexual Abuse," and "Current Strategies for Sexual Abuse Prevention." 1998; \$20; ISBN 1884444458; *The Safer Society Press, P.O. Box 340, Brandon, VT 05733-0340; Phone: 802/247-3132; Fax: 802/247-4233; Web site: <http://www.safersociety.org>*

**Sexual Abuse of Children
and Adolescents: A Preventive
Guide for Parents, Teachers
and Counselors**

William E. Prendergast, Ph.D.

This book is intended for parents, teachers, and counselors to help them prevent sexual abuse of children and adolescents. It includes information about the victimizer, the needs and reasoning of children and adolescents, and the mistakes that parents, teachers, religious leaders, and counselors make. It also includes a parent's checklist, a glossary, and an index. 1996; \$29.95; ISBN 0826408923; *Publisher Resources, Inc., 1224 Heil Quaker Boulevard, LaVergne, TN 37086; Phone: 800/937-5557; Fax: 800/774-6733; Web site: <http://www.continuum-books.com>*

**Understanding Child
Molesters: Taking Charge**

Eric Leberg

This book, written both for professionals and nonprofessionals, serves as a guide to protect children from molestation and includes information on the criminal justice system, criminal history records, and legal and ethical means of obtaining information about offenders.

1997; \$31; ISBN 0761901876; *SAGE Publications, 2455 Teller Road, Thousand Oaks, CA 91320; Phone: 805/499-0721; Fax: 805-499-0871; Web site: <http://www.sagepub.com>*

**RESOURCES
FOR PROFESSIONALS**

**Art Therapy with
Sexual Abuse Survivors**

Stephanie L. Brooke

This book discusses art therapy as part of treatment for individuals who have suffered trauma as a result of sexual exploitation or abuse. It includes an art therapy assessment, graphic indicators of abuse, traumatic memories, and legal issues. 1997; \$26.95; ISBN 0398068062; *Charles C. Thomas Publishers, Ltd., P.O. Box 19265, Springfield, IL 62794; Phone: 800/258-8980; Fax: 217/789-9130; Web site: <http://www.ccthomas.com>*

**Assessing Sexual Abuse: A
Resource Guide for Practitioners**

*Robert Prentky
and Stacey Bird Edmunds*

This guide is a compilation of psychometric instruments that practitioners can use to assess sexual offenders as well as those who have been abused. Categories include "General Assessment of Personality and Psychiatric Symptoms in Adolescents and Adults," "General Psychological and Behavioral Assessment in Children and Adolescents," "Assessing Traumatic Victimization in Children, Adolescents, and Adults," "Assessing Distorted Attitudes About Women, Children, and Sexuality," and "Assessing Normal and Paraphilic Sexual Fantasies and Behaviors." Each instrument includes a description, author's biography, and other relevant information. 1997; \$25; ISBN 1884444415; *The Safer Society Press, P.O. Box 340, Brandon, VT 05733-0340; Phone: 802/247-3132; Fax: 802/247-4233; Web site: <http://www.safersociety.org>*

**Betrayed As Boys:
Psychodynamic Treatment
of Sexually Abused Men**

Richard B. Gartner

This book studies the impact of childhood sexual abuse on adult males. It provides strategies to help therapists meet the needs of their clients. Chapters include "The Familial and Cultural Context of Abuse," "The Effect of Chronic Boundary Violations," and "The Patient-Therapist Dyad." 1999; \$42; ISBN 1572304677; *The Guilford Press, 72 Spring Street, New York, NY 10012; Phone: 212/431-9800; Fax: 212/966-6708; Web site: <http://www.guilford.com>*

**Breaking the Silence: Group
Therapy for Childhood Sexual
Abuse: A Practitioner's Manual**

Judith A. Margolin

This book presents a 15-session psycho-educational group therapy program for adult survivors of sexual abuse. Key therapy issues include trust, sexuality and disclosure, family dynamics, emotional expression, male survivors, transference, and countertransference. 1999; \$49.95; ISBN 0789002000; *The Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1580; Phone: 800/342-9678; Fax: 800/895-0582; Web site: <http://www.haworthpressinc.com>*

**Childhood Abuse: Effects
on Clinicians' Personal
and Professional Lives**

Helene Jackson and Ronald Nuttall

This book identifies how gender, age, discipline, individual core belief systems, and case factors can affect a person's perception of sexual abuse allegations. It includes a survey designed to heighten a reader's awareness of his or her potential for bias toward sex offenders. 1997; \$37; ISBN 080394781; *SAGE Publications, 2455 Teller Road, Thousand Oaks, CA 91320; Phone: 805/499-0721; Fax: 805/499-0871; Web site: <http://www.sagepub.com>*

**Cultural Diversity
in Sexual Abuser Treatment:
Issues and Approaches**

Alvin D. Lewis

This book includes discussions by 18 professionals about their experiences treating culturally diverse populations and about the importance of cultural awareness in the treatment process. Topics include “Working with Culturally Diverse Populations,” “A Perspective on Sex Offender Treatment for Native Americans,” “Sexual Offending Behavior in the African-American Family,” “Intervention with Hispanic Sexual Abusers,” and “Assessment and Treatment of Spanish-Speaking Sexual Abusers: Special Considerations.”

1999; \$22; ISBN 1884444490; *The Safer Society Press, P. O. Box 340, Brandon, VT 05733-0340; Phone: 802/247-3132; Fax: 802/247-4233; Web site: <http://www.safersociety.org>*

**Female Sexual Abusers:
Three Views**

*Patricia A. Davin, Julia C.R. Hislop,
and Teresa Dunbar*

This book is one of the few resources that provides information on female sexual offenders and the reasons they abuse. Each author addresses one of the three parts of the book: “Secrets Revealed: A Study of Female Sex Offenders,” “Female Child Molesters,” and “Women Who Sexually Molest Female Children.”

1999; \$22; ISBN 1884444547; *The Safer Society Press, P.O. Box 340, Brandon, VT 05733-0340; Phone: 802/247-3132; Fax: 802/247-4233; Web site: <http://www.safersociety.org>*

**From Victims to Survivors:
Reclaimed Voices of
Women Sexually Abused
in Childhood by Females**

Juliann Mitchell, Ph.D., and Jill Morse

This book interweaves narrative, research, and theory. In the process, it tells the story of 80 female survivors of sexual abuse in an

effort to raise awareness among professionals treating women who were sexually abused by female perpetrators. Chapters include “Abusers and Survivors,” “Survivor’s Sexuality and Identity Development,” and “Female Perpetrators.”

1998; \$26.95; ISBN 1560325704; *Taylor & Francis, 7625 Empire Drive, Florence, KY 41042; Phone: 800/821-8312; Fax: 800/248-4724; Web site: <http://www.taylorandfrancis.com>*

**Healing for Adult Survivors
of Childhood Sexual Abuse:
A Twelve Session
Group Treatment
Program**

Bonnie Collins, Ed.M., and Kathryn Marsh

This is a therapist’s manual for a 12-session group therapy program that treats clients whose problems stem from the sexual abuse they experienced as children. The manual addresses issues of social isolation, intimacy, and mistrust. It includes sessions on breaking the silence of sexual abuse, understanding and releasing the shame of sexual abuse, expressing repressed feelings, and confronting the abuser.

1998; \$24.95, \$9.95/reproducible worksheet; ISBN 1570251657; *Whole Person Associates, 210 West Michigan, Duluth, MN 55802; Phone: 218/727-0500; Fax: 218/727-0505; Web site: <http://www.wholeperson.com>*

**I Never Told Anyone This
Before: Managing the Initial
Disclosure of Sexual Abuse
Recollections**

Janice A. Gasker

This book is designed to help professionals work with clients who disclose recollections of sexual abuse. It addresses theoretical and disclosure issues as well as clinical techniques.

1999; \$24.95; ISBN 0789004623; *The Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1580; Phone: 800/342-9678; Fax: 800/895-0582; Web site: <http://www.haworthpressinc.com>*

**Impact: Working
with Sexual Abusers**

Stacey Bird Edmunds, Editor

This book provides data and testimony on the effects that working with sexual offenders has on providers. Chapters include “The Personal Impact of Working with Sex Offenders,” “Personal and Interpersonal Issues for Staff Working With Sexually Abusive Youth,” “Impact on Clinicians: Stressors and Providers of Sex-Offender Treatment,” and “Increasing Efficacy and Eliminating Burnout In Sex-Offender Treatment.”

1997; \$20; ISBN 1884444423; *The Safer Society Press, P.O. Box 340, Brandon, VT 05733-0340; Phone: 802/247-3132; Fax: 802/247-4233; Web site: <http://www.safersociety.org>*

**Juvenile Sexual Offending:
Causes, Consequences,
and Correction**

Gail Ryan and Sandy Lane, Editors

This book, which is for clinicians and graduate students, provides an in-depth look at assessment and treatment issues related to juvenile sexual abusers. Topics include “The Problem of Juvenile Sexual Offending,” “Theoretical Perspectives,” “Consequences of Sexual Abuse,” “Intervention in Juvenile Sexual Offending,” “Treatment of Sexually Abusive Youth,” “Prevention,” and “Working with Sexual Abuse.”

1997; \$43.95; ISBN 0787-08436; *Jossey-Bass Publisher, Inc., 350 Sansome Street, Fifth Floor, San Francisco, CA 94104; Phone: 800/956-7739; Fax: 800/605-2665; Web site: <http://www.JosseyBass.com>*

**The Memory Go Round of
Sexual Abuse: Identifying
and Treating Survivors**

William E. Prendergast, Ph.D.

This book is a guide for professionals to help them identify and treat perpetrators and victims of sexual abuse. It also discusses treatment techniques and illustrates them with pertinent case studies. Chapters

include "Distinguishing Characteristics of Survivors of Sexual Abuse," "The Offender," "Behavioral Effects of Sexual Trauma," "Pre-Treatment Considerations," and "Specialized Treatment Techniques in Incest and Long-Term Child Sexual Abuse."

1993; \$24.95; ISBN 1560243880; The Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1580; Phone: 800/342-9678; Fax: 800/895-0582; Web site: <http://www.haworthpressinc.com>

Recollections of Sexual Abuse, Treatment Principles, and Guidelines

Christine A. Courtois

This book provides clinicians with information about the controversy surrounding delayed or repressed memories of sexual abuse. It also includes treatment principles and guidelines for working with these issues. Topics include "An Overview of the Recovered Memory/False Memory Controversy," "Child Sexual Abuse and Memory," "Evolving Standards of Practice and the Standard of Care: Philosophy and Principles of Practice," and "Clinical Guidelines and Risk Management for Working with Memory Issues."

1999; \$45; ISBN 0393702812; W.W. Norton & Company, National Book Company, 800 Keystone Industrial Park, Scranton, PA 18512; Phone: 800/233-4830; Fax: 800/458-6515; Web site: <http://www.wwnorton.com>

Sexually Aggressive Children: Coming to Understand Them

Sharon K. Araji

This book provides a comprehensive overview of sexual abuse perpetrated by children 12 years of age and younger. The author explores the familial, extrafamilial, and situational factors that can contribute to various types of sexual abuse by young children. Topics include "Distinguishing Normal From Sexually Abusive and Aggressive Behaviors," "Motives for Acting Sexually Aggressive," "How Laws View Children," and "Abused and Sexually Aggressive Children."

1997; \$32; ISBN 0803951760; SAGE Publications, 2455 Teller Road, Thousand Oaks, CA 91320; Phone: 805/499-0721; Fax: 805/499-0871; Web site: <http://www.sagepub.com>

Sibling Abuse Trauma: Assessment and Intervention Strategies for Children, Families, and Adults

John V. Caffaro and Allison Conn-Caffaro

This book provides information on abuse of siblings by siblings. It describes the context in which abuse takes place as well as subsequent assessment and intervention with children, families, and adult survivors. Topics include "The Context of Sibling Development and Abuse," "Sibling Incest and Assault," and "Assessment and Intervention with Children, Families, and Adult Survivors." Appendixes offer interview protocols and questionnaires.

1998; \$69.95; ISBN 0789060078; The Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1580; Phone: 800/342-9678; Fax: 800/895-0582; Web site: <http://www.haworthpressinc.com>

Supervision of the Sex Offender

Georgia Cumming and Maureen Buell

This book describes techniques and methods that will help professionals determine the best treatment for their sexual abuser clients. Chapters include "Pre-Sentence—Investigation Report," "Relapse Prevention As a Supervision Strategy," "Confidentiality and Public Discourse," "Theories of Sexual Deviance," and "Sex Offender Treatment."

1997; \$25; ISBN 1884444407; The Safer Society Press, P.O. Box 340, Brandon, VT 05733-0340; Phone: 802/247-3132; Fax: 802/247-4233; Web site: <http://www.saferociety.org>

Therapist's Guide for Maintaining Change: Relapse Prevention for Adult Male Perpetrators of Child Sexual Abuse

Hillary Eldridge

This guide is designed for therapists using a three-phase program for sex offenders titled *Maintaining Change: Relapse Prevention*. It provides guidelines, suggestions, and exercise descriptions to use in each phase. The therapy program is for offenders assessed as having repetitive abuse patterns. The guide is designed for use with the program manual.

1998; \$69/guide and manual; ISBN 0761911308/guide; ISBN 0761911065/manual; SAGE Publications, 2455 Teller Road, Thousand Oaks, CA 91320; Phone: 805/499-0721; Fax: 805/499-0871; Web site: <http://www.sagepub.com>

Transforming the Pain: A Workbook on Vicarious Traumatization

Karen W. Saakvitne, Ph.D., and Laurie Anne Pearlman, Ph.D.

This workbook discusses vicarious traumatization (VT), the effect that working with survivors of traumatic events has on the lives of professionals. It includes a self-assessment, worksheets, guidelines, and exercises for those who are experiencing such traumatization as a result of their work.

1996; \$17; ISBN 0393702332; W.W. Norton and Company, National Book Company, 800 Keystone Industrial Park, Scranton, PA 18512; Phone: 800/233-4830; Fax: 800/458-6515; Web site: <http://www.wwnorton.com>

Transforming Trauma: A Guide to Understanding and Treating Adult Survivors of Child Sexual Abuse

Anna C. Salter

This book addresses the problems of adult survivors of child sexual abuse. Chapters include "How Do We Know About Sexual Offenders and What Does It Mean?," "Sadistic Versus Nonsadistic Offenders and Their Effects on Victims," and "Links Between Offenders and Victims."

1995; \$69; ISBN 0803955081; SAGE Publications, 2455 Teller Road, Thousand Oaks, CA 91320; Phone: 805/499-0721; Fax: 805/499-0871; Web site: <http://www.sagepub.com>

Treating Children with Sexually Abusive Behavior Problems: Guidelines for Child and Parent Intervention

Jan Ellen Burton, Ph.D.,
and Lucinda A. Rasmussen, Ph.D.,
with Julie Bradshaw,
Barbara J. Christopherson,
and Steven C. Huke, M.S.

This book for professionals presents an integrated treatment approach that focuses on children who display harmful sexual behavior. Chapters include "Sexually Abusive Behavior Problems: Definitions and Current Knowledge," "A Treatment Approach," "Integrated Treatment Planning," "Parallel Group Treatment," and "Treatment Exercises."

1998; \$24.95; ISBN 0789004739; The Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1580; Phone: 800/342-9678; Fax: 800/895-0582; Web site: <http://www.haworthpressinc.com>

Treating Sexually Abused Boys: A Practical Guide for Therapists & Counselors

Lisa Camino

This book, which focuses on treating sexually abused boys between seven and 17 years of age, offers options for both individual and group therapy. It contains 50 activities designed to help these abused boys regain a sense of power as they overcome feelings of helplessness, fear, and vulnerability. 2000; \$34.95; ISBN 0787947938; Jossey-Bass Publishing, Inc., 350 Sansome Street, Fifth Floor, San Francisco, CA 94104; Phone: 800/956-7739; Fax: 800/605-2665; Web site: www.JosseyBass.com

Women Survivors of Childhood Sexual Abuse: Healing through Group Work: Beyond Survival

Judy Chew, Ph.D.

This book is a guide for professionals who work with sexually abused women. It offers practical approaches to conduct a 13-session group that will address such subjects as "Boundaries: The Lines Between Self and Others," "Building Strength: Cultivating Resourcefulness," "Relationships and Trust: For the Health of It," and "Celebration of Life: Cultivating a Future and Closing Ritual."

1998; \$18.95; ISBN 0789002841; The Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1580; Phone: 800/342-9678; Fax: 800/895-0582; Web site: <http://www.haworthpressinc.com>

Working with Sexually Abusive Adolescents

Masud S. Hoghugh, Surya R. Bhate,
and Finlay Graham, Editors

This book provides an overview of the key factors involved in working with adolescent sex offenders. Chapters include "Sexual Abuse by Adolescents," "Cognitive-Based Practice with Sexually Abused Adolescents," "Relapse Prevention," and "Professional Reports on Abusive Adolescents."

1997; \$26.50; ISBN 080397759; SAGE Publications, 2455 Teller Road, Thousand Oaks, CA 91320; Phone: 805/499-0721; Fax: 805/499-0871; Web site: <http://www.sagepub.com>

rienced the trauma of child sexual abuse, it specifically addresses how they learned to cope with the aftermath of the abuse. Topics include "Why Me?," "Buried Feelings," "Silent Ways of Telling," and "Why Didn't I Tell?"

1993; \$12.95; ISBN 1555610579; Fisher Books, 5225 West Massingale, Tucson, AZ 85743; Phone: 800/225-1514; Fax: 800/324-3791; Web site: <http://www.fisherbooks.com>

The Sexual Healing Journey

Wendy Maltz

This book is a guide to help sexual abuse victims overcome the negative impact on their sexuality by such abuse. Filled with first-person accounts of men and women at every stage of sexual healing, it offers exercises and techniques for survivors as well as their partners. A revised edition is scheduled for publication in early 2001.

1992; \$14; ISBN 0060921552; Harper Collins, 1000 Keystone Industrial Park, Scranton, PA 18512; Phone: 800/242-7737; Fax: 212/822-4090; Web site: <http://www.harpercollins.com>

The Survivor's Guide to Sex: How to Have An Empowered Sex Life after Child Sexual Abuse

Staci Haines

This guide for female sexual abuse survivors offers sex-positive tips to help them build fulfilling sexual lives. The author provides practical exercises, a bibliography, and resources. Male survivors will also find the tools and resources helpful in their recovery.

1999; \$21.95; ISBN 157344795; Cleis Press, P.O. Box 14684, San Francisco CA 94114; Phone: 800/780-2279; Fax: 415/575-4705; Web site: <http://www.cleispress.com>

RESOURCES FOR SURVIVORS

Breaking Free: A Self-Help Guide for Adults Who Were Sexually Abused As Children

Carolyn Ainscough and Kay Toon

This book offers techniques for dealing with and overcoming the effects of child sexual abuse. Told by adults who have expe-

**Triumph Over Darkness:
Understanding
and Healing the
Trauma of Childhood
Sexual Abuse**

Wendy Ann Wood, M.A.

This book is a collection of prose written by male and female sexual abuse survivors. It provides therapeutic insights on incest, rape, abuse, and the recovery process. Chapters include "Seeing the Darkness Before the Light," "Moving Beyond the Darkness," "Voices of Ritual Abuse Survivors," "Voices of Male Survivors," "Voices of Multiplicity," and "The Healing Process." 1993; \$12.95; ISBN 0941831868; *Beyond Words Publishing, Inc., 20827 N.W. Cornell Road, Suite 500, Hillsboro, OR 97124; Phone: 800/284-9673; Fax: 503/531-8773; Web site: <http://www.beyondwords.com>*

**RESOURCES
FOR CHILDREN**

Annie and Andy

Rape and Abuse Crisis Center
of Fargo-Moorehead (ND)

These two booklets—*Annie* and *Andy*—are designed to encourage children four to eight years of age to explore their feelings about confusing touch. Each tells the story of a child who is afraid to tell anyone that he or she was touched in an inappropriate way. Both children eventually decide to tell someone. 1992; \$2.50 each; ISBN 0914633031/*Annie*; ISBN 0914633198/*Andy*; *Red Flag Green Flag Resources, Rape and Abuse Crisis Center of Fargo-Moorehead, P.O. Box 2984, Fargo, ND 58108-2984; Phone: 800/627-3675; Fax: 888/237-5332; Web site: <http://www.redflaggreenflag.com>*

**Back on Track: Boys Dealing
with Sexual Abuse**

Leslie Bailey Wright and Mindy Loiselle

This book for boys 10 years of age and older is designed to help them recognize

their feelings, deal with their fears, and heal from sexual abuse. Exercises and blank pages are provided for creative expression. Chapters include "So Where Do I Start," "Why Most Kids Don't Tell (And What Happens When They Do)," "What If It Didn't Feel Like Abuse," "Sorting Out Feelings," and "Staying on Track." 1997; \$14; ISBN 1884444431; *The Safer Society Press, P.O. Box 340, Brandon, VT 05733-0340; Phone: 802/247-3132; Fax: 802/247-4233; Web site: <http://www.saferociety.org>*

**Bobbie's Story: A Guide for
Foster Parents and Bobbie's
Story: A Feelings Workbook**

Brennan Lynn Mars
with illustrations by D.H. Tsai

This guide provides adults with information to help them talk to their children about sexual abuse. The accompanying workbook provides space for children to express their feelings through writing and drawing exercises. Targeted to children five to 10 years of age, both the guide and the workbook tell the story of a sexually abused boy who goes to live with foster parents. 1999; \$8.95; *A Guide for Foster Parents, ISBN 0878687017; \$5.95, A Feelings Workbook, ISBN 0878687351; CWLA, P.O. Box 2019, Annapolis Junction, MD 20701-2019; Phone: 800/407-6273; Fax: 301/206-9789; Web site: <http://www.cwlapmds.com>*

**Feeling Good Again:
A Workbook for Children Who
Have Been Sexually Abused**

Burt Wasserman

This workbook is intended to help therapists and parents teach sexually abused children six to 12 years of age about healthy sexuality. It is also helpful for sexually abused teenagers and adults. *A Guide for Parents & Therapists of Sexually Abused Children* is also available to use in conjunction with the workbook. 1998; \$16/workbook, \$8/guide; ISBN 1884444512/workbook, ISBN 1884444520/guide; *The Safer Society Press, P.O. Box 340,*

Brandon, VT 05733-0340; Phone: 802/247-3132; Fax: 802/247-4233; Web site: <http://www.saferociety.org>

**My Body Is Mine, My Feelings
Are Mine: A Storybook About
Body Safety for Young Children**

Susan Hoke

This storybook introduces the basic concept of body safety to children through the use of dialogue and illustrations. It includes a "Body Rules Safety Quiz" as well as an adult guidebook for parents, caretakers, counselors, relatives, clergy, and educators. 1995; \$18.95; ISBN 1882732243; *Childwork/Childplay, 135 DuPont Street, P. O. Box 760, Plainview, NY 11803-0760; Phone: 800/962-1141; Fax: 800/262-1886; Web site: <http://www.childwork.com>*

**Shining Through: Pulling It
Together after Sexual Abuse**

Mindy Loiselle and Leslie Bailey Wright

This book is intended to help young women 10 years of age and older heal from sexual abuse. Chapters include "Something Happened," "Why You Told (And Sometimes Regret It)," "What About the Rest of My Life: Relationships," and "What You Need to Heal." Blank pages are provided for creative expression. This book is also helpful for boys. 1997; \$14; ISBN 1884444393; *The Safer Society Press, P.O. Box 340, Brandon, VT 05733-0340; Phone: 802/247-3132; Fax: 802/247-4233; Web site: <http://www.saferociety.org>*

**STOP! Just for Kids:
For Kids with Sexual Touching
Problems, By Kids with
Sexual Touching Problems**

Adapted by Terri Allred, M.T.S.,
and Gary Burns, M.S.

This book is based on a resource written by a group of boys 10 to 13 years of age in a residential treatment program for young sexual offenders. It can be used as a tool for therapists to use with their young male and female clients who have abused. Chapters include

“The First Big Step: Honesty!,” “What Happened to Us and What We Did,” “Sexual Touching Problems,” “Sexual Offense Cycle,” and “Making Good Choices.”

1997; \$15; ISBN 1884444377; *The Safer Society Press*, P.O. Box 340, Brandon, VT 05733-0340; Phone: 802/247-3132; Fax: 802/247-4233; Web site: <http://www.safersociety.org>

Tell It Like It Is: A Resource Guide for Youth in Treatment

Alice Tallmadge with Gayle Forster

This resource is for adolescent sex offenders entering or continuing a treatment program. Using quotes from interviews with other adolescent offenders, it consists of 13 sections with questions at the end of each chapter. Topics include treatment, feelings, the abuse cycle, fantasies, and victims.

1998; \$15; ISBN 1884444466; *The Safer Society Press*, P.O. Box 340, Brandon, VT 05733-0340; Phone: 802/247-3132; Fax: 802/247-4233; Web site: <http://www.safersociety.org>

CURRICULA

Child Sexual Abuse: A Solution

This curriculum, which is intended for kindergarten through sixth grade, uses the story of the cartoon character Chester the Cat and his human friends to teach about touching. It consists of six videos—one for kindergarten through first grade, one for grades two through four, one for grades five and six, one for parents, and two for teachers. 1985; \$249; *The James Stanfield Publishing Co., Inc.*, P.O. Box 41058, Santa Barbara, CA 93140; Phone: 800/421-6534; Fax: 805/897-1187; Web site: <http://www.stanfield.com>

Child Sexual Abuse Curriculum for the Developmentally Disabled

Sol R. Rappaport, Sandra A. Burkhardt,
and Anthony F. Rotatori

This curriculum is divided into five parts: “Understanding Child Sexual Abuse of the Developmentally Disabled,” “The Treatment of Sexually Abused Children,” “Sexual Abuse: The Emotional and Behavioral Sequelae,” “Factors That Mediate the Sequelae of Child Sexual Abuse,” and “The Rappaport Curriculum for the Prevention of Child Sexual Abuse in Children with Developmental Disabilities.” The last chapter includes 10 lessons on sexuality and sexual abuse prevention for children who are in the mild range of mental retardation. An appendix is included, which parents and caregivers can review with children.

1997; \$32.95; ISBN 0398067341; *Charles C. Thomas Publishers, Ltd.*, P.O. Box 19265, Springfield, IL 62794; Phone: 800/258-8980; Fax: 217/789-9130; Web site: www.ccthomas.com

Circles II Stop Abuse

Marilyn P. Champagne, R.N.,
and Leslie Walker-Hirsch, M.Ed.

This curriculum is for people with mild to moderate developmental disabilities. It consists of two videos with 12 stories that teach students how to avoid exploitative situations. Part I, titled “Recognizing and Reacting to Sexual Exploitation,” encourages student assertiveness and teaches students how to recognize and react to sexual exploitation. Part II, titled “Learning Appropriate Protective Behaviors,” discusses the potential for sexual abuse from acquaintances and strangers, and teaches students how to deal with unwanted advances. A teacher’s guide is included.

1986; \$399; *The James Stanfield Publishing Co., Inc.*, P.O. Box 41058, Santa Barbara, CA 93140; Phone: 800/421-6534; Fax: 805/897-1187; Web site: <http://www.stanfield.com>

LifeFacts 2 Sexual Abuse Prevention

This curriculum, which includes 17 lessons for adolescents and adults with mild-to-moderate developmental disabilities, teaches sexual abuse recognition, prevention, and protection strategies. The package provides pictures, worksheets, and slides.

1990; \$199; *The James Stanfield Publishing Co., Inc.*, P.O. Box 41058, Santa Barbara, CA 93140; Phone: 800/421-6534; Fax: 805/897-1187; Web site: <http://www.stanfield.com>

“No-Go-Tell” Protection Curriculum for Young Children with Special Needs

The James Stanfield Publishing Company

This curriculum, which is designed for children in preschool and the early elementary grades, focuses on teaching assertiveness skills and encouraging communication with caring adults. The curriculum includes 55 picture panels, male and female anatomically correct dolls, poster cards, a parent’s and teacher’s guide, and a postinstruction assessment test. The curriculum is intended to be used alone or with an existing safety program.

1991; \$299 without dolls, \$399 with dolls; *James Stanfield Publishing Co.*, P.O. Box 41058, Santa Barbara, CA 93140; Phone: 800/421-6534; Fax: 805/897-1187; Web site: <http://www.stanfield.com>

Preventing Child Sexual Abuse Ages 5–8,

Kathryn Goering Reid
Ages 9-12,

Kathryn Goering Reid with Marie M. Fortune

These two curricula provide information about child sexual abuse prevention in the context of a Christian education program. The curriculum for children five through eight years of age consists of 10 sessions; the curriculum for children nine through 12 years of age consists of 13 sessions. 1994; Ages 5-8: \$11.95; 1989; Ages 9-12: \$9.95; *Pilgrim Press*, 230 Sheldon Road, Berea,

OH 44017; Phone: 800/537-3394; Fax: 216/736-2206; Web site: <http://www.ucc.org>

**Preventing Sexual Abuse:
Activities and Strategies
for Those Working with
Children and Adolescents**

Carol A. Plummer

This sexual abuse-prevention curriculum is divided into two sections. The first is a three- or five-day presentation for grades K through six, which is also adaptable for the developmentally disabled. The second is a one-, three-, or five-day presentation for grades seven through 12. The curriculum also provides information about involving parents and making the program work. Also included are guidelines for instructors and an appendix.
1997; \$23.95; ISBN 1556911149; Learning Publications, Inc., P.O. Box 1338, Holmes Beach, FL 34218; Phone: 800/222-1525; Fax: 941/778-6818; Web site: <http://www.learningpublications.com>

**Red Flag Green Flag ABCs:
Personal Safety for
Pre-Kindergarten Age Children**

Rape and Abuse Crisis Center
of Fargo-Moorehead (ND)

This curriculum, which is for children three to five years of age, uses the letters of the alphabet to teach them about "OK" and "Not OK" touches as well as "permission," "stranger danger," "secret touches," and general safety rules. The curriculum also teaches children to recognize who can help them and to know where they can go for help when they feel threatened. Materials are also available in Spanish.
1997; \$14.95, *facilitator's guide*; ISBN 0914633317; 1997; \$3.25, *coloring book*; ISBN 0914633236; 1997; \$29.95, *video and video guide*; Red Flag Green Flag Resources, Rape and Abuse Crisis Center of Fargo-Moorehead, P. O. Box 2984, Fargo, ND 58108-2984; Phone: 800/627-3675; Fax: 888/237-5332; Web site: <http://www.redflaggreenflag.com>

**Red Flag Green
Flag People:
A Personal Safety
Program: Materials for Early
Elementary Age Children**

Rape and Abuse Crisis Center
of Fargo-Moorehead (ND)

This curriculum, which is for children five to eight years of age, is designed to teach them about different kinds of touch, how to recognize potentially harmful situations, and how to use assertive responses. Instructors can implement the curriculum in three one-hour periods. The workbook is also available in Spanish.
2000; \$10.95, *facilitator's guide*; ISBN 0914633120; 1995; \$3.25, *workbook*; ISBN 0914633104; 1996; \$1, *parent's guide*; ISBN 0914633244; 1996; \$4.95, *pre-test and post-test*; Red Flag Green Flag Resources, Rape and Abuse Crisis Center of Fargo-Moorehead, P. O. Box 2984, Fargo, ND 58108-2984; Phone: 800/627-3675; Fax: 888/237-5332; Web site: <http://www.redflaggreenflag.com>

**Red Flag Green
Flag People II:
A Sexual Abuse Prevention
Program: Materials for Older
Elementary Age Children**

Rape and Abuse Crisis Center
of Fargo-Moorehead (ND)

This curriculum, which is for children eight to 11 years of age, is designed to teach these children how to recognize abusive situations involving people they know and to tell a trusted adult who will listen. Instructors can implement the curriculum in two 45- to 60-minute sessions.
1994; \$14.95, *facilitator's guide*; ISBN 091463321X; 1994; \$3.25, *workbook*; ISBN 0914633201; Red Flag Green Flag Resources, Rape and Abuse Crisis Center of Fargo-Moorehead, P. O. Box 2984, Fargo, ND 58108-2984; Phone: 800/627-3675; Fax: 888/237-5332; Web site: <http://www.redflaggreenflag.com>

**Reducing Vulnerability:
Child Sexual Abuse,
Harassment, and
Abduction Prevention
Curriculum for Grades K-6**

Marjorie Fink, C.S.W.

This curriculum, which is for grades K through six, is organized into three units: "Child Sexual Abuse Prevention," "Teasing, Bullying, and Sexual Harassment Prevention," and "Child Abduction Prevention." This curriculum is designed to empower children with knowledge and skills to help them stop or avoid abuse. It is also designed to encourage children to turn to a trusted adult for help.
1998; \$24.98; ISBN 1556911246; Learning Publications, Inc., P.O. Box 1338, Holmes Beach, FL 34218; Phone: 800/222-1525; Fax: 941/778-6818; Web site: <http://www.learningpublications.com>

**Risking Connection:
A Training Curriculum
for Working with Survivors
of Childhood Abuse**

Karen W. Saakvitne, Ph.D., Sarah Gamble,
Ph.D., Laurie Anne Pearlman, Ph.D.,
and Beth Tabor Lev, Ph.D.

This curriculum is for professionals and para-professionals who work with sexual abuse survivors. It offers a theoretical framework to guide those who treat trauma and abuse survivors. It also describes specific intervention techniques to use with clients and discusses the needs of trauma workers. The curriculum consists of five modules: "Understanding Trauma," "Using Connections," "Keeping a Trauma Framework," "Working with Dissociation," "Vicarious Traumatization." Each module is appropriate for either a half- or full-day training.
2000; \$75; ISBN 188696808X; Sidran Traumatic Stress Foundation, 200 East Joppa Road, Suite 207, Baltimore, MD 21286; Phone: 888/825-8249; Fax: 410/337-0747; Web site: <http://www.sidran.org>

Sexual Abuse Prevention: A Course of Study for Teenagers— Revised and Updated

Rebecca Voelkel-Haugen and Marie M. Fortune

This six-session curriculum is designed to help teens distinguish between healthy sexuality and sexual abuse. Topics include sexual harassment, dating violence (including date rape), incest, sexually explicit materials, and abusive images found in popular media. The subjects are framed in terms of theology and ethics.

1996; \$8.95; *Pilgrim Press, 230 Sheldon Road, Berea, OH 44017; Phone: 800/537-3394; Fax: 216/736-2206; Web site: <http://www.ucc.org>*

Sexual, Physical, and Emotional Abuse in Out-of-Home Care: Prevention Skills for At-Risk Children

Toni Cavanagh Johnson, Ph.D., and Associates

This curriculum, which is intended for use in group, foster, and residential treatment settings, addresses sexually, physically, or emotionally offensive behaviors among children or between caregivers and children. It consists of 20 exercises covering such subjects as “Exploring Communication,” “Exploring Touch,” “Differentiating between Sexual Play and Sexual Abuse,” “Personal Space,” “Sexual Knowledge,” and “Prevention of Sexual Misuse or Abuse.”

1997; \$24.95; ISBN 0789001934; *The Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1580; Phone: 800/342-9678; Fax: 800/895-0582; Web site: <http://www.haworthpressinc.com>*

T is for Touching: Abuse Prevention Program for Kindergarten Age Children

Rape and Abuse Crisis Center of Fargo-Moorehead (ND)

This video is designed to teach abuse-prevention skills to groups of children five to six years of age. It consists of three six-

minute vignettes: “T is for Touching,” “H is for Helping,” and “P is for Prevention.” It teaches children to recognize appropriate and inappropriate touch; to say “no” to, and “get away” from abusive situations; and to identify and then “tell a helper.” A facilitator’s guide is enclosed.

1995; \$79.99; *Red Flag Green Flag Resources, Rape and Abuse Crisis Center of Fargo-Moorehead, P.O. Box 2984, Fargo, ND 58108-2984; Phone: 800/627-3675; Fax: 888/237-5332; Web site: <http://www.redflaggreenflag.com>*

Talking About Touching: A Personal Safety Curriculum, Grades 1–3

Ruth Harris, Ed.D., Diane Davis, M.A., and Andrea Mackey, Ed.M.

This curriculum, which is based on social-learning theory, consists of 14 lessons for first graders, 14 lessons for second graders, and 12 lessons for third graders. All units discuss personal safety, touching safety, and assertiveness and support. The curriculum consists of a teacher’s guide and lesson cards with photos to illustrate concepts. Also included are a book and audio cassette titled *Sam’s Story*, a poster, a resource that tells how Sam learned the “touching rule,” and a video titled *Willy Learns the Touching Rule*, and a video for parents titled *What Do I Say Now? How to Keep Your Child from Sexual Abuse*.

1996; \$195; *Committee for Children, 2203 Airport Way South, Suite 500, Seattle, WA 98134-2035; Phone: 800/634-4449; Fax: 206/343-1445*

Talking About Touching: Personal Safety for Preschoolers and Kindergartners

Ruth Harms, Ed.D.

This curriculum, based on social-learning theory consists of 14 lessons that teach children general safety. It specifically focuses on self-protection skills to reduce children’s vulnerability to sexual abuse. The curriculum consists of a teacher’s guide and

lesson cards with photos to illustrate concepts. Also included are a book and audio cassette titled *Sam’s Story*, a poster, a resource that tells how Sam learned the “touching rule,” and a video titled *Willy Learns the Touching Rule* and a video for parents titled *What Do I Say Now? How to Keep Your Child from Sexual Abuse*.

1996; \$250; *Committee for Children, 2203 Airport Way South, Suite 500, Seattle, WA 98134-2035; Phone: 800/634-4449; Fax: 206/343-1445*

When Children Abuse: Group Treatment Strategies for Children with Impulse Control Problems

Carolyn Cunningham and Kee MacFarlane

This book includes activities for children four to 12 years of age who are sexual abusers. It addresses self-esteem, problem solving, anger management, sexuality, victimization, and perpetration.

1996; \$28; ISBN 1884444237; *The Safer Society Press, P.O. Box 340, Brandon, VT 05733-0340; Phone: 802/247-3132; Fax: 802/247-4233; Web site: <http://www.saferociety.org>*

The Woodrow Project: A Sexual Abuse Prevention Curriculum for Persons with Developmental Disabilities

Rape and Abuse Crisis Center of Fargo-Moorehead (ND)

This curriculum, which is intended for young adults 15 to 25 years of age with a mild to moderate range of mental retardation, includes eight 25- to 30-minute sessions on sexual abuse-prevention skills.

1986; \$99.95; ISBN 0914633112; *Red Flag Green Flag Resources, Rape and Abuse Crisis Center of Fargo-Moorehead, P.O. Box 2984, Fargo, ND 58108-2984; Phone: 800/627-3675; Fax: 888/237-5332; Web site: <http://www.redflaggreenflag.com>*

RESOURCES

ETR Associates

P.O. Box 1830, Santa Cruz, CA 95061-1830; Phone: 800/321-4407; Fax: 800/435-8433; Web site: <http://www.etr.org>

Channing L. Bete Company, Inc.

200 State Road, South Deerfield, MA 01373; Phone: 800/628-7733; Fax: 800/499-6464; Web site: <http://www.channing-bete.com>

Positive Promotions

40-01 168th Street, Flushing NY 11358; Phone: 800/635-2666; Fax: 800/635-2329

JOURNALS

Journal of Child Sexual Abuse

This is a quarterly journal focusing on research, treatment, and program innovations for victims, survivors, and offenders of child sexual abuse.

\$175; *The Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1580; Phone: 800/342-9678; Fax: 800/895-0582; Web site: <http://www.haworthpressinc.com>*

Sexual Abuse: A Journal of Research and Treatment

This quarterly journal focuses on clinical and theoretical aspects of the treatment of sexual abusers.

\$52; *Kluwer/Plenum Academic Publishers, 233 Spring Street, New York, NY 10013; Phone: 212/620-8472; Fax: 212/807-1047; Web site: <http://www.wkap.nl.com>*

ORGANIZATIONS

American Association of Sex Educators, Counselors, and Therapists (AASECT)

This interdisciplinary organization certifies sexuality educators, counselors, and therapists and provides a list of certified therapists in specific geographic areas to individuals upon request. All requests must include a self-addressed, stamped envelope.

P.O. Box 238, Mt. Vernon, IA 52314; Phone: 319/895-8407; Fax: 319-895-6203; Web site: <http://www.aasect.org>

Association for the Treatment of Sexual Abusers (ATSA)

This association educates, facilitates information exchange, and provides for advancement in the sex offender treatment field. 4900 S.W. Griffith Drive, Suite 274, Beaverton, OR 97005; Phone: 503/643-1023; Fax: 503/643-5084; Web site: <http://www.atsa.com>

Interfaith Sexual Trauma Institute (ISTI)

This organization promotes the prevention of sexual abuse, exploitation, and harassment through research, education, and publications. ISTI offers leadership, gives voice, and facilitates healing to survivors, communities of faith, and offenders as well as to those who care for them.

St. John's Abbey and University, Collegeville, MN 56321; Phone: 320/363-3994; Fax: 320/363-3954; Web site: <http://www.csbsju.edu>

National Child Abuse Hotline

This anonymous hotline is dedicated to the prevention of both sexual and nonsexual child abuse. The 24-hour hotline provides crisis counseling, referrals, and information. Phone: 800/4-A-CHILD or 800/2-A-CHILD (TDD line). *Childhelp USA National Headquarters, 15757 N. 78th Street, Scottsdale, AZ 85260; Phone: 480/922-8212; Fax: 480/922-7061; Web site: <http://www.childhelpusa.org>*

The National Children's Advocacy Center (NCAC)

This nonprofit organization provides prevention, intervention, and treatment services to physically and sexually abused children and their families.

200 Westside Square, Suite 700, Huntsville, AL 35801; Phone: 256/533-0531; Fax: 256/534-6883; Web site: <http://www.ncac-hsv.org>

National Clearinghouse on Child Abuse and Neglect Information

This clearinghouse is a resource for professionals seeking information on the prevention, identification, and treatment of child abuse, neglect, and related issues.

330 C Street, S.W., Washington, DC 20447; Phone: 800/394-3366 or 703/385-7565; Fax: 703/385-3206; Web site: <http://www.calib.com/nccanch>

Rape, Abuse & Incest National Network (RAINN)

This organization operates America's only 24-hour confidential national hotline for survivors of sexual assault. 635-B Pennsylvania Avenue, S.E., Washington DC 20003; Phone: 800/656-HOPE; Phone: 656-4673; Fax: 202/544-3556; Web site: <http://www.rainn.org>

The Safer Society Foundation

This nonprofit organization advocates the prevention and treatment of sexual abuse. It focuses on offenders and offers them referrals.

P.O. Box 340, Brandon, VT 05733-0340; Phone: 802/247-3132 (to order books); 802/247-5141 (referral line); Fax: 802/247-4233; Web site: <http://www.saferociety.org>

Survivors of Incest Anonymous (SIA)

This organization provides information on incest and child sexual abuse as well as referrals to local support groups. Individuals should make requests by mail only; send business-size, self-addressed envelope with two stamps.

P.O. Box 190, Benson, MD 21018; Phone: 410/893-3322; Web site: <http://www.siaus.org>

Voices in Action

This international organization provides assistance to victims of incest and child sexual abuse through information and referral. It strives to increase public awareness about the prevalence of incest.

P. O. Box 148309, Chicago, IL 60614-8309; Phone: 800/7-VOICE-8 (786-4238); Fax: 847/498-0505; Web site: <http://www.voices-action.org>

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I N S T R U C T I O N S F O R A U T H O R S

Submitting Articles and Book and Audiovisual Reviews for Publication in the *SIECUS Report*

Each issue of the *SIECUS Report* features groundbreaking articles and commentary by leaders and front-line professionals in the field of sexuality and education, along with news, special bibliographies on varied topics, book and audiovisual reviews, recommended resources, and advocacy updates. All of this comes to members and other subscribers six times each year.

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Feature articles are usually 2,000–4,000 words. Book and audiovisual reviews are typically 200–600 words.

Manuscripts should be submitted on 8½ x 11 inch paper, double-spaced, with paragraphs indented. Authors should also send a computer disk containing their submission.

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The beginning of an article should include the title, subtitle, author's name and professional degrees, and author's title and professional affiliation.

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The beginning of a book review should include the title of the book, author's or editor's name, place of publication (city and state), publisher's name, copyright date, number of pages, and price for hardcover and paperback editions.

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The beginning of an audiovisual review should include the title of the work, producer's name, year, running time, name and address of distributor, and price.

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SIECUS affirms that sexuality is a natural and healthy part of living. SIECUS develops, collects, and disseminates information; promotes comprehensive education about sexuality; and advocates the right of individuals to make responsible sexual choices.

