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HAS ANYTHING CHANGED IN WHAT WE KNOW ABOUT SATYRIASIS FROM ITS ORIGINAL IDENTIFICATION OF THE DISORDER?

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For my partner, Mike Cramer

Who helps me to dream and make my dreams come true!

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ABSTRACT

This study explores the question, “Has anything changed in what we know about satyriasis from its original identification of the disorder?” This question arose around whether anything new has been discovered or used in the treatment of satyriasis.

From the original writings it is found that those with hypersexual behaviors risk legal consequences as well as losing their reputation and social graces. Krafft-Ebing was the first to write about this saying that, “This pathological sexuality is a dreadful scourge for its victim, for he is in constant danger of violating the laws of the state and of morality, of losing his honor, his freedom and even his life” (Krafft-Ebing 1965). This is still what seen today in the literature for those suffering from hypersexuality.

Since the first reports in the psychological and sexological literature there continues to be an absence of scientific evidence explaining how or why people become afflicted with hypersexuality. Many anecdotal theories exist about the etiology and treatment of hypersexuality with each agreeing that the sexual acting out involves managing anxiety and becomes out-of-control to the person suffering with the problem. However, after it is identified and treated there is controversy around what healthy sexuality is for the client. It is often based on the therapists bias and judgments and not the clients. The findings of this study may be used for therapists in both the fields of sexual addiction and sexology to explore possibilities in developing one or more healthy recovery models after the sexual behavior is not longer out-of-control.

CONTENTS

PROBLEM STATEMENT

There is an absence of a healthy recovery model within the field of sexual addiction and compulsivity. The absence of evidence based treatment leaves the field dependent on antidotal thoughts and clinical impressions.

PURPOSE OF STUDY

This paper is based on a retrospective consideration of hypersexual behavior over the years starting with its original name Satyriasis. The focus of this paper is confined to nonviolent and non-offending hypersexual behaviors and hence does not include information about sexual offenders and legal matters related to such.

The purpose of this study was to explore the etiology, treatment and recovery process of those with hypersexuality since it was first labeled satyriasis. This study will add to the literature in developing a treatment plan which can be generalized and use with individuals suffering with hypersexuality.

HYPOTHESIS

Is the treatment for satyriasis more effective today than historically?

CHAPTER 1

REVIEW OF LITERATURE

History

The origin of the word satyriasis comes from the Greek mythological word satyr which were spirits consisting of half-man, half beast (Encyclopedia Britannica 1937) In the Oxford Classical Dictionary (2nd Edition) a satyr is defined as, "'spirits of wild life in woods and hills', bestial in their desires and behavior, and having details of animal nature, either of a horse or of a goat." Satyrs historically were young and were half human half goat and later had elements of human and some details of a horse (Hammand and Scullard 1970). The Oxford English Dictionary in 1989 2nd Edition defines satyr as part of a myth in which he is "one of a class of woodland gods or demons, in form partly human and partly bestial……"

The word satyr itself is Greek for *membrum virile* or penis as the mythical creatures were prone to lust (Wahl 1967).

Reportedly satyriasis has been present in every society since the sexology of man was first recorded (Kilousky 1967) The satyr was assessed as man who would ejaculate at every sexual contact without full gratification causing him to endlessly seek as many women or even young boys as could be acquired in a single day (Kilousky 1967) There are tales about the satyr even from the early Arab superstition writings (Kilousky 1967; Encyclopedia Britannica 1937).

"The original satyr was a sylvan Greek deity who served Bacus, the god of drunken revelry" according to Klaf who found that Krafft-Ebing described one of his therapy cases as 'on the verge of alcoholic insanity' with the client's hypersexual behaviors (Klaf 1966).

During Roman times, heterosexual excess was "something to be proud of" according to Klaf as he reflected on historic cultures (Klaf 1966). "Divorces were easily obtainable, adultery was not listed as a criminal offense, and sadistic pleasures were practiced as a group activity in public places like the Coliseum, or in the privacy of baths" (Klaf 1966).

The word Satyriasis became used to illustrate that hypersexual men were acting like satyrs.

Terminology

Many terms have been used to describe the phenomenon of excessive sexual behavior, including compulsive sexual behavior, sexual addiction, hypersexuality, pseudohypersexuality, erotomania, promiscuity, nymphomania, satyriasis, Don Juanism, paraphilia, sexual dependence, sexual deviance, hypereroticism, hyperlibido, hyperphilia, hyperaesthesia, perversion, and atypical impulse control disorder. Many of these concepts overlap, some are no longer popular, and some are used interchangeably (Giugliano 2004). Giugliano believes that of all these terms, sexual compulsivity, sexual addiction and sexual impulsivity are the main categories and admits that these explanations of out-of-control sexual behavior "still remain hypotheses and have not yet been established as testable models" (Giugliano 2008).

The word satyriasis can only be found in brief references in the older sexological literature. The Oxford English Dictionary 2nd Edition states that it was first used in the psychological community as a synonym for Priapism in 1897 in the Manual of Psychiatric Medicine. Priapism is a disorder in which a man experiences a painful erection for hours and it was thought to be one of the reasons a man might express hypersexuality.

The first time out-of-control sexual behavior appeared in psychosexual literature appears to be in the work of Krafft-Ebing's *Psychopathia Sexualis* (1965, 1st ed. 1886) which was a

collection of sexual abnormities were based on sexual prejudice at the time of the writings. They were thought to be moral degenerates and the products of defective heredity (Klaf 1966).

Krafft-Ebing used the terms "hyperaesthesia" to describe an abnormally increased sexual desire. (Krafft-Ebing 1886/1965) In later sections of his writings he began using the terms "nymphomania" and "satyriasis" but the distinctions, if any between these terms and hyperaesthesia are not clear (Orford 2002).

Satyriasis is derived from the word "Satyr" which described excessive heterosexual interests and desires in males. This term has morphed into various understandings, reasoning's and labels up to today where the most popular terminology is sexual addiction, compulsive sexual behavior and sexual impulsivity.

Krafft-Ebing originally wrote a book in 1886 which described hypersexuality:

[S]exual appetite is abnormally increased to such an extent that it permeates all his thoughts and feelings, allowing of no other aims in life, tumultuously, and in a rut-like fashion demanding gratification without granting the possibility of moral and righteous counter-presentations, and resolving itself into an impulsive, insatiable succession of sexual enjoyment…This pathological sexuality is a dreadful scourge for its victim, for he is in constant danger of violating the laws of the state and of morality, of losing his honor, his freedom and even his life [pp. 70-71] (Krafft-Ebing 1886/1965).

Historically it was believed that the satyr finds his female counterpart in the nymphomaniac, and like her, follows a path of feverish lust that finds no calming. (Kilousky 1967)

In the 19th century there have been other more modern day examples of satyrs.

Don Juan

The story of Don Juan was another important story which contributed to the thinking about males with satyriasis. Don Juan was seduced numerous women and then rejected them. It is not known if Don Juan was a real man or not however what made his story so compelling was that he was a believer in religion and G-d but that something had gone wrong while looking for his spirituality (Klaf 1966). As long as he was seen as suffering and looking for redemption and to stop his sexual escapades than he was somewhat of a hero. The question remains, however, as to why he needed to be seen in a negative light and could someone like Don Juan simply have enjoyed a life of many sexual experiences and many women? Is it the sign of the times from which he came and from those who see his story as sex negative that makes him a problematic character whether he is real or a universal type?

Casanova

The first mention that sex could be an addiction of any kind came from Freud in the late 1800's. Freud described masturbation as "the original addiction" in 1897 and felt that it was the primary addiction of all and that others were simply a substitute for it. (J. R. Giugliano 2008).

In 1978, Jim Orford attempted to explain excessive behaviors not from an addiction point of view but through the lens of excessive sexual appetites and activities (Kafka 2007). Orford felt that excessive sexual behavior could be looked at as a syndrome which resembled an addiction but not being an addiction given that there was no an actual substance being used (Orford 2002).

John Money, Ph.D., refers to "lovemaps" which, in your childhood**,** were created by your caretakers and the society and culture you were raised in**.** Healthy lovemaps evolve within a community or society that encourages affectionate caregiving and recognizes sex as natural, with no taboo or stigmatization. Money sees sexually compulsive behavior as the result of a lovemap that's been "vandalized" through physical, emotional and sexual abuse, where children have

suffered post-traumatic stress and injured their self-esteem, personal boundaries, and sense of trust. (John Money 1986)

Patrick Carnes, Ph.D., has written extensively on the subject. In fact, he popularized the term in the subtitle of his landmark book, *Out of the Shadows: Understanding Sexual Addiction*. (Carnes 1983).

Eli Coleman, Ph.D., affiliated with the Program in Human Sexuality at the University of Minnesota Medical School, has written extensively on sexually compulsive behavior. He believes that addiction isn't an accurate description for this disorder. He believes what he calls sexual compulsivity is "driven by anxiety reduction mechanisms, rather than by sexual desire." (Eli Coleman 1990) Coleman does not believe that Sex Addiction is accurate description of this disorder.

According to Money, it is "a developmental representation or template in the mind and in the brain depicting the idealized lover and the idealized program of sexual and erotic activity projected in imagery or actually engaged in with that lover." (John Money 1986)

The most recent version of a document produced by The World Health Organization, ICD-10, includes "Excessive Sexual Drive" as a diagnosis (code F52.7), subdividing it into *satyriasis* (for males) and *nymphomania* (for females) even today (World Health Organization 1992).

What is most certain is that the lack of an agreed upon term for what out-of-control sexual behavior is and is not has contributed to the paucity of research in this area (Stein, Black Shapira, Spitzer 2001). At best what we know from the available literature on the etiology and treatment is anecdotal and borrowed from the substance addiction field (Giugliano 2004).

Incidence and Prevalence of Satyriasis

In the writings of Havelock Ellis between 1897 and 1939, he wrote that satyriasis was rare (Ellis 2008). In the 1960's when it was studied it was written that it is difficult to find accurate data on the incidence of satyriasis (Stan Moore 1982). Klaf stated in his book, *Male Satyriasis*, that satyriasis was a rare deviation (Klaf 1966). Coleman's work points out that because of the lack of reliable and valid assessment tools it is difficult to know the prevalence, cofactors and etiologic factors of compulsive sexual behaviors (Coleman 2007). Given this Carnes and Coleman both cite some studies which show three to five percent of the general population have this disorder (Coleman Gratzer Nesvacil Raymond 2000; (Carnes 1991).

Much of the information known today about out-of-control sexual behavior is from research involving case histories, therapist's assessments, belifs and judgments from therapists and researchers, spouses, clergy and those suffing with hypersexuality themselves.

Etiology

Limited information exists as to the etiology of hypersexuality (Bancroft and Vukadinovic 2004). Various reasons given for hypersexual behavior include sexual abuse, sexual trauma, attachment disorders, erotic rage, brain dysfunction, vandalized love maps, boredom, developmental disturbances, homosexuality, shame and growing up gay in a heterocentric world.

Havelock Ellis quoted Krafft-Ebing as saying that satyriasis was likely to develop in men leading lives which resemble those of women (Ellis 2008). Ellis also quoted sexologist Gustave Bouchereau who wrote about erotomania as saying that "the men most liable to satyriasis are those with vigorous nervous system, developed muscles, abundant hair on body, dark complexion, and white teeth" (Ellis 2008).

Some believed that temporary sexual abstinence would lead to satyriasis. These "withdrawal" symptoms are not much different than what is reported today by the sexual addiction literature when sex addicts abstain from their sexual behaviors. In the writing of Havelock Ellis in 1859-1939 where he quotes sexology Dr. Hermann Rohleder that those who experience prolonged periods of sexual abstinence may produce serious side effects such as "nervous irritability, anxiety, depression, disinclination for work; also diurnal emissions, premature ejaculations, and even a state of approaching satyriasis" (Ellis 2008)

"Originally it was thought to be caused by the dry sands of the desert, resulting in an internal inflammatory condition that kept a man in almost a constant state of erection from which no amount of coitus could free him" (Kilousky 1967).

Organicity

Some theorists believed that satyriasis was organic (Kilousky 1967). Krafft-Ebing felt that psychical degeneration was responsible for hyperaesthesia with both alcohol and prolonged sexual abstinence contributing to it. (Krafft-Ebing 1965) Chemical and hormone imbalances were thought to contribute to hypersexuality (Moore 1982). It was thought that neurological pathology could also be present. Epilepsy was also cited as a contributing factor to hypersexual behaviors Blumer documented his observations of hypersexuality in temporal lobe epilepsy and theorized that "sexual changes are due to the presence or absence of excitatory neural activity in the limbic portion of the temporal lobe"(Moore 1982). He felt that this caused a lack of inhibition and created "continuous stimulation of the sexual excitation centers….." (Moore 1982). Another contributor to the discussion was C. Auen who thought that the onset of excessive sexual behavior was from schizophrenia. He thought that someone might be displaying

schizophrenic traits due to the latter stages of schizophrenia exhibiting an insatiable sexual desire due to lack of inhibition (Moore 1982).

Today there is still a need for further investigation of whether medical etiology contributes to hypersexuality. In one study by Reid, Carpenter and Lloyd they ask, “Do hypersexual patients experience abnormal levels of androgens that might influence their behavior?” (Reid 2009).

One new approach which is still in the early stage is the study of central inhibitory mechanisms by using brain imaging (Bancroft 2008). This could be informative in terms of comparing brain activity in response to sexual stimuli in hypersexual patients compared to people within normal limits of sexual behaviors. Bancroft and his associates are particularly interested in this from their Dual Control model theory that there is a lack of inhibition around sexual impulses and the brain imaging potentially could show some “deactivation in the temporal lobe and indicate reduction of inhibitory tone” (Bancroft 2008). It is still too early and there are many difficulties understanding how the central nervous system or neurotransmitters work in hypersexual individuals (Goodman 1998).

Internal Chemicals

Another natural drug called phenylethylamine, PEA for short, is an essential chemical for those addicted to inherently risky behaviors like gambling, shoplifting, bungee jumping, and sex. PEA’s molecular structure parallels amphetamines, and its strongest when first released. (Many individuals dependent on drug and alcohol say they’re always seeking the feeling they had during their first high, and want to re-experience it.)

Both PEA and sexual arousal are highly boosted by the presence of fear, risk and danger. The higher the fear and risk involved, the more PEA is released. Part of the thrill is the danger of being caught which occurs so frequently with those suffering with hypersexuality.

Research finds that testosterone is linked to sex drive. However we know very little about hormones so it is anecdotal at best (Granzig 2009). In her book, *The Truth About Love,* Pat Love writes:

> *Scientists have known for decades that male sex drive is correlated with testosterone . . . a hormone produced in the testes and adrenals. While testosterone has been conclusively shown to highly correlate with male libido, it was long dismissed as a facto in the sex drive of women. Then in the early 1990's, Dr. Barbara Sherwin, a researcher at McGill University in Montreal, published her classic study showing that women who received a testosterone treatment reported a greater upsurge in sexual arousal, more lustful fantasies, a stronger desire for sex, more frequent intercourse, and higher rates of orgasm.*

Other organic reasons which attempted to understand and explain hypersexual disorders were temporal lobe tumors, extratemporal lesions, tumors of deep anterior temporal lobe and front lobe along with Rabies, tuberculosis, and syphilis (Moore 1982).

Psychodynamic

In the 1960's it was theorized that the satyr was a man with innate narcissism and striving for eternal youth (Klaf 1966). Some felt it to be the result of ego-dystonic homosexual wishes thus thrusting the individual to having excessive sexual contacts with women (Moore 1982).

Others felt it was the result of the oedipal complex in which the individual was looking for his mother in every sexual contact he had with women (Moore 1982). Others explained it to be the result from a narcissistic personality disorder in which a man's erotic successes were used to cover his inferior feelings within himself—particularly around his inadequate feelings about his male identity. It was believed that the obsession and excessive behaviors left him completely ungratified only to then cause him to want to do it all over again therefore providing an empty search (Moore 1982).

Another concept in the psychoanalytic thinking was that of male hysteria being the contributor to excessive sexuality. It was thought these men failed in their repression of hysteria which led to a hypersexuality or compulsive sexuality. The belief was that their masculinity became exaggerated by exhibiting ultra-masculine activities like gun collecting and belong to paramilitary exercises as well as hypersexuality (Lube 2003).

Trauma Model

Freud envisioned trauma as "a breech in the protective barrier against (over)stimulation leading to feelings of overwhelming helplessness" (Levine 1997). It is this sense of helplessness children experience that is humiliating and victimizing.

Trauma repetition is a maladaptive attempt to reconcile the traumatic experience, find reason and meaning in what happened, (even if that means reliving it) which is a huge part of trauma resolution. Usually hypersexual behavior is not, in fact, about sex at all. It is about recreating unresolved childhood trauma involving emotional, physical or sexual abuse or neglect in the erotic. Compulsive sexual behavior is, by definition, behavior the client engages in despite not wanting to—just as trauma is something the child is forced into against his or her will. In

other words, the acting out is a “return to the scene of the crime” and the psyche believes this time there can be resolution through sex.

Through the trauma model lens, one is looking at trauma re-enactment where the individual is traumatized in some way in childhood and then in adulthood unconsciously re-enact this trauma repeatedly. The trauma model in hypersexuality is that the individual experienced some pain and distress such as sexual abuse, physical abuse, gender abuse (name calling and insulting one’s gender expression and development), and/or physical and emotional neglect which would cause them to act out sexually in inappropriate ways (Schwartz and Masters 1994).

Engaging in behavior that helps the psyche return to a level of excitement and arousal similar to the original abuse. The pairing of such repetitions with pleasure or orgasm, stress release, fear, and possibly endorphin release probably cements the association and establishes long-term habits (Schwartz and Masters 1994).

For the sake of this paper, trauma will be referred to as an event or episode, acute or chronic that causes overstimulation without an outlet or release for that overstimulation. This leaves individuals feeling helpless and overwhelmed. According to this definition, any seemingly harmless event or situation can create be *subjectively* traumatic when it leaves an individual feeling unable to cope, or fearing some ongoing threat (Herman 1992).

Many clients recount traumatic experiences—typically abrupt, dramatic, and therefore memorable. Victims of long-term verbal abuse from a parent also enter the therapy room. These clients grow accustomed to chronic insults and habitual belittling that, if it were to come all at once from a stranger, would feel intolerable and would spark a normal fight-or-flight reaction.

Mark Schwartz, a pioneer in the field of sexual addiction, works at Master’s & Johnson Treatment Center in St. Louis and defines compulsive sexual behavior as an “intimacy disorder.”

Typically, in his view, the compulsive individual has, as a child, been victimized by abusive, neglectful, or smothering caretakers. Lacking nurturing, he had to look after himself. As a result, now he equates sex with nurturing. His psyche—seeking pleasure, not pain—passes painful emotional pains or memories through a sexual filter to make them "feel better." His passive rage is expressed as deviation, or even perversion (Schwartz and Masters 1994).

The sex addict hasn't developed the skills to form and maintain intimate relationships with other adults. And so, according to Schwartz, close relationships cause him fear, shame, and anxiety.

Mark Schwartz and William H. Masters devoted their article, *Integration of Trauma-Based, Cognitive, Behavioral, Systemic and Addiction Approaches for Treatment of Hypersexual Pair-Bonding Disorder* to the concept that sexual development in childhood is fused with the later development of sexual addiction. They addressed the various ways that childhood sexual abuse can be traumatizing and later promote compulsive sexual behaviors. They stated that, "deviant sexual arousal and compulsivity symptoms are the result of the influence of stigma and trauma to unfolding sexuality". They talked about the deviant arousal being manifested during adolescence and referred to the sexual acting out as a survival mechanism that developed to cope with the "need to depend on other people whom they fear can injure or destroy them". The symptoms, they explained, "become functional in dealing with anxiety, depression, loneliness and myriad other emotions, and thereby become 'both necessary and distressing'."

As a child, the compulsive individual has typically been a victim of abusive, neglectful or smothering experiences from inadequate caretakers and is, consequently, experiencing passive rage expressed as deviation or even perversion. The individual has not developed the basic skills needed to form and maintain intimate relationships with other adults.

Instead, he or she experiences fear, shame, and anxiety in close relationships. Sex has become a source of nurturing. As children they lacked nurturing and had to look after themselves.

As Bessel A. van der Kolk warned in his book *Trauma Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*:

> *. . . if clinicians fail to pay attention to the contribution of past trauma to the current problems in patients with these diagnoses, they may fail to see that they seem to organize much of their lives around repetitive patterns of reliving and warding off traumatic memories, reminders, and affects.*

According to van der Kolk, therapists' attitudes toward the traumatic symptoms will determine their approach to treating their clients. He wrote that "… the younger the age at which the trauma occurred, and the longer its duration, the more likely people were to have long-term problems with regulation of anger, anxiety and sexual impulses" (van der Kolk 1996). Most overt as well as covert molestation occurs within the context of pseudo-cooperation, manipulation, and coercion rather than overt force. That agreement is part of the problem. The internalization of this trauma can manifest in symptoms such as impairment of basic trust, negative effects on identity, negative impact on play and relationships with others, and excessive interpersonal sensitivity (van der Kolk 1996).

The effects of trauma surface at different times—sometimes not for years. The more individuals push themselves or are pressured toward staying closeted around their sexual desires and behaviors, the more they'll have to struggle with PTSD symptoms. Staying in the closet about anything can be prolonged trauma

Judith Lewis Herman eloquently described the effects of chronic trauma:

. . . the features of post-traumatic stress disorder that become most exaggerated in chronically traumatized people are avoidance or constriction. When the victim has been reduced to a goal of simple survival, psychological constriction becomes an essential form of adaptation. This narrowing applies to every aspect of life—to relationships, activities, thoughts, memories, emotions, and even sensations. And while this constriction is adaptive in captivity, it also leads to a kind of atrophy in the psychological capacities that have been suppressed and to the over-development of a solitary inner life (Herman 1992).

Hypervigalence and Hyperarousal

Another factor that occurs during trauma is hyperarousal which could also be a contributor to hypersexuality as a means to self-soothing. Judith Herman writes that "After a traumatic experience the human system of self-preservation seems to go onto permanent alert, as if the danger might return at any moment. Physiological arousal continues unabated. In this state of hyperarousal, which is the first cardinal symptom of post-traumatic stress disorder, the traumatized person startles easily, reacts irritably to small provocations, and sleeps poorly" (Herman, 1992).

Trauma experts talk about how "trauma arrests the course of normal development by its repetitive intrusion into the survivor's life." (Herman 1992). The most common way to cope with trauma is to forget about it—consciously. So that the person can cope, it becomes encoded in nonverbal, visual ways. Herman writes, "Traumatic memories lack verbal narrative and context; rather, they are encoded in the form of vivid sensations and images . . . In their predominance of imagery and bodily sensation, and in their absence of verbal narrative, traumatic memories resemble the memories of young children." Traumatized people relive the *crime* repetitively in

their thoughts, behaviors, and dreams. Often people with hypersexual behaviors are reenacting early abuse. This needs to be taken into account when dealing with hypersexuality as it would not indicate a sexual addiction as much as it would indicate trauma induced hypersexuality.

Dissociation

Dissociation is an integral part of trauma—and long after it has occurred. An individual isolates the memory of the painful event and stores it in another compartment of the mind, along with any associated strong feelings and emotions. Children who are abused at home dissociate to get through each day and be functional at school, sports, religious institutions, and anywhere they need to perform. The dissociative split allows the rest of the personality to achieve and thrive as if nothing has happened. Dissociation can help suppress anxiety-provoking knowledge about the self and make life more manageable. As trauma survivors begin the process of reintegration, those repressed memories can leak out and interfere with everyday functioning. The individual is left disconnected not just from himself, but also from others.

Sexual Abuse

A look at the existing literature (Maltz 2001 Rev. ed; Lew 2004; Gartner 1999; Hunter 1990) shows that those who have been sexually abused develop in ways that can lead to sexual aversion or hypersexuality as they carry the effects of the trauma into adulthood. Kafka and Prentky did a study on this topic and found that 12 percent of 34 men with paraphilias and 19 percent of 26 men with paraphilia-related disorders had reported being sexually abused (Goodman 1998).

In most material written about sexual addiction, it is reported that a high percentage of sex addicts have been sexually abused as children. Various writers have reported different

percentages all of which are high. Patrick Carnes reported in his book, *Don't Call It Love*, that 81 percent of sex addicts have been sexually abused as children. In an article called, *The Link Between Incest Abuse and Sexual Addiction*, authors Margaret Hueppelsheuser, Patricia Crawford, and Darren George, found that 19% of the 100 male participants were sexually abused as children.

Much of the information about sexual abuse and sexual addiction consists of contact and non-contact sexual abuse. In *Don't Call It Love*, Carnes talked about non-contact forms of abuse in which there is no sexual touching or touching of any kind. He cited an example of a father talking to his daughter about her developing breasts and getting turned on. The daughter feels violated and tries to change the subject. Even though physical touch is not involved it is still considered an indirect act of sexual abuse.

A helpful definition of sexual abuse (both covert and overt) comes from Wendy Maltz's *The Sexual Healing Journey: A Guide for Survivors of Sexual Abuse.* She defines sexual abuse as whenever one person dominates and exploits another by using sexual feelings and behavior to hurt, misuse, degrade, humiliate, or control another. The abuser violates a position of trust, power, and protection of the child. In other words, sex is simply a tool with which to exert power, dominance, and influence—just as in rape.

Overt sexual abuse involves direct touching, fondling, and intercourse with another person against that person's will. *Covert* sexual abuse is subtle and indirect. It includes inappropriate behaviors such as sexual hugs, sexual stares, or inappropriate comments about one's buttocks or genitals, as well as verbal assaults and denigration, such as punishing a child for not being the "right type" of male or female and homophobic name-calling. Covert sexual abuse will be addressed later in this paper.

What hypersexual theorists believe is that sexual abuse is one of the major contributors to sexual addiction. In their book, *Male Victims of Same-Sex Abuse: Addressing Their Sexual Response,* John M. Preble and A. Nicholas Groth write:

> *". . . this may actually reflect an effort at mastery of the traumatic event . . when he was being sexually victimized, someone else was in control of him sexually. During masturbation he is literally in control of himself sexually, and this may be a way in which he attempts to reclaim mastery over his own sexuality. Likewise, his participation in consensual sex reflects his choice and decision."*

The authors go on to say that "the fantasy thoughts are prompted by fear more than desire, by anxiety more than pleasure." In other words, they become a way of managing fear and anxiety.

Covert Cultural Sexual Abuse of Gay Men

Covert Cultural Sexual Abuse (CCSA) is another piece to the etiology of hypersexuality amongst gay men. The gay male community is a covertly sexually abused one (Kort 2008). The homosexual or bisexual individual suffers covert sexual abuse and risks developing sexual addiction in a similar way as other sexual abuse victims. The idea that people have is that gay equates to sexual behavior. Telling someone you are gay automatically the person hearing that news imagines an adult gay sex act. This makes gay men vulnerable to sexual addiction and sexual anorexia. (Kort 2008)

It's not enough to simply say that gays and lesbians were permanently scarred by the homophobia and heterosexism they experienced growing up. Homophobia and heterosexism are *inherent* to covert cultural sexual abuse and have devastating, complicated psychological and

psychosexual consequences, causing guilt and shame to run as deep as in those who have been sexually abused (Kort 2008).

Covert cultural sexual abuse is defined as chronic verbal, emotional, psychological, and sometimes sexual assaults against an individual's gender expression, sexual feelings, and behaviors. Conceptually, it is similar to sexual harassment in that it interferes with a person's ability to function socially, psychologically, romantically, affectionally, and sexually. Its effects persist into adulthood and wreak havoc in people's lives—as does sexual harassment.

Covert *cultural* sexual abuse involves bullying through humiliation, offensive language, sexual jokes (of antigay nature), and obscenities. These attacks can be directed at the gay or lesbian person directly or indirectly. In other words, what I define as covert cultural sexual abuse is the expression of heterosexism, a belief in mainstream society that demands that all people be—or pretend to be—heterosexual. Heterosexism uses homophobia to exploit the sexual feelings and behaviors of those who are not heterosexual. In other words, heterosexism perpetrates and violates the trust that gay and lesbian children have in those in who are in positions of trust, power, and protection of them.

To be clear, this is *not* saying that gays and lesbians are sexually abused. Nor is it diminishing the profound negative effects of overt sexual abuse.

Others have also noticed how the results of sexual abuse parallel the experience of growing up gay. In 1993, Joseph H. Neisen wrote an article in which he explored the parallels of heterosexism and sexual abuse. He wrote of heterosexism as being "a form of cultural victimization that oppresses gay/lesbian/bisexual persons" (Neisen 1993). Niesen's article points to the cultural victimization as an abuse that causes painful effects similar to those of sexual/physical abuse. The cultural victimization of heterosexism, he added, stymies individual

growth and development just as it does in individuals who have been sexually or physically abused. I don't believe Neisen takes this far enough.

Don Wright has also compared the effects of homophobia to those of sexual abuse (Wright 2000). He talked about homophobia as a "sexuality abuse" with "deep lasting effects on a bisexual or gay male, undermining his sense of self as a male, and tainting what for him is a natural attraction to his own gender". He paralleled the resulting shame and guilt with the shame and guilt experienced by those who have been sexually abused.

Being an adolescent can be a traumatic time. Being a gay adolescent can be even more traumatic. It is a time where sexuality and concern for others is brought to the forefront of a person and practiced. For gay teenagers, this development of sexual identity is suppressed. A gay teen has to role play heterosexuality and suppress the natural desire to date, kiss and love a member of their own sex. Brian McNaught, author of *Now That I Am Out What Do I Do* stated:

> *.....most gay people have been enormously, if not consciously, traumatized by the social pressure they felt to identify and behave as a heterosexual, even though such pressure is not classified as sexual abuse by experts in the field. Imagine how today's society would respond if heterosexual thirteen to nineteen year olds were forced to date someone of the same sex. What would the reaction be if they were expected to hold the hand of, slow dance with, hug, kiss and say "I love you" to someone to whom they were not and could not be sexually attracted? The public would be outraged! Adult supervisors would be sent to prison. Youthful "perpetrators" would be expelled from school. Years of therapy would be prescribed for the innocent victims of such abuse. Volumes would be written about the long-term effect of such abhorrent socialization (as today we lament the ill-conceived efforts to turn left-handed people into right-handed*

ones). Yet, that's part of the everyday life of gay teenagers. And there's no comparable public concern, much less outcry, about the traumatizing effects on their sexuality.

Children (and adults) are bombarded by messages—from the church, from politicians, from their schools, from their peers and their family—that being gay is morally wrong, sinful, and forbidden, and they internalize these message on some level. The shame and guilt become profound and part of their identity.

The most profound trauma of sexual abuse survivors is sexual secret-keeping. Sexual abuse survivors are taught that their sexuality is their fault and that if they tell someone about it, they will be harmed in some way, whether psychologically, physically, verbally, or emotionally. Silence is rewarded by the dominant mainstream culture and hiding becomes a way of life. Keeping these sexual secrets can also lead to withholding sexual information from others. They are in complete denial.

Survivors of sexual trauma experience feelings of fear, shame, and secrecy which lead to loneliness and isolation, helplessness and hopelessness. The intense fear of being "outed" is similar to the fear of others' learning that you were sexually abused. Survivors think there must be something wrong with them; that it's somehow *their* fault for causing the abuse in the first place.

The sexual abuser's ideal target is a child who's still naive, lacking the "immune system" of emotional and intellectual experience that tells him when he's being violated—and when to resist and say no! A dominant perpetrator—uncle, stepfather, or half-bother who's familiar, trusted, and seemingly all-powerful— can easily lure a boy into a sexual relationship and force him to comply.

In *Male On Male Rape: The Hidden Toll of Stigma and Shame*, Michael Scarce makes it clear that in prisons, sex isn't about sex or intimacy, all about dominance and status. Outside the prison walls, alas, the same ethic's alive and well. Covert abuse can be committed by any dominant individual including psychiatrists, psychologists, social workers, teachers, or anyone employed—and empowered by—a church, synagogue, or community organizations.

Covert cultural sexual abuse is the perfect crime because the perpetrator offends, the victim forgets, and the offender gets away scot-free. By the time gay children become adults, they may repress the abuse, deny that it ever happened, and blame themselves for whatever they do recall. Being warned that homosexuality is evil, they grow up thinking that the evil lies within them. Then, blaming themselves, they believe they deserve to be treated poorly. Out of envy, they may even identify with their homophobic oppressors.

Gays and lesbians who experience the shame of covert cultural sexual abuse as they grow up tend to exhibit PTSD symptoms similar to those who survived sexual abuse, as is illustrated in the following table.

PTSD Symptoms of Sexual Abuse and Covert Cultural Sexual Abuse

Sexual Abuse Survivor	Covert Cultural Sexual Abuse Survivor
Sexual secret about abuse	Sexual secret about homosexuality
Pretend nothing is wrong and abuse is not happening	Pretend nothing is wrong and pretend not to be lesbian/gay by role playing heterosexuality
Self-perception is hopelessly flawed	Self-perception as gay/lesbian is that you are hopelessly flawed

Confusion about your sexual orientation	Confusion about whether you are gay or straight
Self-hate and blame for what is done to you	Self-hate and blame for being gay or lesbian, resulting in internalized homophobia
Believing you are to blame for the abuse	Believing you are to blame for not being able to suppress same-sex desires
Belief that people who care for you may kill you, abandon you, or be harmed themselves	Belief that people who care for you may abandon you, shame you, or harm themselves upon learning about your homosexuality
Isolation from others out of fear and distrust of intimacy	Isolation from others (especially gays and lesbians) out of fear of betrayal and distrust of intimacy
Deadening of all feelings to avoid sexual arousal	Deadening of all feelings to avoid same-sex arousal (staying closeted)
Self-abuse/injury through drugs/alcohol	Self-abuse through drugs/alcohol and unsafe sex
Suicidal thoughts, gestures, and attempts	Suicidal thoughts, gestures, and attempts
Fear and avoidance of sexual arousal	Fear and avoidance of same-sex arousal
Displays of affection are inappropriately sexualized	Displays of affection are inappropriately sexualized (more so for gay men)
Becoming master of pretense and living out of integrity	Becoming master of pretense and living out of integrity, role playing heterosexuality

Settling for too little	Settling for too little and not expecting much as gay or lesbian
Short-lived and volatile relationships	Short-lived and volatile relationships before fully coming out of the closet

Cultural Influences

Sexuality and sexual behavior cannot be talked about without acknowledging the cultural values that deeply are embedded. Early researchers Gagnon and Simon in 1973 wrote extensively on the topic of cultural values shaping sexual scripting. In any given society, sexual scripts provide the standards that determine erotic control and normalcy. Sexual scripts are sets of norms, values and sanctions that govern the erotic acts and roles recognized by a social group (Gagnon & Simon, 1973; Laws and Schwartz 1977). These differences account for extraordinary variation in definitions of erotic normalcy and deviance

By sexual scripting they referred to both homosexuality and masturbation were considered deviant until the 1900's (Kafka 2007).

Depending on where the culture is in terms of sexual norms and values seems to contribute to how a person with excessive sexual behavior is looked upon. In 1973, Gagnon and Simon talked about sexual scripts that set up norms and values that govern what is culturally okay and what is not sexually. Also governing our culture are three competing erotic codes that categorize sexual behaviors: procreative, relational and recreational. The procreative script is based on Judeo-Christian customs and favors only sex for the purpose of procreation in a heterosexual marriage (DeLamater 1981). In many ways the procreative erotic code is sex

negative. Levine and Troiden imply in their article, *The Myth of Sexual Compulsivity* that the diagnosis Don Juanism is a reflection of that in the first DSM from 1952.

The relational and recreational erotic codes discussed by DeLamater are more sex positive and place a "higher value on erotic feelings and expression" (Levine and Troiden 1988). The relational values sexual relations *only* in the context of a committed love relationship. Anything that is outside of the relationship is prohibited.

The recreational code values sexual contact between any two people regardless of whether or not they know each other as long as it is consensual. In response to DeLamater's sexual scripts, Levine and Troiden argue:

These three scripts have different definitions of control over erotic conduct. The procreative code views any nonmarital or nonprocreative sexuality as indicating a lack of sexual control; the relational code regards nonrelational sex as indicating a lack of sexual control, whereas issues of control are irrelevant in recreational scripts, which define only nonconsensual sex as deviant (Levine and Troiden 1988).

Culture shifted to the new categories of sexual problems developed. Classifications of new sexual dysfunctions that were addressed included: low sexual desire, inhibited sexual desire), fear of sex (sexual aversion), lack of orgasm (anorgasmia), inability to sustain an erection (impotence), and the inability to sufficiently control ejaculation for the attainment of adequate sexual pleasure (premature ejaculation) (Levine and Troiden 1988).

Cultural norms even dictate what is excessive and what is not. Levine and Troiden state that "sexual addiction and sexual compulsion represent pseudoscientific codification of prevailing erotic values rather than bona fide clinical entities" (Levine & Troiden 1988). Michael C. Quadland's work on hypersexuality has focused on labeling the hypersexual behaviors as

compulsive well. His concern has been the moralistic labeling of certain sexual behaviors and the arbitrariness of what is normal and what is abnormal by clinicians (Quadland 1985).

Consider the gay male culture. Among gay men is the availability of casual and anonymous sex and unlike their straight male counterparts, gay men have many opportunities to find quick and easy anonymous sex. Gay men are vulnerable to sexual addiction not only from covert cultural sexual abuse but also from being rewarded for the "masculine" trait of being sexually predatory.

Yet another reason gay men are vulnerable to sexual addiction is that initiation into the gay community is still often sexual. There are few ways to enter the gay world without sexuality being involved, particularly when you are closeted. Western culture does not allow for too many avenues that provide discrimination-free places to experiment with meeting other gay men and women. The Internet, pornography, the bars, baths, and rest areas are so readily and immediately available that it makes sense that a gay teen or a closeted man's first exposure to gayness is through the doorway of sexuality (Kort 2008).

When working with gay clients, it is important to recognize the lack of nonsexual ritual and initiation. Society lacks of images of men, particularly gay men, touching and expressing affection. Gay porn reconciles this lack, if only through sexuality. The heterosexually married gay man who lacks the courage to go to a gay bar or support group finds porn the easiest, safest way to explore his homosexuality. The closeted man, who fears being hated and marginalized if he comes out publicly, can find some comfort, knowing that no one will judge him online, in a bookstore or in the privacy of his own home (Kort 2002).

Perhaps the best evidence of culture influencing the therapeutic field is reflected in the DSM. The cultural values and norms shape what changes and gets added or eliminated from the

DSM as has been since it original publication. By the end of the 1800's, both medicine and psychiatry were effectively competing with religion and the law for jurisdiction over sexuality (Herek 2009). As a consequence, discourse about homosexuality expanded from the realms of sin and crime to include that of pathology.

Homosexuality is an excellent example of how the DSM is influenced by politics and cultural norms. In 1973, the weight of empirical data, coupled by changing social norms, led the board of directors of the American Psychiatric Association to remove homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). In 1980, in the third edition of the *DSM*, the term *ego-dystonic homosexual* was created to describe clients who are uncomfortable or in conflict with their homosexuality and want to change their orientation (American Psychaitry Association 1980). Typically, the client would report that homosexual urges were interfering with his or her life and that a lack of heterosexual arousal interfered with the client's desired lifestyle. The opposite term, *ego-syntonic homosexuality*, was used to acknowledge the significant numbers of gays and lesbians who were quite satisfied with their sexual and romantic orientation and showed no signs of psychopathology.

Ego-dystonic homosexuality remained in the *DSM-III* until 1987, when the manual was revised as *DSM III-R*. The board concluded that *all* gays and lesbians start out as ego-dystonic (that is, uncomfortable with their orientation), but upon fully coming out, they become ego-syntonic. The American Psychiatric Association thus voted "to urge its members to stop using the '302.00 Ego-dystonic homosexuality' diagnosis in the current *DSM-III* or future editions of either document" (American Psychiatric Association 1980)

The present *DSM-IV* doesn't include homosexuality as a disorder but still permits a diagnosis of "Sexual Disorder, Not Otherwise Specified" for anyone with "persistent and marked

distress about sexual orientation"—the same diagnosis used for sexual addiction and compulsivity.

Initially in the DSM-I it is seen that men and women have their own classifications of hypersexuality with men having the diagnosis of Satyriasis and women have one of nymphomania. The cultural script at that time in 1952 was one of procreation so it makes sense that at that time anything outside that cultural script would have been seen as deviant and mirrored diagnostically (Giugliano 2004). However as the sexual revolution exploded during the 1960's and the culture became more sex positive, the lack of sexual expression started to be noticed and identified as problematic moreso than too much sexual expression had been in the past.

Using the DSM is tricky and can be contaminated by both the culture in which it exists along with the therapist's bias and judgment. The DSM-IV-TR carefully mentions that it is classifying the disorder a person receives, not the *person* themselves. Most important, a cautionary statement exists in the DSM-IV-TR which states that "this manual is composed only of guidelines that do not meet the established definition of a legal medical disease, disorder or disability". It also states that the DSM is designed to be used only by clinically trained professionals with experience and expertise in diagnosis and that the mental health disorder diagnosis categories are to be used as a guide only and should not be substituted for professional judgment (American Psychiatric Association 2000)

Differential Diagnosis

There also exists a plethora of information as to how to the existence of comorbid diagnosis along with hypersexual behaviors including Bipolar Disorder, anxiety and depressive disorders, personality disorders and Attention Deficit Disorder (ADHD), to name a few.

Klaf believed that satyriasis was rarely an isolated disorder and believed that it coexisted with sadism and homosexuality (Klaf 1966)

Kafka reviewed the hypersexual literature to study Axis 1 diagnoses relationship to out-of-control sexual behaviors. He found reports of anxious and depressive affects and not actual clinical mood disorders associated with sexual risk-taking behaviors. (Kafka 2007).
It is important for therapists differentiate between paraphiliac behavior and sexual compulsivity. Without this understanding it is easy to misdiagnose someone.

Others warn of pathologizing and misdiagnosing individuals as well. Kinsey criticized labeling sexual behaviors as normal or abnormal and felt that there was little understanding of the range of sexual behaviors (Orford 2002). Eli Coleman warns clinicians to be careful about over-pathologizing sexual behavior that does not seem "normative" as a client might be misdiagnosed. (Coleman 1995).

Paraphilia

Understanding Paraphilias is crucial to ensure not to misdiagnose someone as having satyriasis. It is common for those within the sexual addiction model to bring in paraphilias as part of compulsive and addictive sexual behavior without fully understanding the definition of a paraphilia.

The word Paraphilia was coined by a psychiatrist Wilhelm Stekel which replaced the word perversion. Stekel became one of Sigmund Freud's earliest followers originated from the Greek "para" which means beyond or alongside of and "philia" is love. The term Paraphilia was popularized in the Diagnostic and Statistical Manual of Mental Disorders, third edition (Gijs 2008).

It is estimated that more males than females experience Paraphiliac interests on a ratio from 20:1 (American Psychiatric Association 1994). Other studies report a higher ratio of male to female being 30:1 by Abel and Osborne. While there is some disagreement as to the actual numbers, it is agreed upon that males have higher incidence of paraphiliac interest than do females. (Gijs 2008) Several hypotheses have been proposed as to why men have a higher incidence than women but none have been empirically validated.

One reason is that men have men are more easily conditioned to a wider range of sexual objects because of biological sexual plasticity. Another hypothesis is that men are more visual in terms of sexual sensitivity and are more vulnerable to develop paraphilias. Still another hypothesis is that males are conditions to detach from their primary love objects—that being their mothers—at an early age so would be more vulnerable to developing a paraphilia. And last, men are culturally allowed to explore and experiment with their sexual preferences moreso than women (Gijs 2008).

There are nine subtypes of Paraphilia according to the DSM IV including exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, voyeurism and Paraphilia not otherwise specified (American Psychiatric Association 1994).

The DSM IV defines Paraphilia as "…recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other nonconsenting persons, that occur over a period of at least 6 months (American Psychiatric Association 1994). The person has to experience distress around this behavior for the diagnosis to be valid.

The individual possessing a Paraphilia experiences obligatory erotic fantasies for sexual arousal around non-living things for sexual arousal and sexual gratification. Some need them all

the time, some need to act them out and some only need them and use them (Gijs 2008) episodically. For this paper Paraphilia will be referring everything under the definition except for the sexualization of children.

Paraphilias, like hypersexuality, are repetitive, compulsory and ritualized at times can occupy a lot of time—sometimes hours—involving sexual urges, behaviors and fantasies (Kafka 2007). Some people have just one Paraphilia, some have more than one and others have normative sexual desires, fantasies and behaviors along with Paraphilias. For many who possess Paraphilias, they might find it disturbing, time consuming and interfering in terms of not wanting this particular thought and interest to be their desire, but it differs from satyriasis.

There is some evidence and strong beliefs in the psychotherapy community that paraphilias (including fetishism) may be part of the obsessive-compulsive disorder spectrum (Darcangelo 2008).

The problem with those who enter therapy with a Paraphilia is that they report experiencing much distress just as those do with satyriasis. The clinician must assess if the experienced distress is from shame and lack of education around their sexually arousing desires and/or what the degree of impairment is within their lives such as interfering with forming attached relationships, employment, education or any other areas of their lives.

There exists controversy over the validity and reliability around the classification of paraphilias. There is also controversy around removing some of the paraphilias from the DSM IV particularly sadomasochism and transvestic fetishism as these do not usually involving nonconsenting adults nor are they breaking any laws (Gijs 2008).

There are even some theorists who believe that paraphilias are part of the normative sexual expression for those who possess it. In 1914, sexologist Albert Eulenburg wrote about a

commonality across the paraphilias, stating that “their roots reach down into the matrix of natural and normal sex life; there they are somehow closely connected with the feelings and expressions of our physiological erotism. They are...hyperbolic intensifications, distortions, monstrous fruits of certain partial and secondary expressions of this erotism which is considered 'normal' or at least within the limits of healthy sex feeling” (Eulenburg 2004). Stekel did not believe that paraphilias were necessarily pathological unless it placed a partner secondary on a consistent basis (Eulenburg 2004). This clearly separates paraphilias from hypersexuality as that is clearly something unnatural to the person possessing it.

There is research showing that men with paraphilias are “more likely to report periods of persistently heightened sexual behaviors leading to orgasm, compared to the general population” (Kafka 2007). This is evidence even more that differentiating between someone with a paraphilia should be distinguished from someone with hypersexuality.

Stage Five of Coming Out Gay

A differential diagnosis needs to be established for gay men when assessing hypersexuality. There are six stages to the coming out process from denial to full acceptance (Cass 1979). Stage five of the coming out process involves hypersexual behavior which looks out-of-control. This is actually delayed adolescence in which gay males were unable to express their sexuality during the age appropriate developmental stage as teenagers (Kort 2008). If stage 5 persists for too long (more than 2 to 3 years), a diagnosis of hypersexual may be appropriate. In addition, heterosexually married gay men often are compulsive sexually, as they are secretive and hide their orientation and try to keep it suppressed. Once they come out to themselves and others—including their wives--and integrate a gay identity, they no longer display sexually compulsive behavior.

Like adolescents who do all kinds of things to underscore their "emerging" as individuals—being rebellious, sexually promiscuous, French-kissing in public--anything to draw attention to themselves. Clinicians—and they themselves—don't realize that this is only a phase of development that they missed at their age-appropriate time. The difference is that their "gay age" doesn't match their chronological age. Whereas such behavior is developmentally appropriate for teens, it doesn't seem appropriate for adults.

Therapists who aren't aware of stage five behaviors may misdiagnose clients as suffering from sexual addiction or compulsivity. These therapists may also unwittingly shame their clients by displaying their own discomfort over their clients' stage five behavior.

Axis I Disorders

A plethora of information exists regarding the coexistence of mood disorders with hypersexual behavior. It is crucial here again to be able to distinguish if the hypersexual behaviors are linked to a mood disorder, therefore ruling out a diagnosis of hypersexuality solely or if the hypersexual behavior is causing the mood disorder. Assessment of Axis I diagnosis such as anxiety disorders, Dysthymia, Bipolar Disorder, Attention Deficit Disorder, Substance abuse disorders, social phobias, post-traumatic stress disorders, sexual dysfunction and other impulse control disorders (Kafka 2007; Reid, Carpenter and Lloyd 2009).

Personality Disorder (Axis II)

Differentiating whether a client is exhibiting hypersexuality or a symptom of an Axis II diagnosis demands a thorough assessment in the beginning of treatment. Personality disorders amongst hypersexual clients have largely been untapped and not much information exists on this today (Reid 2009). Various personality traits have been observed with people suffering from

hypersexuality including proneness to boredom, low self-esteem, shame, interpersonal sensitivity and emotional dyregulation (Reid, Carpenter and Lloyd 2009).

Attachment Disorders

Another reason for hypersexuality by those in the field is that it is an attachment disorder. Research in sexual addiction has addressed attachment disorders being the reason for the onset of out-of-control sexual behavior (Carnes 1991; Schwartz and Masters 1994). Unable to tolerate the affect which results from close bonding, the belief is that sexual acting out helps the individual to regulate their affect (Schwartz and Southern 1999)

American psychologist Harry Harlow separated rhesus monkeys from their mothers in a number of controlled experiments and reared them in isolation, with surrogate mothers made of both wire and cloth. Even though the surrogate made of wire offered milk, Harlow found that the infant monkeys spent most of their time clinging to the cloth "mother," although there was no nourishment to be gained. He suggested that monkeys needed the comfort of contact and found that if he introduced them back into the colony after three months, usually they were accepted and adapted well. After six months, however, the monkeys were severely withdrawn or violent, and also found it difficult to mate. If the females raised in isolation produced offspring, often they ignored them (Harlow and Harlow 1963).

Harlow concluded that in all primates, maternal deprivation leads to distorted development, and suggested the importance of mother–child bonding. Not only do children look to their mothers for such basic needs as food, safety, and warmth, but also need to feel love, acceptance, and affection from their caregiver. His findings show that delinquent or inadequate attentiveness to the needs of a child can result in some long-term psychological physical effects (Karen 1994).

Research shows that good primary caregivers provide their children with a secure emotional base. Wherever they explore, they can feel safe and find others with whom to have relationships, and not have to self-soothe. This parental bond becomes an important part of the child's personality, serving as an internal working model or set of expectations about the likelihood of receiving support from available attachment figures during times of stress. This "template" becomes the basis for all future close relationships throughout childhood, adolescence, and adult life (Bowlby 1988). Otherwise, problems occur, creating attachment disorders.

Attachment is the first crucial stage of development. How one learns to attach and bond sets the stage for later relationships and some theorists believe that it can set the stage for sexual disorders—particularly hypersexuality.

Three developmental processes are created that are associated with a child's development of emotional competence, a sense of well being and skills for successful relationship development. These processes include the need to be physically close to a primary attachment figure; when upset having an emotionally secure, stable attachment figure to turn to for soothing; and after repeated experiences with the attachment figure, the child internalizes the relationship as secure so that he or she can hold it in the mind for a sense of comfort when physically distant from the care provider (Greenspan 1977). This imprinting serves as the future template of attachment and will dictate how the individual will interpret and respond in adult relationships to a partner's expression, tone, scent, and tactile response. Depending on the interactions between infant/child and caretaker, the attachment style formed will be either secure or insecure (Bowlby 1988).

The theory is that attachment disorders are at the root of hypersexuality. An individual does not develop healthy attachment skills he is likely to have problems self-soothing, regulating his own affect, have low self-esteem and high levels of anxiety in relationships either fearing engulfment or needing excessive mirroring from a partner using sexual acting out as his way of regulating his affect (Schwartz and Southern 1999).

Treatment Models

Sexual Addiction and Compulsivity

Sexual addiction is described primarily as a problem for males, both gay and straight. Patrick Carnes has written extensively on the subject of sexual addiction. In fact, he popularized the term *sexual addiction* in his landmark book from 1983 *Out of the Shadows: Understanding Sexual Addiction*, which illuminates for many men how to identify and get help for sexual behaviors that are out of control and causing them distress. *Cruise Control: Understanding Sex Addiction in Gay Men* by Robert Weiss is written for gay men with sexual addiction.

In the model, *addiction* is any activity that interferes in a client's life in some way, but which he continues to partake of despite the negative consequences.

Addictive Cycle

Carnes identified what he calls a four step addictive cycle consisting of preoccupation, ritual, sexual behavior and despair. (Carnes 2001). Interestingly, this was not the first time that hypersexual behavior was seen as cyclical. Krafft-Ebing referred to "cyclical bursts", it was said that the satyr could not suppress his physical needs. During his heightened sexual energy, Krafft-Ebing believed that the satyr could not distinguish between right and wrong and was legally irresponsible (Klaf 1966). Carnes explains in *Out of the Shadows* that the sex addict has

impaired thinking, is delusional and his behaviors begin to become unmanageable. This is very similar to what Krafft-Ebin described.

During the preoccupation stage, a sex addict makes sure he has enough time and money to go to bars or clubs. He plans his day, even his week, around his hunt for sex. He might ruminate and obsess over his next sexual conquest. In *ritualization*, he'll frequent the same bars, clubs and internet sites, wearing the same clothes or cologne, verbalizing and behaving in similar ways each time. Unconsciously, most sex addicts prefer preoccupation and ritualization to actual *sexual behavior*—because after orgasm, they "crash" into the last stage: *despair*. To relieve their depression, they start the cycle over again (Carnes 1983).

Carnes' Anatomy of Sexual Addiction

1. A pattern of out of control sexual behavior.
2. Severe consequences due to sexual behavior.
3. Inability to stop despite negative consequences.
4. Persistent pursuit of self-destructive or high risk sexual behavior.
5. On-going desire or effort to limit sexual behavior.
6. Sexual obsession and fantasy is a primary coping strategy.
7. Increasing amounts of sexual experience because the current level of activity is no longer sufficient.
8. Severe mood changes around sexual activity.
9. Inordinate amounts of time spent in obtaining sex, being sexual, or recovering from sexual experience.
10. Neglecting or reducing social, occupational, or recreational activities because of sexual behavior. (Carnes 2001)

Carnes talks about the progression of the addiction which he parallels to chemical addictions. He believes that like the drug addict and alcoholic, the sex addict requires more and more of whatever behavior satisfied him in the past. Because this progression occurs over time, it's not always obvious. Initially, masturbation with fantasy is enough to satiate his sexual appetite. Later, he needs to view pornography while masturbating. Then he feels the need to actually meet someone. Suddenly, he's cruising at a bar or sex club, or going online more often than he wants to (Carnes 2001).

In the sexual addiction model, problems crop up when, in spite of negative consequences, a man acts out risky behaviors that most men could enjoy safely in their imaginations or within rules and safe boundaries Typically, the sex addict prefers swift, quick sex over the challenge of negotiating with a possible partner. He'll spend hours online, viewing internet porn, scanning personal ads, and frequenting chat rooms. Family and friends can be watching TV in the same room, while he's enjoying gay-porn websites on his laptop. If someone glances over at what he's doing, he can switch to a different screen with the click of the mouse. Cybersex doesn't have to be associated with masturbation. The chase and the hunt are more exciting than the catch (Carnes 1991).

In addition to strongly recommending the 12-step work into the treatment of sexual addiction, Carnes also emphasizes cognitive distortions which need to be changed involving their core believe system. Carnes says that that the sexual addict suffers from four erroneous core beliefs such as 1) I am basically bad and unworthy; 2) No one will love me as I am; 3) My needs will never be met if I have to rely on others and 4) Sex is my most important need. (Carnes 2001)

Sexual Addiction Inventory

Carnes sexual addiction inventory is anecdotal. In 1997, Patrick Carnes and Robert Weiss developed the Gay and Bi-Sexual Addiction Screening Test (G-SAST) to help assess sexually compulsive or "addictive" behaviors (Weiss 2005). Following is an adaptation of the test, which you can use with your gay male clients to determine whether or not they are struggling with sexual addiction.

Simply give clients one point for every "yes" answer. A score of 13 or higher indicates a possible sexual addiction that should be further explored in therapy.

Sexual Addiction Screening Test

1. Were you sexually abused as a child or adolescent?
2. Have you subscribed or regularly purchases sexually explicit magazines like Playboy or Penthouse?
3. Did your parents have trouble with sexual behavior?
4. Do you often find yourself preoccupied with sexual thoughts?
5. Do you feel that your sexual behavior is not normal?
6. Does your spouse (or significant other(s), ever worry or complain about your sexual behavior?
7. Do you have trouble stopping your sexual behavior when you know it is inappropriate?
8. Do you ever feel bad about your sexual behavior?
9. Has your sexual behavior ever created problems for you or your family?
10. Have you ever sought help for sexual behavior you did not like?
11. Have you ever worried about people finding out about your sexual activities?
12. Has anyone been hurt emotionally because of your sexual behavior?
13. Are any of your sexual activities against the law?
14. Have you ever made promises to yourself to quit some aspect of your sexual behavior?
15. Have you ever made efforts to quit a type of sexual activity and failed?
16. Do you have to hide some of your sexual behavior from others?
17. Have you attempted to stop some parts of your sexual activity?
18. Have you ever felt degraded by your sexual behavior?
19. Has sex been a way for you to escape your problem?
20. When you have sex, do you feel depressed afterwards?
21. Have you felt the need to discontinue a certain form of sexual activity?
22. Has your sexual activity interfered with your family life?
23. Have you ever been sexual with minors?
24. Do you feel controlled by your sexual desire?
25. Do you ever think about sexual desire is stronger than you are?

The Gay and Bisexual Male Sexual Addiction Screening Test

1. Were you sexually abused as a child or adolescent?
2. Have you subscribed or regularly purchased/rental sexually explicit magazines or videos?
3. Did your parents have trouble with their sexual or romantic behaviors?
4. Do you often find yourself preoccupied with sexual thoughts?
5. Has your use of phone sex lines, computer sex lines, etc, exceeded your ability to pay for these services?
6. Does your significant other(s), friends or family ever worry or complain about your sexual behavior? (Not related to sexual orientation.)
7. Do you have trouble stopping your sexual behavior when you know it is inappropriate and/or dangerous to your health?
8. Has your involvement with pornography, phone sex, computer board sex, ext. become greater than your intimate contacts with romantic partners?
9. Do you keep the extent or nature of your sexual activities hidden from your friends and/or partners?
10. Do you look forward to events with friends or family being over so that you can go out to have sex?
11. Do you visit sexual bathhouses, sex clubs and/or video bookstores as a regular part of your sexual activity?
12. Do you believe that anonymous or casual sex kept you from having more long-term intimate relationships or from reaching other personal goals?
13. Do you have trouble maintaining intimate relationships once the "sexual newness" of the person has worn off?
14. Do your sexual encounters place you in danger of arrest for lewd conduct or public indecency?
15. Have you spent time worrying about being HIV positive & continue to engage in risky or unsafe sexual behavior anyway?
16. Has anyone ever been hurt emotionally by events related to your sexual behavior, e.g., lying to partner or friends, not showing up for event/appointment due to sexual liaisons, etc.,? (not related to sexual orientation)
17. Have you ever been approached, charged, arrested by the police, security, etc., due to sexual activity in a public place?
18. Has sex been a way for you to escape your problems?
19. When you have sex, do you feel depressed afterwards?
20. Have you made repeated promises to yourself to change some form of your sexual activity only to break them later? (Not related to sexual orientation.)
21. Have your sexual activities interfered with some aspect of your professional or personal life, e.g. unable to perform at work, loss of relationship? (Not related to sexual orientation.)
22. Have you engaged in unsafe or "risky" sexual practices even though you knew it could cause you harm?

23. Have you ever been paid for sex?
24. Have you ever had sex with someone just because you were feeling aroused and later felt ashamed or regretted it?
25. Have you ever cruised public restrooms, rest areas and/or parks looking for sexual encounters with strangers?

Criticisms of Sexual Addiction Model

Sexual addiction is the most popular term today in the public's awareness is the term for Satyriasis which has raised several criticisms. Many object to the term "addiction" applied to sexual behavior for many reasons. The World Health Organization (WHO) discredited the term "addiction" as clinically valid in favor of using the word "dependence". Using the word "dependence" allows for the disorder to exist in varying degrees rather than a disease which you either have or not (Siegel and Siegel 2010). There is even concern that using the disease model on sexuality "threatens the civil liberties of sexually variant peoples (Levine and Troiden 1988). The term "addiction" is not in the DSM and is controversial in and of itself (Goodman 1998). What does exist in both the DSM and the International Classification of Diseases (ICD-10) is abuse and dependence mainly used for substance abuse problems (Siegel 2010).

Another criticism with the term sexual addiction is that the general public may use the term 'sex addict' to refer to anyone from a sexually demanding spouse to the serial rapist to the pedophile (Giugliano 2004). To some, the term "sexual addiction" leaves too much room for inclusion of any sexual expression that falls outside the Christian view of marriage (Siegel and Siegel 2010). Orford felt a shortcoming in calling satyriasis sexual addiction would be that any sexual desire or behavior that was different from customary social habits would be deemed unimportant and devalued. (Orford 2002)

Kafka wrote his concern about labeling hypersexuality an addiction by saying that males are sexually driven largely from their biological makeup and to label them as addicts was like labeling those with excessive thirst or sleep as addicted to sleep and fluids even when they are using to self-sooth in excess (Kafka 2007).

Labeling sex as an addiction has the potential to make anything sexually deviant pathological and would undo what the 1960's and 1970's did to depathologize sexual behaviors (Levine & Troiden 1988). Levine and Troiden basically argue that if the decision around what is healthy and what is pathological sexually rests on the clinician than it will be filled with value ridden judgments and treatment will follow what the therapist's beliefs are and not what is healthy for the client. Their concern is the lack of scientific validity to the terms sexual addiction and sexual compulsion. The concern is that the clinicians will stigmatize erotic conduct based on what the cultural values are at the time in arbitrary ways (Levine & Troiden 1988; Orford 2002). Levine and Troiden cite other studies which talk about "medicalizing" morality and cloaking judgments as pseudoscientific diagnosis (Levine and Troiden 1988). They basically believe that sexual addiction and sexual compulsion are "value laden and conceptually flawed" (Levine and Troiden 1988).

Although various theories of satyriasis have had considerable influence in mental health and in the larger culture, they have *not* been subjected to rigorous empirical testing. Instead, they have been based on therapist's clinical observations of clients already known by them to have trouble with out-of control sexual behavior. Bancroft writes that sexual addiction and compulsivity has been overly focused on definitions in its attempt to be included in the DSM-IV rather than focusing more on the questions of how and why someone's sexual behavior becomes

problematic. Bancroft faults the sexual addictions theorists for reporting clinical impressions rather than reported data (Bancroft 2008).

Overall, it seems that the negative framing of hypersexual behaviors by the mental health field has been the result of theoretical orientations, expectations, and personal attitudes that biased clinicians' observations of these clients. This is perhaps the biggest concern from those in the mental health field is that because sexual addiction does not receive much scientific attention or background; many believe there is a "danger of introducing a moralistic element (Orford 2002). Words of caution are used by various writers about out-of-control sexual behavior. Giugliano writes, "….there is always a danger when research lags behind anecdotal and pseudoscientific attempts to explain a phenomenon" (J. R. Giugliano 2008). He explains that it makes it difficult who has decided that the problem exists for the client—the client or the clinician.

Another article also expresses caution in terms of how treatment is implemented given the limitations which exist without adequate scientific research around out-of-control sexual behavior. In it he challenged the psychological and sexological professions to look beyond the dominant theoretical base to include a much wider appreciation for diverse opinions from a much more comprehensive community of interests in order to transcend well-intended, initially necessary but unintentionally self- limiting paradigms. This article which is a useful addition to the field of excessive sexual behavior seems to have gone unnoticed in the sexual addiction community as it has never been cited or referenced. The author basically writes that "within the sexual addiction community are people who use religion to support responsible sexual behavior and their colleagues who recoil against the sexual damage caused by the church. There are those who privilege heterosexual marriage and others who champion the morally equivalent right for

same-sex couples. Sobriety in one person's approach to compulsive sexual behavior is anorexia to another. Abstinence and harm reduction models feed from different springs. Many people in the field embrace 12-step concepts but the percentage that does not is likely to grow. Which of these different groups doesn't deserve representation within this organization?" Herring goes on to say that he believes that "the field of sex therapy is the obvious 'go-to' group on any matter of sexuality. Since this community has a history of privileging a robust, rather than a restricted, sex drive, the active involvement of sexologists is especially essential to the ongoing creation of concepts of sexual compulsivity"(Herring, 2004).

Herring writes that without this it is inevitable that a bias will exist. He invites the sexual addiction field to also ask for help and dialogue from the pornography or professional sex industry to reduce sexual shame and making sex the enemy rather than its poor usage (Herring 2004). Because of the fact that sexual addiction is not based on science and is based on theory and conjecture there was concern in the 1990's that it would become stagnate (Orford 2002). Becoming stale and failing to further develop as a field seems to be exactly what is seen today amongst the field of sexual addiction. One major way this shows is the lack of defining what healthy sexuality will look like once the hypersexual behavior is removed.

One criticism of the sexual addiction model is that there is withdrawal from this type of addiction like other chemical addictions. However, this is not necessarily the case.

Some of the physical withdrawal symptoms that clients report in Carnes' hospital studies—include headaches, nausea, chills, sweats, and itchy skin, possibly because the body is no longer being numbed by high doses of neurochemicals. They also include fatigue, anxiety and depression, feeling more tense and nervous, even rapid heartbeat. Under the sexual addiction model many addicts use sexual behavior as a way to cope with stress, they may suffer periods of

insomnia, irritability, and feelings of hopelessness and helplessness, and changes in appetite. In addition both high and low sexual arousal is reportedly experienced by being flooded with sexual thoughts and urges more so than while they were sexually acting out. Others say that their libido shuts down entirely they worry about becoming asexual (Carnes 1991).

Withdrawal symptoms from sexual addiction usually last fourteen to fifteen days (Carnes 1991). For some, however, they can last for up to eight to ten weeks. This point is very important, because if not understood and treated, these symptoms may lead to relapse (Carnes 1991). This is what Krafft-Ebing talked about when he addressed that prolonged sexual abstinence was the causation of hypersexuality (Krafft-Ebing 1965).

However, Levine and Troiden distinguish between psychological withdrawal symptoms and life threatening symptoms from an actual drug. They state that "sex is an experience, not a drug (Levine and Troiden 1988). The withdrawal symptoms they describe such as delirium, convulsions and/or death are different than withdrawing from a "learned pattern" of behaviors (Levine and Troiden 1988).

Another criticism is from those who see addictions as a physiological dependence on foreign substances. While they see the parallel Carnes makes between behavioral similarities from gambling to drug and alcohol addiction they state "behavioral similarities do not overrule the original definition of addiction" (Barth and Kinder 1987)

Some feel that the calling repetitive behaviors addictions which do not include chemicals will only trivialize the concept of addiction and prevent public support for research and intervention in chemical addictions (Giugliano 2004) Like today's sex addicts, historically, lesbians and gays were told that their only salvation was to seek good psychotherapy and that they really had to *want* to change. If they weren't highly motivated, they were told,

psychotherapy would fail, condemning them to a life plagued by depression that would ultimately end in suicide. They were told to be constantly on guard for relapse warning signs triggering them back into homosexuality (Kort 2008)

Siegel and Siegel perceive the term sexual addiction as telling the client they are destined also to be constantly vigil to prevent their sexual behaviors from reoccurring and that it is lifelong process. They feel that this instills "people to live in fear of the 'demon' luring around every corner: themselves" (Siegel & Siegel 2010). This is very similar to what happened to gays and lesbians early in the psychotherapy community (Kort 2008).

Contemporary attitudes toward sexuality, including those in psychotherapy, have religious, legal, and medical underpinnings, and prejudice and misinformation have prevailed over accurate information. The past offers a sad litany of ineffective, wrong-headed treatment for sexuality. Every such "cure" is based on some faulty etiology, yet the debate of nature versus nurture still rages with regard to the "origins" of sexual compulsivity.

Given this history of pathologizing sexuality, it is therefore crucial that clinicians know and understand the history of psychotherapy for sexually compulsive behaviors. It is also important to remember that, like other clients, most men with satyriasis seek therapy for help in dealing with their presenting out-of-control sexual problems—they don't want to be bothered with what the clinician might do or feel about their sexual behaviors and fantasies.

In terms of treatment of sexual addiction there does not exist a healthy model for erotic recovery. The individuals in recovery are taught how the problem originated; learn how to address the out-of-control sexual through cognitive-behavioral therapy as well as the 12-step model and refrain from the sexual behaviors which caused them problems. However, what is left is a vacuum and void in terms of what is appropriate and not appropriate for them in their

recovery. Some of the recovery models are extremely restrictive specifically Sexaholics Anonymous which is rigid, orthodox, cookie-cutter approach in that no sexual relations should occur outside heterosexual legal marriage. They tell participants what their recovery and sobriety should look like: “any form of sex with one's self or with partners other than the spouse is progressively addictive and destructive” (Sexaholics Anonymous 2001) It promotes that the only healthy sexual activity and fantasy is within a heterosexually legally married context and limits sexual expression to only procreative and relational sex (calling anything other than this lust) and discourages being sexual for feeling better or self-soothing. Here is evidence that using the sexual addiction model leaves the disorder open to Judeo-Christian values and “reflect an arrogance that sex addiction proponents are the keepers of the scepter of morality and normalcy (Siegel and Siegel 2010).

Perhaps the biggest critic of the sexual addiction model is Marty Klein who wrote that sexual addiction instills fear in people about the darker parts of their sexuality and in so doing increases their sexual guilt. Klein is vocal on rejecting the notion that anyone is powerless over their sexual behavior and teaching that sexuality can be destructive (Klein 1998).

Compulsive sexual behavior (CSB)

One of the most well-known sexologists of the Compulsive Sexual Behavior (CSB) model is Dr. Eli Coleman. He defines CSB as a behavior that is driven by the need to reduce anxiety and not by sexual desire (Coleman 1995). This is consistent with the sexual addiction model which also defines the out-of-control sexual behavior as being about anything other than sexual desire. Michael Quadland who worked with Coleman and used the obsessive-compulsive model in their research also supported the theory that hypersexual behaviors were anxiety based. He attributed the cycle of sexual compulsivity to low self-esteem, intimacy issues and poor

relationship skills (Quadland 1985). Both Coleman and Quadland have gone to great lengths to ensure that the sexually compulsive person is not overpathologized and understands that with sexual prejudices amongst therapists, laymen, and the politics involved that there is constant danger of this occurring (Coleman 1995).

Coleman does not agree, however, that hypersexual behavior is a sexual addiction and refers to that comparison as a "popular metaphor" (Coleman 1990). There has long been a debate between Patrick Carnes and Eli Coleman over the diagnostics of hypersexual disorder. Eventually there was a creation of a hybrid term, "sexual compulsivity/addiction" or "sexual addiction/compulsivity" to cover both cases (Shaffer 1994).

Coleman asserts that hypersexual behavior is symptomatic of obsessive compulsive disorder and should be treated as sex being the means to reduce ones anxiety. He acknowledges that while most people with obsessive compulsive disorder do not report feeling pleasure as do those with sexually compulsive behaviors, there are enough of those with compulsive sexual behavior who report displeasure and disdain for what they have done and continue to do (Coleman 1991).

Coleman writes that the sexually compulsive model provides a stronger description of what happens to the sexually compulsive person in terms of how it manifests along with a stronger treatment model and recovery process. Perhaps the most important points of the sexual compulsion model are that it does not identify any particular sexual behaviors as problematic, only those with which the client reports are problematic for them, it allows for a continuum of severity of compulsions and it allows for a greater range of treatment to be implemented. Overall the sexual compulsive model incorporates theoretical explanations such as biological,

sociocultural, personality, and environmental factors which must be assessed in each individual client (Coleman 1990).

Similar to the sexual addiction model, Coleman attributes the compulsive sexual behaviors as related to childhood trauma or abuse and where children were raised in restrictive and rigid households.

There is a continuing debate, however, as to whether or not hypersexual behavior should be diagnosed as obsessive-compulsive disorder. Aviel Goodman has addressed this thoroughly in his book, *Sexual Addiction: An integrated Approach*, where he writes that typical compulsive behaviors are done to avoid feared events and to lessen one's stress and not to seek a desired objective or condition. Goodman advocates for the use of sexual addiction over sexual compulsion stating that for sex addicts, the behaviors are ego-syntonic as opposed to sexual compulsives where the behaviors are ego-dystonic. He supports the addiction model further by reinforcing his distinction that compulsive behavior is about something the individual does not look forward to and is instead dreaded whereas sex addicts is about enjoyment and gratification (Goodman 1998).

The DSM IV defines compulsion as "repetitive behaviors (e.g. hand washing, ordering, checking) or mental acts (e.g. praying, counting, repeating words silently) the goal of which is to reduce anxiety or distress, not to provide pleasure or gratification (DSM IV, American Psychiatric Association 1994). Given this definition there is argument then that sexual compulsion is not the accurate diagnoses since it involves *pleasurable* activity. However, what is true is that those with hypersexual behaviors who enter the therapy rooms do not report pleasure at all and instead report going against their own will similar to those with OCD. There is talk about recognizing that while sexual pleasure is experienced through hypersexuality, the

compulsivity around the behaviors robs one of the pleasure and therefore should be "viewed as a variant of OCD" (Coleman 1990).

Coleman also shows in his research how the sexually compulsive model is more effective in treatment using medication which will be explore in the treatment focus of this paper (Coleman 1995)

Criticism of the Sexually Compulsive Model

Goodman refers to the research in Lance M. Dodes' 1995 book, *The Heart of Addiction*, which Dodes observed the affect that arises from compulsive behaviors which are avoided is anxiety whereas he observed that when addictive behavior is avoided in addition to anxiety emerging, the prime affect that surface is rage (Goodman 1998). Given this it would imply that for the sex addict the main drive is not to reduce anxiety but instead to reduce rage. Goodman has also been the most vocal I reviewing all of the models and supporting the addiction model over the sexually compulsive model. He disagrees with Coleman that the sexual addiction model targets certain sexual behaviors as problematic and other behaviors as not (Goodman 1998). Another disagreement Goodman has with Coleman is the assertion that hypersexual individuals mostly come from conservative and restrictive environments growing up and believes that more than simply these types of sociocultural environments are responsible for sexual compulsion.

In the research by Howard Shaffer, he is a proponent of the sexual addiction model over the sexual compulsion model not because there is much of a difference but moreso that clinicians can expect more treatment compliance. Shaffer also criticizes Coleman's dismissal of using spirituality in his model due to what Shaffer says is Coleman's failure "to acknowledge that almost every medical treatment includes a divine component. Another criticism from Shaffer to Coleman is Coleman's calling the sexual addiction a *popular metaphor* which Shaffer says is

also true about the compulsive sexual behavior model or any other model which exists about a disease (Shaffer 1994). In their study, Barth and Kinder did not agree that Coleman's compulsive sexual behavior model was valid due to the fact that pleasure was involved along with the behavioral intent being about escape from present anxiety not something in the future as well as their intention to keep the diagnosis clinically sound and in doing so using the DSM categories which only spoke of compulsive behaviors are something that brought pain and discomfort—not pleasure (Barth and Kinder 1987).

Sexual Impulse Control Disorder

Barth and Kinder favored concept of hypersexuality as being about sexual impulsivity given that nothing new was learned in the literature on neither sexual addiction nor compulsive sexual behavior to warrant a new name (Barth and Kinder 1987). Their interest was in keeping what already existed in the DSM IV. The DSM IV defines impulse-control disorders as:

"…the failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others. For most of the disorders in this section, the individual feels an increasing sense of tension or arousal before committing the act and then experiences pleasure, gratification or relief at the time of committing that act. Following the act there may or may not be regret, self-reproach, or guilt" (American Psychiatric Association 1994).

Barth and Kinder felt that the hypersexual individual experienced Atypical Impulse Control Disorder and nothing more.

Support for Barth and Kinder's findings come from Kafka who concluded that most individuals with hypersexuality have multiple lifetime comorbid mood disorders such as depression and anxiety along with psychoactive substance abuse and other impulse control disorders (Kafka 2007).

Barth and Kinder also criticized the fact that empirical evidence did not exist in the work of hypersexuality as Carnes used case histories as his source of information. While they respected that for all those doing the research their subjective clinical information was similar they pointed more to the empirical findings of Michael Quadland who actually did an empirical investigation on sexual impulsivity. However, Quadland's research only included gay men and thus his findings could not be generalized (Barth and Kinder 1987). What Quadland's findings did show is a support of sexual impulsivity and not inflated sexual desire by showing that those within normal limits of sexual desire did not differ on their desired number of partners only on the actual number having acted upon. Also those with sexual disorder had less long-term relationship which Barth and Kinder felt supported that they tended to isolate themselves and keep their behavior a secret (Barth and Kinder 1987).

One criticism of the sexual impulse control disorder is that some feel that hypersexual behavior is planned as well as considerable amount of time is spent on the behavior--therefore calling it impulsive is in error. (Goodman 1998). Another criticism is that their explanation of hypersexual behavior isn't much different at all from Carnes, Coleman or Mark Schwartz (who was also one of the top researchers of this disorder at that time). Barth and Kinder believed as did the others that hypersexual behavior was a reaction to anxiety and that it was a way to escape and avoid boredom, personal and professional problems, unhappiness, anger and stress. They asserted that the shame and isolation caused these individuals to continue sexually acting out (Barth and Kinder 1987).

Paraphilia-Related Disorders

The term, Paraphilia-related disorders (PRD's), grew out of research by Martin Kafka who rejected both the sexual addiction, sexual impulsivity and compulsive sexual behavior

models because “it was not bound to explanatory models for these specific actions and behaviors” (Kafka 2007). His observation was that there were sexual behaviors that were culturally normative—unlike paraphiliac behaviors which were unconventional—and that the sexual acting out of them resembled the same type of manifestation as did the paraphilias. He defined these behaviors as recurrent and intense sexually arousing fantasies, sexual urges or behaviors which were culturally normative sexual behaviors that were engaged in increasingly in frequency and intensity causing impairment in the person’s life. He noticed they caused significant distress in the person’s life socially, personally and psychologically. And also important was that the behaviors had comorbid with Axis I or II diagnoses (Kafka 2007).

He wrote that the sexual addiction and compulsivity models missed a central concept in that sexual behavior is driven largely by biology in males (Kafka 2007). As in paraphilias being 20:1 ratio in prevalence, Kafka reported an estimated 5:1 for PRD’s reinforcing that they are still a predominately male problem (Kafka 2007). From this Kafka reported that in his findings the most sexually engaged in behaviors for PRD’s were masturbation and the usage of porn causing them to prefer that over their partners and thus creating intimacy dysfunctions much the same way other clinicians viewed hypersexual disorders (Kafka 2007; Carnes 1991; Coleman 1995).

Dual-Control Model

This model was developed by John Bancroft and associates out of the Kinsey Institute. They have outlined a theoretical dual-control model. Bancroft and associates explore the balance between two systems in a person’s brain; the sexual activation or excitation system and the sexual inhibition system. (Bancroft 2009). Bancroft refers to *sexual risk takers* as showing lower inhibitions or higher excitation or both, and ultimately tends toward promiscuous behavior. The belief is that the occurrence of sexual arousal depends on a balance between sexual excitation

and inhibition of sexual response and that individuals vary in their propensity for both excitation and inhibition, with typical inhibition proneness being adaptive across species (Bancroft and Vukadinovic 2004). In other words what Bancroft has found is an association between negative mood and out-of-control sexual behavior. For most individuals negative affect inhibits sexual responsiveness. People prone to out-of-control sexual behavior might not know how to keep their sexual inhibition therefore sexual excitation may occur and be conditioned to be associated between negative mood and sexual arousal (Bancroft and Vukadinovic 2004). These individuals report a higher sexual interest and arousability during these negative mood states. Consequently what this is highlighting is an inability to regulate their affect.

The research of the Dual Control Model explains out-of-control sexual behavior as it relates to neurophysiologic aspects of an individual.

Overall what Bancroft is suggesting is that the "role of inhibition of sexual arousal is normally adaptive but that if sexual arousal occurs in inappropriate circumstances this results in an altered emotional state which is assumed to adversely affect normal 'risk management', in a manner analogous to alcohol intoxication". (Bancroft 2009)

Treatment for Hypersexuality over the years

Today there is agreement that to help someone with hypersexuality involves a multimodal treatment approach utilizing behavioral, psychodynamic, group, psychoeducational and pharmacological (Kafka 2007). There is no question that therapists and sexologists have seen clients with problematic sexual behavior and most agree that these clients use sex to reduce tension, relieve stress and regulate their affect. There have been a few theoretical attempts to explain out-of-control sexual behavior as a problem in and of itself which then dictates treatment. It is generally understood that these clients are either disassociating from unpleasant

moods or self-soothing (Reid 2009). The two most popular bodies of work is from Patrick Carnes and Eli Coleman. The other research is gaining popularity and is adding to the literature including sexual impulsivity by Barth and Kinder (Barth and Kinder 1987), paraphilia-related disorders by Kafka (Kafka 2007) and dual control by Bancroft (Bancroft 2008).

The main issue to consider is whether the hypersexual behavior should be treated or the cause of the behavior or both. The question then becomes is it really a problem in and of itself or a manifestation of another problem which when cleared the hypersexual behavior dissipates.

Concerns about treatment involve the use of a sexual addiction model when the hypersexual behavior might be related to OCD and/or to sexual abuse. If untreated for OCD or sexual abuse the sexual addiction model will not be helpful to hypersexual patient.

Historically treatment consisted of many of the same ways we try and help those with hypersexuality today. Both behavioral and medicinal attempts were used from the beginning and continue today under different forms. Some of the earlier treatments, however, were barbaric.

In the 19th century treatment for hypersexual behavior considered “eugenics and sterilization the most important ways of controlling the spread of deviation”. (Klaf 1966) Castration was another way of attempting to control excessive sexual behaviors especially if they involved sexual offending (Stan Moore 1982). Behavioral methods used aversion therapy for compulsive masturbation, adultery and infatuation (Orford 2002).

If it were viewed as being caused by temporal lobe epilepsy then treatment would have been using anticonvulsive medication and progesterones (Moore 1982). If schizophrenia was thought to be the cause of hypersexual behavior than it would have been with lithium for control over the mania (Moore 1982). Even without organic reasons for excessive sexual behavior the literature discusses that medications were used when psychotherapy was not enough to help the

client. The medications used were those which decreased sexual arousal by using progesterones, estrogens and antiandrogens to treat hypersexual behavior with the two major drugs in America being Estradiol and medroxyprogesterone acetate (Moore 1982). In the 1960's it was believed that the hypersexual patient could improve and not be cured. Control of the behavior was hoped for at best in terms of keeping away negative consequences such as legal and family (Klaf, 1966).

Interestingly today the same is said in terms of helping hypersexual patients with only controlling and improving their behaviors but not being able to cure them. There are various 12-step meetings are available to those hypersexual individuals who self-identify as sexual addicts and for whom are told and believe that as long as they use the 12-step program and philosophy they will be successful in remaining sexually sober from their sexual acting out behaviors. However, if they stop using the model and going to meetings they are taught that they are at risk for relapse. Whether a therapist believes in the 12-step model or not the fact is that these meetings help the client become accountable to others and have a place where they will not be judged and can openly share and support one another.

Hypersexuality blocks its sufferers from deep connecting relationships as has been addressed earlier in this paper. That's why it's so important to have another person to relate to on a nonsexual level. Time and again, studies show that for best results, the individual with hypersexuality should engage in individual, group, and 12-step programs—all three together. In proximity to others, he's forced to develop his intimacy and relationship skills.

Not all the 12-step meetings are the same and clinicians should know the differences. It's vital to recognize the fundamental differences between Sex Addicts Anonymous, Sex and Love Addicts Anonymous, Sexual Compulsives Anonymous, and Sexaholics Anonymous.

Sex Addicts Anonymous (SAA) is most liberal in letting people define their own sexual boundaries. SAA welcomes everybody: men, women, gay, straight, bi-attractional and others. Because paraphilia is far more common in men (20:1 according to Kafka) than in women, far more men attend these meetings.

*Sex and Love Addicts Anonymous (*SLAA) focuses on sex and love addiction—that "*in love with love*, PEA infatuation high. Men and women, gay, straight and bi-attractional are welcome at these meetings. These meetings attract more women who tend to focus on the relational—loving—side of their relationships in western culture.

This program helps men and women who tend to move from one infatuation relationship to another—and who, as soon as troubles arise, they move on, hoping that a new relationship will provide with what the last one failed to deliver.

Sexaholics Anonymous has a more rigid, orthodox, and cookie-cutter approach is that no sexual relations should occur outside marriage. They tell participants what their recovery and sobriety should look like: "any form of sex with one's self or with partners other than the spouse is progressively addictive and destructive." Many gay clients report they feel excluded from this particular group because their approach allows sex only within a marital context.

Sexual Compulsives Anonymous, (SCA) was born from Sexaholics Anonymous (SA), when some gay men felt uncomfortable with SA's fundamentalist, heterosexist overtones. Members of SCA design their own recovery program like SAA. In these groups, gay men can discuss their special needs and talk openly and honestly. Lesbians and heterosexuals are welcome, but most members are gay males.

There are several advantages for patients with hypersexual to attend 12-step fellowship groups including the fact that they are no cost other than voluntary contributions, they help

people lessen their shame and secrecy behind the feeling of being stigmatized as well as the 12-step recovery model being a relapse prevention plan based on cognitive-behavioral therapy (Kafka 2007).

Psychopharmacology

The medications which were used historically were anaphrodisiacs to calm and stunt the sexual libido such as Benperidol which is a drug used for antisocial hypersexual behaviors along with major tranquilizer and even estrogen (Orford 2002). These drugs were called, "miracle drugs" and were reported to have positive effects on most of these patients (Kilousky 1967). Since the development of tranquilizing medication they discovered this lowered and diminished and even abolished sexual desire. Historically it was the side effects which were depended upon to help them achieve a normal libido (Klaf 1966). Interestingly this is still the case today 40 years later from the research by Klaf.

Today there is increasing evidence that hypersexuality can be reduced by mood elevating drugs as the SSRI's which supports the idea that hypersexuality is related to affective disorders (Bancroft 2009). In *Sexual Addiction: An Integrated Approach*, Aviel Goodman, M.D. cites a study that sexual behaviors are sustained by "mood-dependent motives." In short, if sexual addiction is driven by emotions, medication can help manage the mood disorder, eliminating the behavior. Libido drives the behavior, and some medications—including Prozac, Zoloft, Paxil and Celexa—help lower sex drive, as well as improving mood. Other medications Goodman reports as helpful include Prozac, Zoloft, Luvox, Tofranil, Norpramine, Anafranil, Lithium, Sertraline plus lithium, and Buspar—all of which are affect-regulating agents (Goodman 1998).

The hypothesis is that hypersexual behaviors are maintained by mood-dependent motives

and that pharmacological treatment of the underlying mood disorder consequently eliminate the hypersexual behavior by alleviating the mood conditions that motivated it. Another research team, Bradford and Gratzer found that serotonin reuptake inhibitors were helpful in treating paraphilias but that they were less effective than they typically are with sexual obsessions and compulsions that occur in the context of OCD (Goodman 1998).

John Sealy provided an exhaustive overview of pharmacology as it relates to hypersexuality. He addressed how several researchers found different medications worked for various hypersexual behaviors such as fluoxetine (Prozac) for voyeurism and exhibitionism, buspirone (Buspar) for tranvestic fetishism, Lithium for autoerotic asphyxia and obsessional gender dysphoria and clomipramine (Anafranil) for exhibitionism (Sealy 1995).

Sealy did his own study using over 300 subjects on a 28-day inpatient setting of sexual behavioral disorder using the sexual addiction model. From this he recommends three major distinct categories when assessing the need for medication. The three categories are sexual addiction with three subtypes, sexual addiction with major mood disorder and sexual addiction with obsessive-compulsive disorder (Sealy 1995). The sexual addiction with three subtypes he does not recommend use medications as they include highly impulsive people without boundaries, denial over how much out-of-control they are along with being completely disconnected to any uncomfortable feeling state. He reported that these individuals did not respond to medications and instead benefitted from cognitive restructuring, boundary setting, and highly structured milieu (Sealy 1995). The subtype of sexual addiction with major depression he reports responded well to SSRI (selective serotonin reuptake inhibitor) antidepressant medication. He found the most effective was fluoxetine (Prozac) 20 mg. Medications such as

Effexor, Luvox and Serzone were not yet available however have been found to be successful as well for this category as well as those with obsessive compulsive disorder (Kafka 2007).

CHAPTER 2

CONCLUSIONS, IMPLICATIONS, RECOMMENDATIONS

CONCLUSIONS

The answer to the question if anything has changed since the initial reporting of hypersexual behavior called satyriasis is no—not much has changed at all. The earliest reports by sexologists have confirmed that a hypersexual disorder does, in fact exist. They saw the same dynamics as all their future counterparts saw in terms of the behaviors cycling, causing negative consequences with the law and family, the need for medication and its side effects to reduce libido as well as the problems remaining within normal limits sexually. There is more in terms of studies and treatments however mostly all of it is anecdotal and based on clinical impressions and not science.

There is also no agreed upon or outlined erotic recovery. It is left to the clinician and the client to determine what is sexual health and that can leave the client vulnerable to unhealthy recoveries. Clinicians need to look toward already existing definitions which are in place about sexual health. The World Health Organization (WHO) in 2001 stated that sexual Health is defined as the integration of the physical, emotional, intellectual, and social aspects of being sexual in ways that are positively enriching and enhance personality, communication, and love. In 2004, WHO states that sexual Health is also explained as a state of physical, emotional, mental and social well being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable safe sexual experiences, free of coercion, discrimination and violence.

Patrick Carnes also provides an outline of the dimensions of healthy sexuality (Carnes 1997). Carnes describes these twelve dimensions as

1. *Nurturing*—capacity to receive care from others and care for oneself.
2. Sensuality—awareness of physical senses that creates emotional, spiritual, and physical presence.
3. Self-image—positive self-perception that includes embracing your sexual self.
4. Self-definition—clear knowledge of both your positives and negatives, and ability to express boundaries as well as needs.
5. Comfort—capacity to feel at ease with yourself and others about sexual matters.
6. Knowledge—about sex in general and your own unique sexual patterns.
7. Relationship—capacity to enjoy intimacy and friendship with friends of both genders.
8. Partnership—ability to maintain a relationship that's intimate and erotic, and interdependent but equal.
9. Nongenital sex—ability to express erotic desire emotionally and physically, without using your genitals.
10. Genital sex—ability to express erotic feelings freely.
11. Spirituality—ability to connect sexual desire and expression to the meaning of life.
12. Passion—capacity to express deeply held, meaningful feelings of desire about one's sexual self and intimate relationships.

Implications

What seems most important is that the terms be clear on what the disorder of out-of-control sexual behavior is to determine the proper therapeutic treatment and intervention. Type of treatments have been addressed in multimodality approaches using approaches including,

psychodynamic, psychoeducational, cognitive-behavioral therapy, addictionology as well as group, individual and couples' therapy. Also pharmacological interventions have been researched to be successful including serotonin reuptake inhibitors.

The best approach may be different for various clients, though some benefit from a mixture of group, individual and couple's therapy along with cognitive-behavioral therapy and possibly self-help groups for relapse prevention (Kafka 2007). The addiction model may offer a behavioral management and cognitive path to recovery. Medication may help those whose behavior is an anxiety-reducing form of obsessive-compulsive disorder (OCD. Finally, viewing the behavior as a vandalized lovemap suggests inquiry into childhood and early abuse might help using a psychodynamic approach.

Bias of Therapists

A major weakness for all of these treatment models is there is nothing scientific or evidence based nor is there an agreed upon model for what sexual recovery can look like. The models are effective for helping clinicians to identify the problem and start the process in learning what is unhealthy. The problems arise when therapists use this to identify which sexual practices are healthy and which are not. In Bill Herring's article, *The Next 20 Years: Developmental Challenges in the Field of Compulsive Sexual Behavior*" he challenged the profession to look beyond the dominant theoretical base to include a much wider appreciation for diverse opinions from a much more comprehensive community of interests in order to transcend well-intended, initially necessary but unintentionally self- limiting paradigms. He warned of clinicians failing clients without doing so and he makes a valid point.

Unless a clinician is trained in sexuality their bias and judgments will interfere in their work with these clients—especially if they are uncomfortable and/or unfamiliar with the wide

variety of *normal* sexual fantasies and behaviors (Siegel 2010). The dangers of therapists being untrained and using their bias is that they will misdiagnose someone as hypersexual quickly in their countertransference rather than seeing other things which have been addressed in this paper such as those who are in conflict with their values and their sexual behvaior such as gay men, those with strong religious beliefs and histories as well as those trapped in rigid gender cognitions just to name a few. Rather than understand the culture and/or negative influences on these people within their culture the risk is that they will be labeled inappropriately as someone with a sexual disorder whereas the problem may be coming from the outside—not from within.

What clinicians need to examine within themselves and what they learn are questions such as are certain sexual behaviors between consenting adults advocated for and approved? If so, by how did the clinician come to this understanding? Most importantly is that that clinicians should not be acting as "sex police". Condemning certain sexual expressions while condoning others is not the job of the therapist. Understanding the sexual behaviors as they relate to the client while also examining the relationship the client has to the sexual behavior is also crucial.

The lack of healthy treatment models for erotic recovery reflects the confusion and lack of understanding as to unhealthy behaviors end and the healthy behaviors begin. Some clinicians say that they support natural sexual energy and what is healthy and normal for couples and individuals who is solely based on their bias and judgment and not necessarily what their clients need nor want. It is inappropriate and unethical to apply to the general public pathologized sexual behaviors which are addressed in psychological studies examining men with sexual issues who were *already* under psychiatric care. Patients are not necessarily representative of well-adjusted individuals in the general population. Generalization from observations of patients with sexual problems cannot be placed on the entire population. There are plenty of men with high

sex drives for whom are not bothered by their sexual behaviors or fantasies and for whom it does not interfere with their lives.

Other researchers and clinicians have made attempts such as these and have caused more damage than anything else. Pepper Schwartz wrote in 1983 in her book, *American Couples*, that lesbians were out of the norm based on their frequency of sexual contacts which was less than their heterosexual and gay male counterparts. She coined the term *Lesbian Bed Death*. Lesbians protested asking people not to define what natural sexual energy was for them. They invited folks to understand that for them counting the frequency of orgasms was not what sex was about. It didn't always have to include penetration. Lesbians said that for them a sensuous bath and cuddling was just as sexual for them as having penetrative and orgasmic sex from the night before (Kort 2008). Schwartz did an injustice labeling something negatively before reaching out to that community to make sure she understood their culture.

Charles Socarides felt that homosexuality was unnatural sexual energy and started National Association for Research and Therapy of Homosexuality (NARTH) which still exists today led by Joseph Nicolosi. They insist that homosexuality is unnatural sexual behavior and have harmed thousands of gays and lesbians for whom homosexuality is absolutely natural and healthy. Some men who cathect toward males don’t want to come out as gay. They feel that living a gay affirmative life would be living a life of depression. Many gay affirmative models have told them that living a life in the closet would lead to a life of depression. As part of the American Psychological Report in 2009, the task force identified that some clients enter therapy to change their sexual orientation due to distress because of conflict between their sexual orientation and religious beliefs. The task force recommended that clinicians treating these clients help them "explore possible life paths that address the reality of their sexual orientation,

reduce the stigma associated with homosexuality, respect the client's religious beliefs, and consider possibilities for a religiously and spiritually meaningful and rewarding life." (American Psychological Association; 2009) This is different from the past where the APA and gay affirmative therapy models said everyone closeted should come out (Kort 2008)

Very little understanding of what sex is really all about to different orientations, different cultures, different religions and different genders.

The research has demonstrated time and again that sexual fantasy is, in fact, a normative aspect of sexual arousal and enjoyment for many people. Nancy Friday's classic *My Secret Garden*, Lisa Diamond's work in her book *Sexual Fluidity* (2009), as well as Brett Khar's, *Who's Been Sleeping in your Head* (2008) - have demonstrated that sexual fantasy is complex, multidimensional and serves as both respite and a source of deep erotic connection with oneself and ones partner. In fact, there are common themes to sexual fantasy that cover the spectrum. It isn't the sexual behaviors or fantasy that are problematic, but the guilt and shame that one may encounter for having fantasies that they have been taught to be ashamed of. Shame separates people from people - and in that void - one begins to hide their sense of shame - further distancing from others and learning to isolate. Shame is more damaging to the inside-outside relationship to healthy sexuality than is porn, let alone the cultural conditioning that permeates all aspects of sex in this country.

However, again dealing with the issue of shame without scientific evidence there is danger of therapists biases. This is seen in Anne Stirling Hastings, Ph.D. book, *Healing Humanity: Life Without Shame* where she writes that fantasy and pornography are powerful tools to push shame aside. Hastings believes that those people who are unable to heal shame sufficiently, fantasy and porn may be used in order to have a sex life. She believes that when

shame is healed, the pleasure from porn is not nearly as pleasurable as the pleasure from looking into one's partner's eyes and feeling their skin. While this may be true for some people, generalizing this to all people is dangerous and create more shame for those who do enjoy pornography. It doesn't leave room for inclusion but rather exclusion.

With all this said there are still those coming to therapy with painful relationships to sex and sexuality. Therapists need to be skilled at delineating the "intent" of the action, not assuming that the "action" itself is the problem. From there the work can begin with clients to develop a sexual health based on their needs and experiences.

Lacking Healthy Sexuality Model

Perhaps the biggest missing piece in all of the work with hypersexual patients is that it is missing a healthy recovery model of healthy and erotic sexuality. Marty Klein calls that, "outrageous" (Klein, 1998) who feels that one should be in place that relates to most people's experiences.

Recommendations

Erotic Template is the way to help clients

No matter what out-of-control sexual behavior a client presents in therapy, there is one way that is consistently effective for each of them and that understands their arousal template. This paper theorizes that an effective tool in helping any client with sexual issues is to help them understand the nonsexual meanings of their fantasies and desires.

In his book, *Male Sexuality: Why Women Don't Understand It and Men Don't Either,* Michael Bader writes, "Freud said that dreams were the 'royal road to the unconscious'. I would argue that we get there faster by studying sexual fantasies." This paper argues the same for treatment of hypersexual behaviors.

Bader and others have written extensively on sexual fantasies (Bader 2002; Perel 2006; Stoller 1975; Morin 1996 and Kahr 2008). Their theoretical and clinical approach to sexuality is an affirmative one and view sexual fantasy and arousal as a result of one's psychological makeup. Each agree that sexual fantasies and arousal templates are unconscious attempts to *solve* problems and not, to recreate them" (Bader, 2002; Perel, 2006; Kettelhack, 1996; Stoller 1975). Your sexual fantasies are attempts overcome for the unresolved issues from childhood. It is in the details of the fantasy sometimes offer clues into that person's childhood or history.

This is not to say that one's orientation is shaped by childhood. Here is where it's crucial to differentiate sexual orientation and sexual preferences. Sexual mapping and imprinting shapes sexual preferences, not sexual orientation. There are those who believe that one's sexual orientation − how one self-identifies in terms of gay, straight, bisexual − is learned in childhood. One is born with one's orientation and that preferences are learned.

These arousal templates are about more than just love: They enter our erotic minds as well (Morin, 1996). William Granzig defines one's arousal template as the "The sexual template can be best understood as the sum of all sexual erotic desires **(**Granzig 2004**).** Granzig talks about the sexual and erotic template being one's *cathexis*. Cathexis is defined as one's "affectional, emotional and sexual energy in determining a sexual object choice" according to Freud (Gay 1989). Granzig writes:

> *The first step in defining each individual's sexual template is to determine if the sex object choice is male, female or both. The use of cathexsis also allows the therapist to get away from political, religious and societal adjectives such as sexual orientation, sexual preference or sexual deviation. The cathexsis is in each person's sexual template. This bypasses the etiology of homosexuality which is of no concern for the therapist.*

Acceptance of the patient's cathexsis is the crucial first step in beginning to deconstruct the sexual template and then to use it to improve a person or couple's sex life.

In the work of Esther Perel in her book, *Mating in Captivity*, she writes, "Tell me how you were loved as a child and I will tell you how you make love as an adult." This reflects further knowledge that our arousal templates are embedded in our childhood

In Jack Morin's book, *The Erotic Mind: Unlocking the Inner Sources of Sexual Passion and Fulfillment* he invites people to explore their peak sexual experiences, favorite masturbation fantasies, and the pornography they choose to read and watch. Examining these things helps discern what he calls core erotic theme (CET). Morin believes that this internal arousal blueprint "transforms old wounds and conflicts into excitation" (Morin 1996). "Hidden within your CET is a formula for transforming unfinished emotional business from childhood and adolescence into excitation and pleasure."

One's cathexsis is to be interpreted like dreams. The facts and things that go on are symbols and metaphors. The story line is extremely important to the man's sexual desires and fantasies. Ignore no details of what the man enjoys with other men. The child has difficulty recalling details in words what happened to him in his past and it becomes coded in the erotic template.

Questions to ask clients include to help clients are about their peak erotic fantasies and scenarios:

1. Do you pursue or prefer being pursued?
2. Do you please them and/or do they please you?
3. Does it matter what they are thinking?

4. What do you hope they are thinking and wanting?
5. Does the type of person matter or just the scene and/or body types/parts?
6. Does the “other” in the fantasy care that you are getting pleasure or no?
7. Do you care if they are enjoying it or not?
8. What is your peak erotic fantasy(s)?
9. What physical types of people are most attractive to you?
10. What is the language and the scripts in the fantasy that is being used by you and/or the others?
11. What are the details within the sexual imagery?

The answers leave a trail, a blueprint, into the client’s past either in childhood or past sexual experiences. The job of the clinician is to help them make the connections to their sexual acting out behaviors. The treatment is finding the non-erotic themes and meanings from the details of the sexual desires, fantasies and behaviors and helps the client step into the positives intention of the erotic code. It doesn’t necessarily mean they won’t enjoy the fantasy any longer but the compulsivity is likely to fall away.

Pay careful attention to client’s sexual desires, erotic needs, and sexual fantasies, and there can learn a great deal about what their hypersexual behavior is about for them. The details of the sexual fantasies don’t matter as much as their themes—an important distinction, lest the clinician get lost looking at the details and not be able to see the forest for the trees. Following the themes is like interpreting a dream. The details seem silly, but the symbolism is full of information about you. Whether they have healthy or unhealthy sexual desires, fantasies, or behaviors, it is in their benefit to understand what they represent for you. Some even believe that

people can improve your romantic relationships by restoring desire for a partner from making logical sense from them (Granzig 2004).

As Guy Kettelhack writes in *Dancing Around the Volcano*, "sexual symptoms and fixations are the psyche's energetic and ingenious attempts to cure itself—to give itself what it craves." That is, sexual fantasies and erotic desires are not pathological, but a form of self-help—erotic blueprints that can help you discover yourself, along with the right partner for you.[1]

Sexual fantasies and erotic templates are unconscious attempts to adapt and resolve unpleasant and unwanted childhood memories. Bader writes that there is a construction of particular sexual fantasies and sexual preferences that negate self-denigrating beliefs and feelings, thus allowing sexual excitement to emerge (Bader 2002). In order to feel aroused, people temporarily transform themselves from frogs to princes and princesses. Sexual fantasies move people from trauma to triumph, turn victims into victors, redeem feelings of unworthiness, and relieve depression (Bader 2002).

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DISSERTATION APPROVAL

This dissertation submitted by **Joe Kort** has been read and approved by three faculty members of the American Academy of Clinical Sexologists.

The final copies have been examined by the Dissertation Committee and the signatures which appear here verify the fact that any necessary changes have been incorporated and that the dissertation is now given the final approval with reference to content, form and mechanical accuracy.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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AMERICAN ACADEMY OF CLINICAL SEXOLOGISTS

AT MAIMONIDES UNIVERSITY

CHILDREN WHO MOLEST OTHER CHILDREN: A GROWING TREND

A DISSERTATION SUBMITTED TO THE FACULTY OF THE AMERICAN ACADEMY OF CLINICAL SEXOLOGISTS AT MAIMONIDES UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREM ENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

BY

LORRAINE A. MITCHELL

DISSERTATION APPROVAL

This dissertation submitted by Lorraine A. Mitchell has been read and approved by three faculty members of the American Academy of Clinical Sexologists at Maimonides University.

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ABSTRACT

This paper explores the fact that children are by their very nature, sexual beings. The paper attempts to focus on the recent sexual abuse hysteria and discredit those who label children as sexually reactive and future perpetrators. Studies are included which provide therapeutic intervention for these children.

Exhibiting non-coercive sexual behaviors does not make children dysfunctional, sexually reactive or future sexual predators. In fact, children who are labeled as sexually reactive are no different from other children and no more likely to become sexual perpetrators. These children are being labeled during their formative years with no proof that they will sexually offend or reoffend in the future.

Society is putting this population at an unfair disadvantage and is actually assisting in the development of their future abusive behavior. By isolating, stigmatizing and labeling these children while in their formative years, does not give them the opportunity to interact with their peer group, causing them to miss out on dating and seeing how healthy relationships operate. Children have varied sexual practices unlike adults whose sexual practices have become a habit. It should be noted that it takes years for an individual to develop a habit and it would take years to shape a child into having sex with younger children.

The Juvenile Justice System is doing these children a great political injustice by labeling them as sex offenders as early as 18 months old. These children are being forced to carry the label of sexual perpetrator throughout their lives when they may not in fact be deserving of this label. It appears that due to society's sexual hysteria, a witch-hunt has been launched on our children, one which society will come to regret.

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CHAPTER 1

Introduction

Today, there is a new trend of children, those who molest other children. Attempts are made to show how the children are naturally sexual beings and that sexuality is a part of our nature. Exhibiting non-coercive sexual behaviors does not make children dysfunctional, sexually reactive or future sexual predators.

This paper attempts to show that children who are labeled as sexually reactive are no different from other children and no more likely to become sexual perpetrators. These children are being labeled during their formative years with no proof that they will sexually offend in the future. Children have varied sexual practices unlike adults whose sexual practices have become a habit. It should be noted that it takes years for an individual to develop a habit and it would take years to shape a child into having sex with younger children. For example, an adult who smokes cigarettes starts off with mild cigarettes, then as time goes by the cigarettes get stronger until he's maybe smoking marijuana and other more potent substances. So it is with children. They do not have definite sexual practices while they are young; these practices take time to develop. A 30 year old man has definite sexual practices, e.g., he prefers 6 year old females. It took time for him to develop his "taste."

Research shows that these children more than likely will grow up and never offend again. There is no sufficient evidence to prove that these children will go on to become sexual offenders. The chances are they may grow up to become criminal offenders (trust, property, substance, burglary or domestic abusers) and never violate anyone sexually in their lifetime. Society is putting this population at an unfair

disadvantage and actually assists in the development their future abusive behavior. This is done by isolating, stigmatizing and labeling these children while they are in their formative years. By not allowing these young people to interact with their peer group they miss out on dating and seeing how healthy relationships should operate. Instead they are left confused, vulnerable and forced to interact with and form bonds with younger children. It should also be noted that juvenile sex offenders have numerous issues such domestic violence, lack of male role models, lack of social skills and lack of peer interaction during their formative/teenage years.

The Juvenile Justice System is doing these children a great political injustice by labeling them as sex offenders as early as 18 months old. They are causing these children to carry the label of sexual perpetrator throughout their lives when this may not be the case. It appears that due to sexual hysteria in our society that a witch-hunt has been launched on our children, one which society will come to regret.

Several studies are included which provide therapeutic intervention for these children.

CHAPTER 2

The Making of Sexually Reactive Children

This new field of social science study is concerned with preadolescent children who exhibit sexually aggressive behaviors towards other children. Sexually aggressive children are defined as those who are twelve and younger, who exhibit patterned behaviors of sexuality (which are too advanced for their ages) in conjunction with aggression (force, coercion, secrecy) towards other more vulnerable children (West, 1999). Araji (1997), argues against comments written in, Coming to Understand Them (West, 1997), especially that sexually aggressive children are produced in homes where physical violence and sexual abuse can be extreme. Aggression, anger, conflict, neglect and little support are common. Children are exposed to sexualized adult behaviors which may range from poor sexual boundary maintenance to genital contact and even intercourse. These children in turn exhibit coercive sexually aggressive behaviors towards other children. In a study conducted by Gray, Busconi, Houchens, and Pithers (1997), they found that many abusers were themselves abused. The study consisted of 72 children who had engaged in sexual misconduct with other children, and they determined that 95% of the children for whom maltreatment data could be collected had been sexually abused. In addition, 48% had suffered physical abuse. Pithers, Gray, Busconi, and Houchens (1998) also conducted a study exploring the family characteristics of 6 to 12 year olds who had engaged in problematic sexual behavior. In general, the parents of these children established an insecure attachment to their children and rejected those characteristics they found disappointing. In addition, the parents exercised little supervision, which contributed to the sexual acting-out behavior and reduced the chance

that this behavior would stop. Significant levels of sexual abuse in the extended family were also identified. Both sexual abuse victims (72% of the extended families had at least one sexual abuse victim) and sexual abuse offenders (62% of the extended families had a least one additional sexual abuse offender) were found.

In a study comparing offenders who had been abused with offenders who had not, Hunter and Figueredo (2000) noted that adolescent offenders with or without a history of molestation are more likely to demonstrate high levels of pessimism and hopelessness and lower levels of self-sufficiency when compared to a matched group. In addition, multiple molestations at an early age were identified as a risk factor for becoming a juvenile sexual offender.

Juvenile Sexual Offenders

Juvenile sexual abuse offenders represent a large segment of the population of sexual offenders. In fact, juvenile sexual abuse offenders are responsible for 20% to 30% of the rapes and 30% to 60% of the child molestation cases in this country, with an alarming rise in the 6 to 12 year old range (Social and Rehabilitation Services, 1995).

Araji (1997), also argues that a "culture of denial" refuses to see children as capable of initiating aggressive sexuality and this inhibits adequate social service responses. Yet she argues that the physical abuse and aggression towards children may be more salient in explaining these behaviors than sexuality per se. She reviews the variations in system response across the United States which include legal responses such as charging children who demonstrate "culpability" with a sexual crime or sexual harassment; developing social service responses such as tools for identification,

education and psychotherapy for children and their families, and developing community responses with training for schools, the media and other service providers.

Sexual Abuse Hysteria

The "sexual hysteria" movement of the 1990s where a six year old boy gets suspended from school for kissing a six year old girl on the cheek demonstrates how societies or subcultures define sexuality in relation to children and this is extremely problematic. As the adult culture in the United States is struggling over the nature and definition of sexual harassment, sexual consent, and even what constitutes sexual behaviors (President Bill Clinton did not consider oral sex with an intern real "sex"), to take on the task of dealing with sexuality and aggression in small children becomes daunting indeed. Further, are children "aggressors" or "victims?" Are they to be protected or prosecuted by social systems? What are children's rights and who is considered a "child" now? This is topic which requires richer sociological analysis, (West, 1997).

Young Children and Sexual Behavior Problems

Over the past two decades, the incidence and ramifications of sexual behavior problems in childhood have increasingly come to the attention of professionals in the child maltreatment and children's mental health fields and more recently in the juvenile justice system (American Academy of Child Adolescent Psychiatry, 1999; Department of Social and Health Services, 1992, National Task Force on Juvenile Sexual Offending, 1993). Children as young as 3 years of age have been found to exhibit sexually intrusive acts against other children such as fondling and oral sodomy (Freidrich & Luecke, 1988, 1989). Due to the rise in children with sexual behavioral problems a number of treatment

programs designed for this population have rapidly increased, and many of these specialized sexually behavioral treatment programs treat children as young as 3 and 4 years of age (Araji, 1997; Freeman, Longo, Bird, Stevenson, & Fiske, 1994). Demonstrating sexual behavior problems as a young child may be associated with problems of adjustment and development, including socialization difficulties, increased risk of victimization, and care-giver relationship difficulties, which can lead to disruptions in the child's residential placement (Araji, 1997). Recognition of the need to treat children who exhibit inappropriate sexual behaviors is growing, and there is an increased concern that if left unchecked or untreated these problems may graduate into criminal sexual offending (Bonner, Walker, & Berliner, 1999). There is little evidence to support this concern. To date, research on problematic sexual behaviors has focused on young children (12 and younger) and on adolescents who have already committed serious sexual crimes (Silovsky & Niec, 2002). The clinical research picture contains little information on adolescents whose sexual behavior problems have not reached the level of criminal offending.

The goals of the study conducted by Letourneau, Schoenwald & Sheldow (2004) were to describe the characteristics of a sample of youth, ages 5 to 19, with non-criminal sexual behavior problems and to evaluate treatment outcomes for this group. In order to provide a context for the study, researchers briefly reviewed extant research on the characteristics of young children (ages 3 to 12) with sexual behavior problems and on adolescent sex offenders. Chaffin, Letourneau, and Silovsky (2002) defined problematic sexual behaviors occurring in childhood as those occurring with unexpected frequency, in coercive contexts, or between youth in different age groups and as those that resist

intervention, interfere with development, and/or are associated with emotional distress (p.208). The study found that in general, children with sexual behavior problems are a highly heterogeneous group with few characteristics that distinguish them from other children (Chaffin, et. al., 2002). Research identified some individual and family factors that are characteristic of such children as summarized.

Factors that Characterize Children with Sexual Behavior Problems

Individual factors. Several individual factors have been examined in the literature on children with sexual behavior problems and adolescent sex offenders including gender, age, abuse history, and comorbid psychiatric problems. Few of these characteristics distinguish children with sexual behavior problems from other groups. Even gender, a robust factor that characterizes adolescent sex offenders fails to distinguish children with sexual behavior problems. Age appears differentially related to child sexual behavior problems and adolescent sexual offending (Ageton, 1983; Alexander, 1999; Pastore & Maguire, 2000; Worling & Curwen, 2000). Research on sexual behavior problems in children ages 6 to 12 suggests that age is negatively correlated with frequency of inappropriate sexual behaviors (Bonner et. al., 1999; Friedrich, et. al., 1991, 2001). The limited data on adolescent sex offenders suggest younger adolescents (13 to 15) are no more likely than older adolescents (16 to 18) to commit sexual crimes (Ageton, 1983). The severity of sexual crimes does appear to increase with age, however, as older teenagers are more likely to commit crimes involving penetration and overt force (Barbaree, Hudson, & Seto, 1993).

A personal history of sexual abuse is characteristic of children with sexual behavior problems and adolescent sex offenders. It is unclear whether a history of

physical abuse or neglect is another risk factor for inappropriate sexual behavior (Bonner et. al., 1999; Friedrich et. al., 1992). In a small study of preschool-aged children, physical abuse and witnessing domestic violence were related to inappropriate sexual acting out, but this was not the case in a study that compared children (ages 6-12) referred for sexual behavior problems with a group of children referred for other problems (Bonner et al., 1999). For adolescents, however, a history of physical abuse appears to be a clear risk factor for adolescent sexual (and nonsexual) offending (Becker, 1998; Benoit & Kennedy, 1992; Davis & Leitenberg, 1987; Milloy, 1994).

Children with sexual behavior problems are likely to exhibit additional internalizing and externalizing behavior problems. Relative to other delinquent youth, adolescent sex offenders appear to have fewer violence and attention-related problems (Kempton & Forehand, 1992). Relative to non-delinquent youth, adolescent sex offenders are more likely to demonstrate internalizing problems such as anxiety (Blaske et. al., 1989; Jacobs, Kennedy, & Meyer, 1997; Kempton & Forehand, 1992).

Family factors. The most robust family correlate of child sexual behavior problems is family sexuality, defined as family nudity and opportunities for children to view sexual intercourse. Family sexuality has not been systematically assessed with samples of adolescent sex offenders. Family risk factors for adolescent sex offenders parallel risk factors for other delinquent youth. These risk factors include parental violence and abusive parenting. In particular, physical abuse by fathers has been related to increased sexual aggression whereas maternal bonding appears to decrease sexual aggression ((Ageton, 1983; Becker, 1998; Benoit & Kennedy, 1992; Koyayashi, Sales, Becker, Figueredo, & Kaplan, 1995)). Additional family disruptions such as long-term

unemployment, death, or divorce also distinguish delinquent from nondelinquent youth. Delinquent youth (sexual and nonsexual offenders) are more likely to perceive more negative labeling from parents than non-delinquent youth. In addition, family factors such as low parental monitoring; ineffective, harsh, or inconsistent discipline; and family conflict are known predictors of delinquency in youth. It is highly probable that these family factors may well be involved at least for delinquent youth that commit sex offenses (Blaske et. al., 1989; Borduin, Henggeler, Blaske & Stein, 1990).

Peer factors. The influence of peer factors in the development of sexual behavior problems in children has not been examined, but evidence suggests associations between such factors and adolescent sex offending. Clear support for the influence of delinquent peers on adolescents who acknowledged committing criminal sexual behavior was found. However, one study suggests the influence of peers may differ for subgroups of adolescent sex offenders. Specifically, some offenders with much younger victims may spend free time with younger children rather than with same-aged peers delinquent or otherwise, (Ageton, 1993; Milloy, 1994).

School factors. It is unclear whether child sexual behavior problems are related in any way to school related problems. Poor school achievement and the need for specialized school services were suggested by data in one study that lacked a comparison group but were not found in a study comparing children with sexual problems; both groups had average scholastic achievement. Poor school functioning characterizes delinquent youth in general and delinquent youth who commit sex offenses ((Pithers, Gray, Busconi, & Houchens, 1998).

Definition of Problematic Sexual Behavior in Children

Sexual behavior in children is defined as problematic when it:

(a) occurs at a greater frequency or at a much earlier age than would be developmentally expected;

(b) interferes with children's development;

(c) occurs with the use of coercion, intimidation, or force;

(d) is associated with emotional distress (in the child with sexual behavior problems or other children involved); and/or

(e) reoccurs in secrecy after intervention by caregivers. This definition includes both sexually aggressive behaviors (use of force or coercion) and intrapersonal sexual behavior problems (e.g., excessive masturbation) that does not involve other children. Due to the young age of the children, age difference between children is not required for the sexual act to be considered a sexual behavior problem. Thus, this definition includes acts that would not be labeled as "sexually abusive," (adapted from Hall, Mathews, Pearce, Sarlo-McGarvey & Gavin, 1996).

Labeling Children with Inappropriate Sexual Behaviors

In some of the literature, children who demonstrated inappropriate sexual behaviors were given a variety of labels e.g., sexually reactive children, sexual offenders, children who molest, child perpetrators. More recent conceptualizations of these children have used the term "children with sexual behavior problems: (children with SBP) as it more clearly describes the behavior without assigning a negative label to the child (Araji, 1997; Bonner, Walker, & Berliner, 1999; Gray & Pithers, 1997). "Perpetrator," "offender," and related terms when used with children with SBP are not only legal

malapropisms but also potentially detrimental to children's developing self-concept (Chaffin, Letourneau, & Silovsky, in press).

There are many questions that need to be asked when it comes to sexually aggressive children such as:

(1) What is "normal" child sexual behavior?

(2) What term(s) should be used to label children exhibiting sexual behavior problems?

(3) Is child sexual behavior which looks the same as adult sexual behavior really the same?

(4) What role does the family and environment play in developing, sustaining or inhibiting problematic sexual behavior?

(5) Should treatment for the child or protection of others be our primary concern?

(6) Should treatment focus primarily on the child's own victimization issues or on his/her perpetration behavior?

(7) Should children with sexual behavior problems ever be considered to be criminally responsible for their behavior, i.e., are children (12 and under) capable of criminal intent?

These questions have not been answered, and the issues arising from them are far from being resolved. Considerable disagreement still exists among practitioners, as well as in the general community, concerning the most appropriate way to address problematic sexual behavior in children (Araji, 1997).

CHAPTER 3

Understanding the Sexual Behavior of Children in Care

The following information introduces the concerns about inappropriate and abusive sexual behavior amongst children and young people in care. The Children were divided up into four groups:

***Group I*;** natural and healthy sexual play;

Group II; sexually-reactive behaviors

Group III; children who mutually engage in a full range of adult sexual behaviors

Group IV; includes children who molest other children

If one was to ask a group of teachers, school counselors, or social workers, if they think children today express more sexual behaviors than they did a generation ago, they would most likely say "yes". Documenting such an increase, however, would be impossible, because, until recently there has been no reliable collection of data about the number and types of sexual behaviors in which children engage; even now, such research is in its infancy (Cavanagh Johnson, 2001).

All of us can point to certain sociological factors that may be contributing to changes in sexual behaviors, including children's access to wider television programming, adult videos, and communications facilities that provide on-line and telephone sexual experiences for callers. Without an established base of research, however, how are parents, teachers, and counselors able to determine when children's sexual behaviors fall within an acceptable range of sexual behaviors, or when they may require intervention and treatment?

Many professionals continue to argue that intervention around sexual issues is never required for children that all sexual behaviors of children are, by their very nature, benign and uncomplicated. However, a growing body of research largely based on two specific populations, children who have been sexually abused and children who have used some kind of coercion or pressure to force other children into sexual behaviors is causing many professionals to rethink that argument. Many professionals who work with children are aware of contemporary studies that suggest that increased sexual behaviors may be an indication that a child is being, or has been sexually molested. Increasing evidence also points to the fact that it is important to evaluate young children who are coercing other children into unwanted sexual behaviors; research on adult offenders has revealed that many offenders began their coercive sexual behaviors in elementary school and increased the number and violence of their sexual behaviors during adolescence. Such findings indicate that there may be danger in just hoping that children will grow out of coercive sexual behaviors (Cavanagh Johnson, 2001).

It has also been found that overreacting to children's sexual behaviors can also have negative consequences; it could cause them to feel ashamed and self-conscious about a natural and healthy interest in their bodies and sexuality.

It is also important to note that adults who work with children often assume that they "just know" whether a child's sexual behavior is natural and healthy. However, what they are generally using in making their evaluations are just sets of internal, and largely unconscious, intuitive guidelines, which have been drawn from their own sexual experiences as children, their parents' attitudes, their religious beliefs, and other aspects of their personal histories and cultures.

Such preformed guidelines may actually reveal more about the adult evaluator than the child in question. Individual standards for evaluation, not surprisingly, vary widely: some adults think that any behavior of a young child relating to sexuality is unacceptable, while others accept a wide range of sexual behaviors among children. Professionals who work with children need practical data-based guidelines to determine when a child's sexual behaviors are within acceptable limits and when they are causes for concern.

While research data on childhood sexuality is still in the pioneering stages, there is enough information to establish some important observations about the sexual behaviors of children 12 years of age and younger. In looking at the continuum of sexual behaviors, it is important to remember that:

1. There is no single standard for determining normal sexual behaviors in all children, since there are individual differences due to the development level of the child and due to the amount of exposure the child has had to adult sexuality, nudity, explicit television, and videos. Parental and societal attitudes and values, as well as the child's peer group and living conditions, exert additional influences on the types and range of the child's behaviors. A set of guidelines, nonetheless, may provide a base-line by which children's sexual behaviors can be somewhat objectively evaluated by this time, and may help target potential problems.

2. The sexual behaviors of a child represent only one part of their total being. Sexual behaviors should not be used as a sole criterion for determining whether a child has a significant problem as will be shown in the Initial Assessment.

A Continuum of Sexual Behaviors

Professionals who work with children need to have perspectives on the full spectrum of childhood sexual behaviors, from the wide variety of what are perceived to be age-appropriate healthy activities to patterns that may be unhealthy or pathological and may require attention and/or treatment.

Group I: includes children engaged in natural and healthy childhood sexual exploration;

Group II**:** is comprised of sexually-reactive children;

Group III**:** includes children who mutually engage in a full range of adult sexual behaviors; and

Group IV**:** includes children who molest other children.

This continuum of sexual behaviors applies only to boys and girls, aged 12 and under; who have intact reality testing and are not developmentally disabled. Each group includes a broad range of children, some are on the borderline between the groups, and some move between the groups over a period of time (Cavanagh Johnson, 2001).

The Initial Assessment

The initial assessment, to determine where on the continuum the child may fall, includes:

1. An evaluation of the number and types of sexual behaviors of the child.
2. A history of the child's sexual behaviors.
3. Whether the child engages in sexual activities alone or with others.
4. The motivations for the child's sexual behaviors.
5. Other children's descriptions, responses, and feeling sin regard to the child's sexual behaviors.

6. The child's emotional, psychological, and social relationship to the other children involved.
7. Whether trickery, bribery, physical or emotional coercion is involved.
8. The affect (levels of feelings) of the child regarding sexuality.
9. A thorough developmental history of the child, including abuse and out-of-home placements.
10. Access and careful reading of protective services' reports, court reports, and probation documents (if applicable).
11. An assessment of the child's school behaviors, peer relations, behaviors at home, and behaviors when participating in out-of-home activities, such as day care or recreational programs.
12. A history of each family member; the overall family history, and an evaluation of the emotional and sexual climate of the home. Assessment of these areas helps to determine whether the child falls into Group I, II, III, or IV.

If the child falls into Groups II, III or IV, a thorough evaluation to assess the treatment needs of the child, and the family, will be necessary. It is recommended that assessments should be completed by a mental health professional who specializes in child sexual abuse. While the child may not have been sexually abused, the sexual behaviors demonstrated in these groups may be indicative of previous or current sexual abuse.

Group I: Natural and Healthy Sexual Play

Normal childhood sexual play is an information gathering process. Children explore, visually and through touch, each other's bodies (for example, play doctor), as well as trying out gender roles and behaviors (e.g., play house). Children involved in such explorations are of similar age and size, are generally of mixed gender; are friends rather than siblings, and participate on a voluntary basis ('I'll show you mine if you show me yours!"). The typical feeling level of these children, in regard to sexually-related behaviors, is light-hearted and spontaneous. In natural sexual play or exploration, children often are excited, and they feel and act silly and giggly. While some children in Group I may feel some confusion and guilt, they do not experience feelings of shame, fear, or anxiety, (Cavanagh Johnson, 2001).

The sexual behaviors of children who are engaged in the natural process of childhood exploration are balanced with curiosity about other parts of their universe as well. They want to know how babies are made and why the sun disappears; they want to explore the physical differences between males and females and figure out how to get their homework done more quickly, so they can go out and play. If children are discovered while engaged in sexual play and are instructed to stop, their sexual behavior may, to all appearances, diminish or cease, but it generally arises again during another period of the child's sexual development.

The range of sexual behaviors in which children engage is broad; however, not all children engage in all behaviors: some may engage in none, and some may only engage in a few. The sexual behaviors engaged in may include; self-stimulation and self-exploration, kissing, hugging, peeking, touching, and/or the exposure of one's genitals to

other children, and, perhaps, simulating intercourse, (a small percentage of children, 12 or younger, engage in sexual intercourse). Because of this broad range of possible sexual behaviors, diagnosing a child on sole basis of their sexual behaviors can be misleading. Although children who have sexual problems usually manifest more varied and extensive sexual behaviors than Group I children, their behaviors may, in some cases vary only in degree.

Group II: Sexually-Reactive Behaviors

According to Cavanagh Johnson, 2001, Group II children display more sexual behaviors than the same-age children in Group I; their focus on sexuality is out-of-balance in relationship to their peer groups; and they often feel shame, guilt, and anxiety about sexuality.

Many children in Group II have been sexually abused; some have been exposed to explicit sexual materials; and some have lived in households where there has been too much overt sexuality. Young children, who watch excessive amounts of soap operas or television and videos, and who live in sexually explicit environments, may display a multitude of sexual behaviors. Some parents, who themselves may have been sexually and/or physically victimized, express their sexual needs and discuss their sexual problems openly with their young children. This can over-stimulate and/or confuse their children. Some children are not able to integrate these experiences in a meaningful way. This can result in the child acting out his or her confusion in the form of more advanced or more frequent sexual behaviors, or heightened interest and/or knowledge beyond that expected for a child of that age. The sexual behaviors of these children often represent a repetition compulsion or a recapitulation (often unconscious) of previously over-stimulated

sexuality or sexual victimization. The time between the sexual over-stimulation and the sexual behaviors is close, and often overlaps or is contiguous.

Behaviors of Group II children include: excessive or public masturbation, overt sexual behaviors with adults, insertion of objects into their own or other's genitals, and talking about sexual acts. Such sexualized behavior may be the way the child works through his or her confusion around sexuality. After being told that their sexual behaviors need to be altered, Group II children generally acknowledge the need to stop the behaviors and welcome help. The sexual behaviors of this group of children are often fairly easy to stop, as they do not represent a long pattern of secret, manipulative, and highly charged behaviors, such as those seen among child perpetrators in Group IV.

Group III: Extensive Mutual Sexual Behaviors

Group III children have far more pervasive and focused sexual behavior patterns than Group II children, and they are much less responsive to treatment. They participate in a full spectrum of adult sexual behaviors, generally with other children in the same age range, (oral and anal intercourse, for example), and they conspire together to keep their sexual behaviors secret. While these children use persuasion, they usually do not force or use physical or emotional coercion to gain other children's participation in sexual acts. Some of these children however, move between Groups III and IV, i.e. between mutually engaging in sexual behaviors and forcing or coercing other children into sexual behaviors.

One of the striking differences between Group III children and the children in other groups is their affect or emotional level – or more precisely, their lack of affect – around sexuality. Group III children do not have the light-hearted spontaneity of sexually

healthy children, the shame and anxiety of sexually-reactive children, or the anger and aggression typical of child perpetrators. Instead, they display a blasé, mater-of-fact attitude toward sexual behaviors with other children – as one explained, "This is just the way we play".

It might be more accurate to say that sexual interaction is the way Group III children try to relate to their peers. As for relating to grownups, most Group III children expect only abuse and abandonment from adults. Other group III children have been sexually abused, in a group, by one or more adults, and continue the sexual behaviors experienced with the other children after the abuse by the adults has stopped. Other children in Group III are siblings who mutually engage in extensive sexual behaviors as a way of coping in their highly dysfunctional families.

All Group III children have been sexually and/or physically abused and/or have lived in highly chaotic and sexually charged environments. Through these experiences their understanding of relationships has become skewed; distrustful of adults, chronically hurt and abandoned, and lacking in academic and social success. These boys and girls use sexuality as a way to make another child a friend – even briefly. Few of these children report any need or drive for sexual pleasure or orgasm, and although their "What's the big deal?" attitude may have the appearance of sophistication, it conceals significant emotional vulnerability. Their sexual actives appear to be their attempts to make some kind of human connection in a world which is chaotic, dangerous, and unfriendly (Cavanagh Johnson, 2001).

Group IV: Molestation Behavior

Many professionals involved with the care and protection of children find it difficult to believe that children 12 years and younger can molest other children. Evidence that they an, and do, is found not only in a growing group of studies and journal articles, but in FBI reports and newspaper clippings. In one recent case, a fourth grader was sexually assaulted by several students in the bathroom of her local public school. The incident occurred at a small country school in Vermont which serves just 150 children, from kindergarten through fourth grade. The perpetrators of the sexual assault against the little girl were all her age or younger. Two 10-year-old boys from the girl's class initiated the attempted rape, and three other boys watched or helped to hold the struggling victim while her attackers tried to penetrate her. One of these boys was eight years old and the other two were six years old.

This small town incident is just one example of a nationwide in crease in reports of sexual offences by prepubescent children that have taken the system by surprise. Last year, in the state of New York, "juvenile court prosecutors handled 270 cases of sexual crimes involving children 12 years old and younger – more cases than in the 13-to 15 year-old range. Commenting on the statistics, Peter Reinharz, supervisor of the sexual crimes prosecution unit, noted that the age drop meant that the unit was dealing with "eight, nine, ten-year-olds committing rape (and) sodomy. The identified victims are usually other children (Cavanagh-Johnson, 2001).

Only a few treatment programs have been established for these child perpetrators, but preliminary findings on children in Group IV have been published. As a group they have behavior problems at home, and at school, few outside interests, and almost no

friends. These children lack problem-solving and coping skills, and demonstrate little impulse control. Often, they are physically and sexually aggressive. In preliminary findings on child perpetrators, no one – parents, teachers, or peers – described any member of the group as an average child.

The sexual behaviors of Group IV children go far beyond developmentally appropriate childhood explorations or sexual play. Like the children in Group III, their thoughts and actions are often pervaded with sexuality. Typical behaviors of these children may include (but are not limited to) oral copulation, vaginal intercourse, anal intercourse and/or forcibly penetrating vagina or anus of another child with fingers, sticks and/or other objects. These children's sexual behaviors continue and increase over time, and are part of a consistent pattern of behaviors rather than isolated incidents. Even if their activities are discovered, they do not, and cannot, stop without intensive and specialized treatment (Cavanagh-Johnson, 2001).

A distinctive aspect of Group IV children is their attitudes toward sexuality. The shared decision making and lighthearted curiosity evident in the sexual play of children in Group I is absent; instead, there is an impulsive, compulsive, and aggressive quality to their behaviors. These children often link sexual acting out to feelings of anger (or even rage), loneliness, or fear. In one case, four girls held a frightened, fighting and crying 18-month-old child while another girl felated him. The girls (all age six to eight) each took a turn. The little boy required extensive medical attention as a result of penile injuries.

While most of the case studies in this group are not physically violent, coercion is always a factor. Child perpetrators seek out children who are easy to fool, bribe, or force into sexual activities with them. The child victim does not get to choose what the sexual

behaviors will be, nor when they will end. Often the child victim is younger and sometimes the age difference is as great as 12 years, since some of these children molest infants. On the other hand, some child perpetrators molest children who are age-mates or older. In sibling incest with boy perpetrators, the victim is typically the favorite child of the parents. In other cases, the child is selected due to special vulnerabilities, including age, intellectual impairment, extreme loneliness, repression, social isolation, or emotional neediness. Child perpetrators often use social and emotional threats to keep their victims quiet: "I won't play with you ever again, if you tell", this is a powerful reason to keep quiet if the child victim already feels lonely, isolated or even abandoned at home and at school.

Even the bathroom games sometimes seen in Group I children are markedly different from the disturbed toileting behaviors common in Group IV. Some children who molest other children habitually urinate and defecate outside the toilet on the floor, in their beds, outdoors, etc.) While many Group I children may mildly resist changing underwear, some children in Group IV will wear soiled underpants for more than a week or two and adamantly refuse to change. Some constantly sniff underwear. Many of the children regularly use excessive amounts of toilet paper (some relate wiping and cleaning themselves to masturbation) and stuff the toilet until it overflows day after day. The children continue these disturbed toileting patterns even if their families have severely punished them for their behavior. While Group IV children often obsessively focus on toileting and sexual activities, the natural and healthy sexual curiosity and delight of young children in their bodies is absent. Instead, they express a great deal of anxiety and confusion about sexuality. Many Group IV children say they act out sexually when they

feel jumpy, funny, mad (angry) or bad. Yet, after engaging in sexual behaviors, most report that they feel worse (Cavanagh-Johnson, 2001).

Most child perpetrators who have been studied have been victims of sexual abuse themselves, although the sexual abuse generally has occurred years before the children began molesting other children. All of the girl perpetrators (females represent about 25% of child perpetrators) and about 60% to 70% of the boy perpetrators have been molested. All of the children live in home environments marked by sexual stimulation and lack of boundaries, and almost all of the children have witnessed extreme physical violence between their primary caretakers. Most parents of Group IV children also have sexual abuse in their family histories, as well as physical and substance abuse.

This group of children is at the highest risk for continuing, and escalating, their patterns of sexually abusive behaviors, unless they receive specialized treatment specifically targeting their acting out. Unfortunately, there are only a handful of any type of treatment programs specifically targeted for children who molest other children. A jury in New York City took just two months to convict a ten-year-old boy of raping a seven-year-old girl, but two years to find a treatment resource for him

Even in an age of sharply limited government funds, increasing resources for children who molest other children are vital. Gene Abel, MD, Director of the Behavioral Medicine Institute in Atlanta, and the author of more than 80 articles on sexual offenders, has hypothesized that the average adolescent perpetrator could be expected to commit more than 300 sexual crimes in his lifetime. Abel noted, “We know that many adolescent perpetrators engaged in deviant sexual behaviors as early as five or six years of age. When there is persistent and consistent pattern of sexually deviant behavior in young

children, early assessment and specific treatment affords the best opportunity to stop the behavior (Cavanagh-Johnson, 2001).

Conclusion: The Need for Practical Guidelines on Child Sexual Behaviors

While thorough evaluation needs to be provided by an expert in child sexual behaviors, it is almost always a non-specialist who identifies sand refers a child for evaluation. The persistent and consistent pattern of problem sexual behaviors is usually first noticed by parents, caretakers, and front line professionals, including school teachers, nurses, counselors and social workers. For this reason, all professionals who work with children or families need practical guidelines as to which child sexual behaviors are natural and healthy and which behaviors indicate a need for specialized assessment (Cavanagh-Johnson, 2001).

According to Cavanagh-Johnson, 2001, research on child sexual behaviors also has immediate practice ramifications for anyone teaching sexuality education classes to youngsters.

- First, the families of children in Group II, III and IV verbally or nonverbally communicate in accurate information about sexuality, gender, and reproduction. Accurate information, and a forum in which to ask questions about sexuality, is essential for these children.
- Secondly, the increase in reports on child perpetrators underscores the importance of including information on child sexual abuse in sexuality education classes. Children should be aware that no other person (whether that person is an adult or another child) has the right to force or pressure them into unwanted sexual behavior.

Signals for Parents, Counselors and Child-Care Workers

1. The child focuses on sexuality to a greater extent than on other aspects of his or her environment, and/or has more sexual knowledge than similar-age children with similar backgrounds who live in the same area. A child's sexual interests should be in balance with his or her curiosity about, and exploration of, other aspects of his or her life.
2. The child has an ongoing compulsive interest in sexual, or sexually-related activities, and/or is more interested in engaging in sexual behaviors than in playing with friends, going to school, and doing other developmentally-appropriate activities.
3. The child engages in sexual behaviors with those who are much older or younger. Most school-aged children engage in sexual behavior with children within a year or so of their age. In general, the wider the age range between children engaging in sexual behaviors, the greater the concern.
4. The child continues to ask unfamiliar children or children who are uninterested, to engage in sexual activities. Healthy and natural sexual play usually occurs between friends and playmates.
5. The child, or a group of children, bribes or emotionally and/or physically forces other child/children of any age into sexual behaviors.
6. The child exhibits confusion or distorted ideas about the rights of others in regard to sexual acts. The child may contend: "She wanted it" or "I can touch him if I want to."

7. The child tries to manipulate children or adults into touching his or her genitals or causes physical harm to his or her own or other's genitals.
8. Other children repeatedly complain about the child's sexual behaviors – especially when the child has already been spoken to by an adult.
9. The child continues to behave in sexual ways in front of adults who say "no", or the child does not seem to comprehend admonitions to curtail overt sexual behaviors in public places.
10. The child appears anxious, tense, angry, or fearful when sexual topics arise in his or her everyday life.
11. The child manifests a number of disturbing toileting behaviors: plays with, smears feces, urinates outside the bathroom, uses excessive amounts of toilet paper, stuffs toilet bowls to overflow, sniffs or steal underwear.
12. The child's drawings depict genitals as the predominant feature.
13. The child manually stimulates or has oral or genital contact with animals.
14. The child has painful and/or continuous erections or vaginal discharge.

Studies on Childhood Sexuality and Sexual Behavior

Childhood sexuality and sexual experiences remain highly controversial and have, apart from the early Kinsey studies, received relatively little scientific attention until recently. The increasing bulk of knowledge and theory on the impact of sexually abusive experiences on children's developing sexuality has led to a demand for contemporary empirical studies on child sexual behavior. Some alternative lines have crystallized, based either on observation of present behavior by adults in different settings or on retrospective questions to adults (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy,

Martin, & Gebhard, 1953). First, professionals have observed children playing with anatomically correct dolls in studies designed to discriminate between abused and nonabused children (Koocher, Goodman, White, Sivan, & Reynolds, 1995). Second, investigations have been made on the sexual behavior of clinical samples. Third, parents have been interviewed about their child's sexual behavior or answered questions in observation rating scales about a variety of sexual behavior items. Finally, one line of observational studies has been to ask teachers about behavior at preschools (Larsson & Svedin, 2002; Lindblad, Gustafsson, Larsson, & Lundin, 1995; Lloyd Davies, Glaser, & Kossoff, 2000).

The other main approach has been to study sexual behavior by retrospective interviews or questionnaires to teenagers or adults. In a nationwide sample of 17-year olds in Sweden, Edgardh and Ormstad (2000), and Edgardh (2001) studied adolescent sexual experiences of nearly 2,000 girls and boys in the early 1990s. Although her focus was on consensual adolescent sexuality, the teenagers' experiences of nonconsensual sexual encounters with someone at least 5 years older were also investigated. Edgardh found 2.3% of the boys and 7.1% of the girls to have had such experiences (exhibitionism excluded). The average age at onset was 9 years (SD = 4.3 for boys and 3.9 for girls). Thirty-seven percent of the abused boys and 19% of the abused girls had had their abusive experience with a friend, whereas 5% of the boys and 4% of the girls had had their nonconsensual experiences with an older sibling. Another study in a multicultural high-school setting in Stockholm by Edgardh (2001) revealed that 7.4% reported sexual abuse experiences (2.2% of the boys and 13% of the girls), most of which were peer experience, especially for the boys. In an American study by Haugaard and Tilly (1988),

undergraduate students were asked about their most memorable childhood sexual experience; their reports illustrate which types of experience last in memory into adulthood, but give no data on the frequency of sexual experiences or the range of sexual behaviors. In a later study by Haugaard (1996), also targeted at undergraduates, 59% stated that they had had at least one sexual experience with another child, most of which occurred in the ages between 7 and 12 years. A study of female undergraduates' normative sexual play in childhood found that 85% of the women described a sexual game experience, of which 30% reported that they had been persuaded, manipulated, or coerced to participate. Another 13% remembered that they themselves had been the initiators (Lamb & Conkley, 1993).

Studies from North America of child sexual behavior are frequently cited, but few of these are comparative studies. Goldman and Goldman (1982) compared sexual knowledge among children in four Western societies. They found that 85% of the participating Swedish children said they had received some sex education at school, whereas in the samples from the English-speaking countries, fewer than 40% had had any such education. In Finkelhor's early study of college student's memories of childhood sexual experiences with other children, nearly two thirds described such experiences as occurring before adolescence, although very few of the experiences were revealed to anyone at that time (Finkelhor, 1983). Schoentjes, Deboutte, and Friedrich (1999) conducted a comparative study of Dutch and American children and found no significant differences in their sexual behavior. Larsson et al. (2000) compared a group of Swedish preschool children with an American sample and found that the Swedish children were

reported to show more sexual behavior than the American children. The kinds of behaviors reported from both countries were similar.

Although the above-mentioned studies sketch a framework for contemporary knowledge about childhood sexuality, they do not provide a basis for distinguishing between consensual or nonconsensual sexual encounters between children. The children's feelings about the sexual behaviors they participated in have also not yet been properly explored. The main aim of the paper was to study aspects of young adults' recollections of their sexual experiences before the age of 13, solitary and shared, mutual as well as nonconsensual. Another aim was to study any possible correlation between different kinds of childhood sexual experiences with peers and inappropriate sexual experiences with adults.

The empirical literature on young children with Sexual Behavior Problems (SBP) is particularly scant but supports a relationship between SBP and child sexual abuse. Friedrich and Lueck (1998) studied 22 children (half younger than 7 years old) referred due to SBP. All but 1 of the young children was male. Five of 6 children who had sexually aggressive behaviors had a clear history of sexual abuse; the 6th child was reported to have witnessed sexual violence, but there was no report of direct sexual abuse. Five of six also had a history of maternal absence or neglect.

Further support of the relationship between childhood sexual abuse and SBP is found in the work of Johnson (1988, 1989). The relationship between sexual victimization and demonstrating SBP may be stronger in preschool-age children than in school-age children for boys. In a study of 47 boys with SBP, Johnson (1988) found that 72% of the 4- to 6-year-olds had a history of being sexually abused, whereas 42% of the

7- to 10 year olds and 35% of the 11- and 12-year-olds had such a history. Girls with SBP may be more likely to have a history of child sexual abuse than boys. In a sample of 13 female children with SBP (ages 4 to 12 years), Johnson (1989) found that 100% of the children had a history of child sexual abuse.

Research on the symptomotology of children who have been sexually abused provides additional information about the relationship between sexual abuse and SBP. Kendall-Tackett, Williams, and Finkelhor (1993) conducted a comprehensive review of the research on sexual abuse and found that SBP and post-traumatic stress disorder (PTSD) symptoms were more prevalent in sexually abused children than in clinically referred children without a history of sexual abuse. Of 1,353 children who had been sexually abused (evaluated in 13 different studies), 28% had exhibited SBP (Kendall-Tackett et. al., 1993). The youngest of these children (ages 3-5 years) were noted to have the highest prevalence of SBP (35%). Since this review, a study of 100 sexually abused children (ages 3 to 7 years) by Hall et. al. (, found that 63% of these children demonstrated “interpersonal” sexual-contact that was problematic 1996; Hall, Mathews & Pearce, 1998).

Letourneau, Schoenwald & Ashili, 2004, conducted a study of four randomized trials which tested treatments for children with sexual behavior problems or adolescent sex offenders. Evidence from two trials of treatment for young children with sexual behavior problems suggests these problems respond equally well to a variety of treatments, all of which were relatively short-term (12 to 24 weekly sessions) and all included significant caregiver involvement (Bonner et al.,. 1999; Pithers et al., 1988). It has thus been suggested that caregiver involvement, rather than specific treatment

methods, may be an essential component in the treatment of children with sexual behavior problems (Caffin et al.,. 2002; Pithers et al., 1998).

To summarize, the risk profile for children with sexual behavior problems provided by the research study conducted by Letourneau, Schoenwald & Ashili, 2004, is one of boys and girls who are likely to have been sexually abused and/or to have witnessed family sexuality, who are likely to have comorbid internalizing and externalizing behavior problems, and who are likely to respond well to relatively short-term treatment that includes caregivers. The risk profile for adolescent sex offenders is very similar to that of other delinquent youth. The study found that adolescents who commit sex offenses are usually boys who may have been sexually or physically abused, associate with deviant peers, have significant school problems and have serious problems within the family (Ageton, 1983; Jacobs et. al., 1977; Lewis, Shanok, & Pincus, 1979; Milloy, 1994).

The study conducted by Letourneau, Schoenwald & Ashili, 2004, also examined the nature of sexual behavior problems in a group of youth (ages 5 to 19) referred to community clinics for treatment of serious antisocial and other externalizing behavior problems. In the sample, sexual behavior problems were defined largely by their frequency (e.g., masturbates too often) or inappropriateness (e.g., public masturbation) and do not include other relevant behaviors (e.g., aggressive sexual behavior directed toward others). Outcome data both descriptive and immediate post treatment, on these youth was compared with data on youth from the same sample who did not have sexual behavior problems. Because there is almost no published research on the non-criminal sexual behaviors of non-offending adolescents, Letourneau, Schoenwald & Ashili, 2004,

had few a priori hypotheses. However, based on their review of extant literature on children with sexual behavior problems and on adolescent sex offenders, they hypothesized that, in their clinical sample of children and adolescents, that those with non-criminal sexual behavior problems would be characterized by higher rates of sexual and physical abuse and by higher rates of internalized problems relative to youth without sexual behavior problems.

As noted earlier, there is a growing concern that youth with sexual problems may be at risk for engaging in sexual crimes, and indeed, adolescent behaviors previously viewed as misbehavior have recently been criminalized in many states (Caldwell, 2002). Lacking recidivism follow-up data, the study presented by Letourneau, Schoenwald & Ashili, 2004, cannot address whether non-criminal sexual behavior problems represent a risk factor for future criminal sex acts; prospective studies are needed to address this concern. However, data from this study that youth in the high Sexual Behavior Problem group may have more in common with their younger counterparts (i.e., children ages 3 to 12 with sexual behavior problems) than with adolescent sex offenders. Specifically, relative to youth in the no-SBP group, youth in the high-SBP group included a much higher percentage of girls, were significantly younger (by less than 1 year), were less likely to have substance use problems, and had higher rates of social problems. If delinquent youth with sexual behavior problems are more similar to children with sexual behavior problems than to adolescent sex offenders and if these youth respond well to home based treatment, then criminalizing sexual behaviors previously viewed as misbehavior may be an unnecessarily harsh course of action to take. Likewise, when inappropriate sexual behaviors occur in the context of other externalizing behavior

problems that warrant referral for treatment, individual oriented, specialized, sexual behavior-focused treatment may be unwarranted (Letourneau, Schoenwald & Ashili, 2004). Emphasis should be placed on identifying inappropriate sexual behavior and treating those behaviors within the context of family therapy that is effective with other juvenile delinquents may be sufficient for the amelioration of such sexual behavior problems. In order to determine whether specific treatment for sexual behavior problems in children and adolescents with additional behavior problems would result in faster or more complete amelioration of systems further rigorous, randomized clinical trials need to be conducted.

Developmental Progression of Sexual Behavior Problems to Sexual Offenses

Treatment for young children with SBP has been conceptualized as secondary prevention, with the hopes of preventing the development of a pattern of sexually inappropriate behaviors that would lead to sexual offending behaviors in adolescence and adulthood (Cantwell, 1998; Pithers & Gray, 1998; Ryan, 2000). Retrospective research with adult sexual offenders has suggested that a subgroup of offenders report an early onset of sexual activities. Based on retrospective research and clinical work with children with SBP, Ryan, Lane, Davis, and Isaac (1987) proposed that SBP may be learned at an early age and progress throughout childhood, adolescence, and adulthood. If there were such a developmental progression, young children with SBP would be expected to present with behaviors, family composition, demographic factors, and social history similar to school-age children with SBP.

Two recently conducted federally funded projects provided the most comprehensive data on school-age children with SBP. The definition of SBP for these

studies was consistent with the one provided earlier in this paper. Bonner et al. (1999) evaluated 201 children from 6 to 12 years old with SBP. The children's SBP was classified into one of three groups in an SBP typology: sexually inappropriate (20%), sexually intrusive (37%), and sexually aggressive (43%). Demographic, social history, and adjustment evaluation results indicated that the majority of the sample was male (63%), the sample was ethnically similar to the Oklahoma City and Seattle areas (76.6% Caucasian, 12% African American, and 5% Native American), and the sample lived with biological parents (68%), foster parents (13%), and alternative relative caregivers (15%). On the Kauffman Brief Intelligence Test the mean Composite score was 94.96 (SD = 12.67) and mean Vocabulary Scale score was 95.5 (SD = 14/51), both of which fall in the average range. An assessment of child maltreatment history found that 48% reported to have a sexual abuse history, 32% a physical abuse history, 35% an emotional abuse history, and 16% a neglect history. Forty-one percent were reported to have no known history of child maltreatment. Emotional and behavioral symptoms were reported in the clinical to borderline range on the Child Behavior Checklist (Total score, M = 67.05, SD 10.86; Externalizing Scale score, M = 66.67, SD = 11.29; and Internalizing Scale score, M = 62.37, SD = 12.21). Caregivers reported significantly greater levels of parenting stress on the Parenting Stress Index (M = 265.88, 90th percentile, SD = 49.51) than the caregivers in the control community sample of children without known SBP (M = 234.43, 65th percentile, SD = 33.66) (Bonner et al., 1999).

The above study found that the sample of young children they used exhibited a particularly high frequency and severity of SBP's. Evidence was found that some young children do exhibit aggressive sexual behaviors, including forcing others to engage in

sexual acts. The children displayed a complex array of other behaviors and emotional symptoms and experienced multiple stressful events, including changes in caregivers and home placements. Many of the children experienced PTSD symptoms, separation anxiety and a remarkable level of depressive symptoms. The study also found that the young children also presented with a wide range of emotional, behavioral, and developmental problems. It remains unclear the extent to which these factors are interrelated as research on treatment for school-age children with SBP has evaluated serves that are focused on the sexual behaviors (Bonner et al., 1999; Gray et al., 1999).

Direct inclusion of caregivers in services is recommended for treatment of behavior problems in young children. Given the level of caregiver stress, group treatment in which the caregiver can also have support from other caregivers who experience similar challenges may be particularly useful when treating young children with SBP. Most treatment programs for children with SBP do include groups for the caregivers. Reducing the SBP, reducing caregiver stress, and improving the quality of the child-caregiver relationship may in turn improve the stability of the child's placement and make a significant impact on the child's long-term adjustment and social relationships (Bonner, Walker, & Berliner, in press).

One must be extremely careful when making statements about the long-term outcome of these children. The results of this study are not consistent with a conceptualization of SBP as a linear progression from early childhood to school age and adolescence. Although a longitudinal design is required to evaluate the developmental trajectory of SBP, by comparing the young children with SBP in the study to samples of older children with SBP, this study offers preliminary data. The majority of the sample

of young children with SBP were female (65%) in contrast to studies of older children in which the majority of school-age children were male (63% in Bonner et. al., 1999; 65% in Gray et al., 1999) and to research with adolescent and adult sexual offenders who were predominately male (Berliner & Elliott, 1966). Furthermore, the results suggest that the present sample of young children had lower verbal abilities than found in school-age samples and were less likely to be living with their biological parent(s). Given these findings and other evidence, the causes and developmental trajectory of SBP are likely to involve multiple complex pathways. Young girls with SBP may be more responsive to environmental factors and reduce these problematic sexual behaviors once reaching school age. Differential identification of SBP for boys and girls may occur for school-age children and adolescents. Furthermore, a subgroup of boys may have a later onset of SBP.

The finding of a relatively low frequency of a history of substantiated sexual abuse was unexpected. Only 38% had a substantiated sexual abuse history. Substantiating sexual abuse in young children is quite problematic due to the secrecy that is predominant in child sexual abuse cases, the lack of physical evidence in many cases, the controversy regarding the memory and veracity of the testimony of preschoolers, and the complicated process of disclosure in children (Berliner & Elliott, 1996, Bross, 1987; Saywitz & Goodman, 1996).

The impact of exposure to violence through witnessing domestic violence or being physically abused appears to be a fruitful area for further investigations. A substantial portion of the sample – 25 (68%) – was exposed to interpersonal violence. The relationship between exposure to violence and problematic sexualized behaviors in

young children remains unclear but may result from a combination of traumatic experiences with exposure to sexualized materials. Furthermore, experiencing physical abuse may increase the likelihood of demonstrating interpersonal SBP in young children who have been sexually abused, perhaps by the impact on feelings of anger and shame and beliefs about use of control with others (Hall et al., 1988). Another potentially critical factor that was not assessed in the current study is child neglect. Childhood neglect has been found to be associated with significant behavior problems, including increased risk of sex crimes as an adult (Widom & Ames, 1994).

The severity and frequency of SBP, as measured by the CSBI, did not differ by substantiated history of child sexual abuse. Given the relatively small sample in the above study, such findings should be tested with further research. The presentation of specific SBP in young children maybe influenced by other factors, such as impulse control skills, environmental controls, and related conditions, such as presence of oppositional defiant disorder, attention-deficit/hyperactivity disorder, PTSD, or other disorders. Typologies of SBP and related problems have been proposed to classify the sexual behaviors and enhance the understanding of the children (Berliner, Manaois, & Monastersky, 1986; Bonner et al., 1999; Hall et al., 1996, 1998; Pithers et al., 1998a).

Demonstrating SBP as a young child has broad implications for the child's social, emotional, and behavioral development and long-term adjustment. Stigmatizing responses from adults, particularly caregivers, may impede these children's developing self-concept. Poor impulse-control skills, other aggressive behaviors, and inaccurate perceptions of social stimuli in some children with SBP further hinder social relationships and cause problems at school (Araji, 1997; Friedrich & Luecke, 1988; Gil & Johnson,

1993; Horton, 1996). In addition poor boundaries and indiscriminate friendliness often found in young children with SBP may place them at increased risk of being victimized. Raising children with SBP is often stressful for the caregiver and may lead to dysfunctional adult-child interactions and disruptions in the child's residential placement. Indeed, in the present study, caregivers reported stress associated with raising these young children with SBP, and many of the children had already experienced changes in their residential placements. Foster parents reported in a national survey that behavior problems demonstrated by the foster child was the primary reason they requested that foster children be placed in another home, with sexualized behavior reported as a specific concern (U.S. Department of Health and Human Services, 1993). Multiple disruptions in the caregiver-child relationship may place the child at risk for continued behavior problems and attachment difficulties. In the above study, many children were already experiencing high levels of separation anxiety. Thus, eliminating problematic sexualized behaviors is considered critical for the long-term well-being of these young children with SBP.

CHAPTER 4

Stages of Sexual Development

Roughly 10 years ago, children with sexual behavior problems were first recognized as a clinical population having unique needs (Araji, 1997). Concurrently researchers inaugurated studies to differentiate sexual behaviors characterizing healthy and abnormal child development (Friedrich et al., 1989). Over the past 10 years, the number of practitioners offering clinical services to families of children with sexual behavior problems has escalated dramatically (Safer Society Program and Press, 1994), and a standardized measure has been developed that discriminates between expected and atypical sexual behaviors in children (Friedrich, 1995).

For many of us it may be difficult to accept the fact that children can engage in sexual behaviors that might be harmful to others and to themselves. Childhood is supposed to be a time of protected innocence. However, even at a logical level little reason exists to believe that children are less likely to experience problems in sexual development than with any other behavior. The fact that children can engage in sexually problematic behavior is confirmed by two lines of data: (a) scores on an observational rating instrument of children's sexual behaviors and (b) the proportion of substantiated child sexual abuse in which the perpetrator was less than 12 years old (Pithers & Gray, 1998).

The concept of "child sexuality" has only recently been a topic of research. Historically, Freud's theories and ideas have been important in denying the existence of sexual feelings in children, especially in the so-called latency period between the ages of 6-10. However, Kinsey, Pomeroy, Martin, and Gebhard (1953) already reported about

sexually exploratory behavior in children in the middle childhood (i.e., Freud's latency period). Recent research shows that children explore their world in a sexual way, that this exploration process manifests itself in a different way from that of adults, and that there are large individual differences. It seems plausible to believe that this behavior is determined by different motives than the adult ones and that it has a different function from adult sexual behavior. We believe that the development of sexual scripts is one of the most important functions of these early phases of sexual behavior. Sexual scripts can be considered the blueprints of sexual meaning, which will only be put into practice at a later age.

In the practice of child psychiatry, it is known that certain children deal with sexuality in an atypical, more grown-up way. This is particularly the case in children with externalizing behavior, specifically children who are diagnosed as suffering from oppositional defiant disorder (ODD) or conduct disorder (CD). For a long time sexuality has been a neglected issue, and even though there are grounds for anticipating that some of the aggressive and sexualized boys will exhibit sexually abusive behavior after puberty (Metzner & Ryan, 1995; Ryan, Miyoshi, Metzner, Krugman, & Fryer, 1996). It is also known that sexually abused girls show sexualized behavior, that they often behave in a seductive way, and run the risk of becoming sexually victimized again later in life (Kendall-Tackett, Williams & Finkelhor, 1993); Messman & Long, 1996). One can assume that the development of sexual scripts in these children is disturbed because they were involved in sexual experiences (often including force and violence) that were inappropriate for their age.

Early Development and Experience

According to Ehrhardt & Meyer-Bahlburg (1981), children are active and sensual creatures, even before they are born. One of the earliest sensory systems of the human body to function is the skin, which begins to function during the embryonic stage of development. The skin enables the organism to first experience its environment through generalized responses which are all over the body. When the embryo is less than an inch long from crown to rump, and less than six weeks old, light stroking of the upper lip region or wings of the nose has been shown to cause a response, a bending of the neck and trunk. The fetus in the womb is massaged regularly as the mother moves about doing her daily activities (Martinson, 1994). Movement of the fetus in the womb is necessary for the development of bones and joints also helping to increase body weight, nerve and body functioning.

There is currently a great surge of interest in attempting to understand all aspects of childhood and the life of children. Childhood has come to be seen not only as a transitional phase in the life of an individual, but children are seen as constituting a distinctive population group in society with their own interests and needs. Mothers are now recognizing that their infants are responding and engaging in sensuous experiences, even experiences that are being labeled as sexual. Western society, particularly American society are extremely slow in recognizing and conceptualizing that sexual experiences are a part of a child's development, and an aspect that is worthy of study. There is not much literature on the subject and to date parental discussion of child sexual behavior has not been a common practice (Martinson, 1994). There has been very little generation of folk knowledge, age-appropriate sexuality education for children has been

rarely initiated, and child sex research has not been encouraged, rewarded, or funded, except where the subject of child sexual abuse is concerned.

During the last three to four decades there has been an explosion of studies of infant and child development but few studies of child sexual development and experience. Only a few K-12 sexuality education courses have been developed and more than a dozen books of advice to parents on how to deal with the sexuality of their children have been written in the past few years.

Infants and Self-Stimulation

During the first year of life infants discover and explore parts of their bodies. This activity is more exploratory than autoerotic. Autoerotism is the technical term used to refer to self-gratification obtained through stimulation of one's own body, especially stimulation one's genitals (Langfeldt, 1990). By five or six months, many infants appear to enjoy pulling their ears or sticking their fingers in them, some even explore their genitals at this age. Levine, 1957 reported that after six months, infants gradually discontinue playing with their ears. Galenson & Roiphe, 1974 reported that most boys begin genital play at six or seven months of age, while most girls begin at ten or eleven months. For their sample of infants, genital play among girls tended to disappear within a few weeks of onset, but boys continued casual play with additional visual and tactile exploration of the genitals starting at about eleven or twelve months of age.

The most important distinction that can be made between genital play and masturbation in infancy is that in the first year of life an infant is not capable of direct-volitional activity required for the behavior we call masturbation (Langfeldt, 1990). Random play with the genitals is therefore a nonspecific activity and should be labeled

genital play and not masturbation. Genital play need not end with the end of infancy as there is physical pleasure to be derived from fondling the genitals. The satisfaction is enough to develop this practice into a habit and touching or holding the genitals is not only associated with erotic pleasuring.

According to Martinson 1994, in the first eighteen months of life genital play is a reliable indicator of the adequacy or inadequacy of mothering. It was found that when the relationship between mother and infant was one in which the mother provided normal physical and emotional care and attention, that genital play by the infant was present in all cases. When it was not provided, genital play was absent (Bonner, Walker, & Berliner, in press).

Infants and Orgasm

The greatest autoerotic satisfaction, and certainly the occurrence of orgasm, depends on manipulation of the genitals that is rhythmic and repeated. Rhythmic manipulation with the hand does not occur before a child is approximately two and a half to three years old, probably because small muscle control is not well developed before that (Martinson, 1994). On the other hand large muscle control is well developed and well coordinated as early as six months of age. It is at this time that some infants form a pattern of rocking that is rhythmic and repeated. They rock and bump their heads against the crib with vigor. Once they are able to sit up, additional types of rocking may be observed, all of which appear to bring satisfaction. Some infants sit and sway rhythmically, some life the trunk and pelvis and bounce up and down off the surface they are sitting on. Some do both by elevating themselves up and down and swaying to and fro, giving the appearance of rising as a person does when riding a trotting horse (Levine,

1957). Infants also can be seen elevating to hands and knees and rocking forward and backward, this appears to be the most frequent type of rocking and is not uncommon as early as six to twelve months of age. In other words, infants may discover the pleasure of rhythmic genital sensation through rocking before they have adequate hand and arm small muscle control to masturbate (Martinson, 1992). Rocking in this manner appears to be more satisfying than manual genital play in that infants in genital play can be easily distracted in contrast to infants who rock. Rockers often rock with great vigor and tension and are not easily distracted. Schaefer, 1964, conducted a study of thirty women who reported that at age six they discovered that rocking and rubbing their genitals on bedclothes bunched between their legs was continued until something would happen, something moved, which they guessed was a little orgasm.

Kinsey, et al. (1948) reported that orgasm is not rare among children, both boys and girls, and has been observed in boys of every age from five months on and in infant girls of four months old. To understand the capacity of infants and small children to reach orgasm, we have to first make a distinction between those who stimulate themselves and those who have been stimulated by others. Given the lack of capacity of infants for sustained rhythmic stimulation of their genitals, to determine the capacity of sexual response in infants would require stimulation by persons other than the infant. Kinsey, et al (1948) had access to such data and reported on stimulation to orgasm of male infants less than one year of age as follows:

The behavior involves a series of physiologic changes, the development of rhythmic body movements with distinct penis throbs and pelvic thrusts, an obvious change in sensory capacities, a final tension of muscles, especially of the abdomen, hips, and back,

a sudden release with convulsions, including rhythmic anal contractions followed by the disappearance of all symptoms. A fretful babe quiets down under the initial sexual stimulation, is distracted from other activities, begins rhythmic pelvic thrusts, becomes tense as climax approaches, is thrown into convulsive action, often with violent arm and leg movements, sometimes with weeping at the moment of climax. After climax the child loses erection quickly and subsides into the calm and peace that typically follows adult orgasm (Kinsey, et al., 1948:177).

Kinsey and his colleagues have been castigated for not exposing the persons responsible for stimulating these infants to orgasm. Such behavior would be regarded as child sexual abuse today (Martinson, 1992). Kinsey did report an increase in the percentage of individuals able to reach a sexual climax from 32 percent of boys two to twelve months of age to 57 percent of those two to five years of age and nearly 80 percent of preadolescent boys ten to thirteen years of age (Kinsey, et al., 1948).

Masturbation

Masturbation has been largely ignored in books on infant and child development, yet it has long been recognized as a near-universal phenomenon. Roberts, Kline & Ganon, 1978, found in a sample of American parents that 80 to 90 percent believed most children masturbate. Galenson & Roiphe, 1974, utilizing interviews with parents for the first year and direct observation for the second year of life, found that for boys the onset of masturbation proper began at fifteen to sixteen months of age, whereas for girls a pattern of intermittent genital play was observed. Levine, 1957 observed that most of the sexual activity at this young age remained genital play rather than true masturbation. He reported that most children, even through twenty-four to thirty months of age, indulge in

genital play with a certain degree of satisfaction but in most cases without any apparent emotional excitement or increased stimulation. There appears to be a great deal of overlap between genital play and masturbation.

According to Gardner, 1991, all normal children explore their bodies from time to time and do not differentiate between genital the area and other parts. They have to learn from others that touching oneself in that particular area is socially unacceptable, especially in public. Children usually learn by themselves that stimulation of that area can provide pleasures different from those derived from touching other areas. He also states that orgastic capacity is possible at birth, most young children under the age of nine or ten do not stimulate themselves to the point where they reach orgasm. This is a contrary to what many other researchers believe. He does believe that those who do stimulate themselves may very well have been prematurely introduced into the pubital and postpubital levels of sexual arousal. Certainly, such introduction can be the result of sex abuse. But this is not the only reason why a younger child might masturbate to orgasm. In some children it is a tension-relieving device, especially when they grow up in homes in which there has been significant privation and/or stress. In some it can serve as an antidepressant. When a knowledgeable evaluator hears that a child is masturbating, the examiner will make detailed inquiry about the frequency, the time of onset, the circumstances under which it occurs, and whether or not the child masturbates to orgasm. All this information is useful in ascertaining whether or not the masturbation is related to sex abuse. Typically, validators do not make such inquiries. They hear the word masturbation and that is enough to prove that the child has been sexually molested (Gardner, 1991).

In the late nineteenth century, in both the United States and England, we witnessed a period of excessive preoccupation and Draconian condemnation of childhood masturbation. Unfortunately, physicians, who should have known better, were actively involved in this campaign of denunciation and attempt to obliterate entirely this nefarious practice. Doctors considered it to be the cause of a wide variety of illnesses, e.g., blindness, insanity, and muscle spasm. Various kinds of restraints were devised in order to prevent children from engaging in this dangerous practice. Some girls were even subjected to clitorectomies, so dangerous was the practice considered to be. Some of the altering signs: temper tantrums, bedwetting, sleep disturbances, appetite changes, mood fluctuations, and withdrawal. Obviously, in the hundred years since those sad times, we seem to have gone back full circle. The same list of symptoms that were indicators of masturbation are now considered to be indicators of sex abuse (Gardner, 1991). Legrand et al. (1989) have written a fascinating article describing the similarities between the masturbation hysteria of the late nineteenth century and the sex abuse hysteria of the late twentieth century with a comparison of the lists of "indicators."

Physicians have played an important role in these crazes. Dr. William Griggs of Salem was the first doctor to "diagnose" the children in the Salem witchcraft trials as being possessed by the devil. Doctors were actively involved in the antimasturbation fanaticism of the late nineteenth century. Unfortunately, there are doctors actively involved in the fiasco today. There are physicians who are diagnosing sex abuse in the vast majority of children they examine, utilizing criteria that are generally considered to be within the normal range (e.g., anal "winking" and hymenal tags). There are other

kinds of doctors (Ph.D., psychologists and M.D. psychiatrists) who are serving as validators and therapists and are perpetrating these abominations (Gardner, 1991).

From three years of age and on, children retain some memories of sexual experiences and can recall them. They may be able to report quite clearly on the first time they remember experiencing pleasurable genital sensation, the first time they masturbated, or the first time they had an orgasm. It may not in fact have been the first time, but earlier sexual experiences have been forgotten. The first memories that a child has appear to be those that were highly emotional (Martinson, 1994).

At three years of age most boys who masturbate do so manually by rubbing the penis or by wrapping the fingers around the erect penis and moving the hand. Still, at this age, many boys lie on their stomachs on a flat surface and writhe while engaged in other activity such as watching television. Some raise themselves slightly from the surface and propel themselves forward and backward, rubbing their genitals in doing so, and continue until orgasm is reached. A small number rub themselves against something, for example, a hard pillow, the leg of a chair, a person's leg, or their own stiff forearm and derive satisfaction in that way (Levine, 1957).

In girls, already at three years of age there are manifold varieties of masturbation. These include thigh pressure; rubbing the genitals against a soft toy or blanket; manually stroking the labia and clitoris; and, less frequently, inserting objects into the vagina (Kinsey, et al., 1953; Levine 1957).

Some form of manual manipulation of the genitalia seems to be most common. Kinsey reports on a mother who observed her daughter masturbating.

Lying face down on the bed, with her knees drawn up, she started rhythmic pelvic thrusts, about one second or less apart. The thrusts were primarily pelvic, with the legs tensed in a fixed position. The forward components of the thrust were in a smooth and perfect rhythm which was unbroken except for momentarily pauses during which the genitalia were readjusted against the doll on which they were pressed; the return from each thrust was convulsive, jerky. There were 44 thrusts in unbroken rhythm, a slight momentary pause, 87 thrusts followed by a slight momentary pause, then 10 thrusts, and then a cessation of all movement. There was marked concentration and intense breathing with abrupt jerks as orgasm approached. She was completely oblivious to everything during these later stages of the activity. Her eyes were glassy and fixed in a vacant stare. There was noticeable relief and relaxation after orgasm. A second series of reactions began two minutes later with series of 48, 18 and 57 thrusts, with slight momentary pauses between each series. With the mounting tensions there were audible gasps but immediately following the cessation of pelvic thrusts, there was complete relaxation and only desultory movements there after (Kinsey, et al. 1953).

Among the women interviewed by Schaefer, the earliest reported experience of first orgasm through self-stimulation was at age four. The subject discovered: that pleasure involved in exposing my genital area to the forceful stream of water in the bathtub. My mother seemed to be very angry when she caught me doing this…There is something very repressive about her when she reprimanded me—as though she was holding in something…but it was coming out in anger from her frozen face and stern eyes (Schaefer, 1964).

Three studies of female sexual activity contained data on the practice of self-stimulation in childhood and the number of subjects who attained climax by this means: in Davis, 1929 study, 25 percent to age ten had practiced self-stimulation and 12 percent had attained climax; in Kinsey et al.'s 1953 study, 19 percent practiced to age twelve and 12 percent attained climax; and in Schaefer 1964 study, 43 percent practiced to age twelve and 23 percent attained climax. Among the Schaefer subjects all those who reported self-stimulation before age twelve and who attained climax thereby continued the practice through adolescence and into adulthood whether or not they had been discovered or reprimanded. For the ones who had not achieved orgasm, the pleasure evidently did not outweigh the guilt feelings and other negative pressures osmosed from the milieu (Schaefer, 1964).

Achieving orgasm can be a powerful motivator for girls as well as for boys. I loved it. I knew it was punishable…yet it was enjoyable, so I did it. It was comforting. Once having produced that kind of experience, it was imperative that I experience this, one way or another, each time. Despite the pleasant feeling associated with orgasm, the words that women with masturbatory experiences used to describe the feeling attached to those experiences seemed to Schaefer, (1964) to be guilt, anxiety, and shame. Kinsey, et. al., (1953) also noted that no other type of sexual activity type had worried so many women as masturbation. Masturbation was a good idea in the sense that it was a pleasure…but guilt robbed it of all those good feelings, I think. One subject was told by teachers in her parochial school that "if you touch yourself in your private places, you'll go crazy" (Schaefer 1964).

In some cases a child fails to find masturbating satisfying because of failure to reach orgasm. The failure may be due to negative prior conditioning, ignorance due to lack of knowledge, or failure to discover a technique for effective self-stimulation. In Scandinavia, where child sexual capacity is more widely recognized, preschool teachers, sex educators, and therapists have on occasion instructed children in better masturbatory techniques (Martinson, 1994).

According to Langfeldt (1990), the Norwegian sex therapist, those with serious masturbatory problems may need therapy to learn how to be orgasmic. He asserted that reducing anxiety, changing masturbatory techniques, and being supportive of sex in privacy are the most common effective aspects of the therapy, but that changing masturbatory patterns once they are established is very difficult in both boys and girls, even in small children as young as three to four years of age. He also reasoned that since girls have less stereotypical masturbatory techniques than boys, girls more often develop a masturbatory technique requiring a higher amount of genital stimulation than would be necessary with better technique. The most satisfactory technique of genital self-stimulation, even for small children, appears to be repeated manipulation of a specific rhythmic form that leads to orgasm. Most children who masturbate to climax stop after one orgasm, but some children have several orgasms, (Langfeldt, 1990).

Not all children relax and go to sleep after reaching orgasm. A few appear to be stimulated by the activity. Levine (1957) reported on a three-year-old boy who would masturbate vigorously and end by sitting up alert, bright-eyed, and apparently satisfied and content. Masturbation is recognized as a tension reliever and is often observed among nursery school children. It is unquestionably increased during periods of

emotional tension, but three-year-old children have been so observed to masturbate as an expression of delight and not when tired, stressed, or unhappy.

A child's initial attempts at self-stimulation are inspired in a number of ways. Many discover the possibility of such activity entirely on their own and quite by accident. The great majority of females in the Kinsey et. al. (1953) study learned to masturbate on their own as a result of their exploration of their genitals, but only 28 percent of the boys had discovered masturbation on their own. Most boys hear about it from others. Boys also learn by observing the behavior of other boys or through deliberate instruction given by one of their acquaintances. In the Kinsey sample, 9 percent of the boys had been masturbated by other males before they began to do it by themselves. Similar same-age activity occurs among girls, but it is not nearly as common. Only about 3 percent of the females in the Kinsey et. al. (1953) sample had begun masturbating as a result of the childhood same-sex contacts. According to Kinsey, et al. (1953), some girls wait months and even years after learning about masturbating before they try it themselves. Unlike girls, boys once they have heard about it rarely delay experimenting on their own.

Masturbation is common during childhood, but by no means do all children masturbate. There is no accurate count of the number who do or the frequency of occurrence for those who do (Martinson, 1997). Several studies have dealt with the topic, but lack methodological rigor and consistency making comparisons between the findings of the various studies less useful than one might think. Sears, Maccoby, & Levine (1957) reported that only two fifths of the mothers said they had never noticed their children doing anything that could be referred to as masturbating. In a study

involving 284 boys, Ramsey (1943) reported that 5 percent of those age six and under had had masturbatory experiences, and 10 percent of seven-year-olds had.

There is little doubt that the attitudes of parents influence the attitudes of children toward masturbation. The parents in Berges, et al., 1983 study, indicated rather apologetically that they had never brought up the subject of orgasm with their children. The majority did not think their children had any understanding of what orgasm was. Masturbation is not a topic commonly discussed in sex education material prepared for parents of young children in our society (Martinson 1992).

Dreams, Fantasies, and Myths

In order to ascertain the extent of sexual knowledge and sexual experience of children, we need to look at the content of their fantasy world as is revealed in their dreams, stories, and myths. Fantasy activity is universal in human life, and represents the ongoing baseline mental activity of humans. Attending to this internal mental activity is behavior learned early in childhood (Rosenfeld et al., 1982). Dreams occur during sleep, while fantasies occur during waking hours; they are similar enough that fantasies are also called daydreams. It is assumed that sometime in the first year of life, before they begin to speak, children begin to fantasize (Gardner, 1969). In studies of child play it has been found that young children are very comfortable with fantasy and are able to move quickly and easily from reality to fantasy and back again (Martinson, 1992). Children's styles of fantasy are remarkably similar to those of adults, except that fanciful daydreaming appears mostly unique to children (Rosenfeld, et al. 1982).

During or subsequent to genital self-stimulation in the second year of life, both girls and boys frequently make affectional gestures toward their mothers and touch their

mothers' bodies. But such open affection begins to disappear after a few weeks and is replaced by an "inward gaze and a self-absorbed look" that soon begins to occur, indicating that a fantasy feeling-state now becomes a regular part of genital stimulation (Roiphe and Galeson 1981: 252).

Although it might be expected that the fantasy feeling-state accompany genital play and it would show up in the stories young children tell, but it does not appear to be so for American children. American children learn very early in life that they must not talk about sex, at least not in the presence of adults. That is one reason why the subject of sex does not commonly appear in their stories. An inability or unwillingness to use words referring to sex was one of the most striking findings of Conn's play interview study of 200 children four to fourteen years of age (Conn and Kanner, 1947; Kanner, 1939).

In his play interviews, Conn found that sexual fantasies accompanying masturbation—imagining the sight or touch of genitals, buttocks, or breasts, and thoughts of coitus, were reported by a very small number of boys below nine years and by no girls of any age. For example, in the play interviews, the children even as young as four years of age, spoke hesitatingly and without embarrassment of the boy's "thing" and the girl's "thing," but other distinctions had something secret or hidden about them. It was not so much that these children did not know the names of the genitals; in fact, Conn found no less than sixty-one different names for the genitals among 200 children. These words were not spoken by the children because they regarded the names as bad, nasty, or dirty and not to be uttered in the presence of adults. Conn found that children with such inhibitions could hardly be expected to report stories they made up or dreams they had

about sex and sexual activity. Another reason for the lack of stories about sex was limited information and lack of sexual experience. Conn estimated that with more information and/or experience, children's fantasy life would change.

Ames, 1966; Pitcher and Prelinger, 19643 conducted two major studies of the stories told by young children. Ames, 1966 found that in children two to four years of age the predominant theme at every age for both boys and girls was violence. Of fifteen two-year-old boys mean age 2.5), 60 percent of the stories dealt with violence, and for fifteen girls the figure was 68 percent. Other themes in the stories to two-year-olds were: food and eating (boys 14%, girls 27%); sleep (boys 77%, girls 28%); good and bad (boys 0%, girls 21%); possible sibling rivalry (boys 21%, girls 7%); possible castration (boys 14%, girls 0%; and reproduction (boys 0%, girls 7%). None of the group of thirty two-year-olds described stories overtly concerned with anal activity.

Pitcher and Prelinger, (1963) show in their study that 137 two to five-year-olds, eight main themes were found: aggression, death, hurt or misfortune, morality, nutrition, dress, sociability, and crying. Aggression appeared most often, 124 times in 360 stories; hurt and misfortune was the next most frequent theme, appearing eighty-nine times. For boys, aggression tended to be much more violent than for girls. Even at two and three years of age, the boys' calamities involved much violence. Boys reported to Ramsey, 1943 on dream content in which they found themselves with erections on awakening. The dream content contained nonerotic but potentially violent stimuli such as fighting, accidents, and wild animals, falling from high places, giants, or being chased and frightened.

Among Pitcher and Prelinger's two-year-olds, the theme of their dreams was largely concerned with violence of body intactness meaning some part of the body was broken or severed. The interest of this theme, especially among boys would appear to be consistent with fears of castration. However, this theme was almost absent in the stories of three-year-old boys. Gardner, 1969 based his observations on clinical experience and does not believe that castration anxiety is a significant concern for the normal boy, nor is penis envy a preoccupation in the well-adjusted girl. Rather, the healthy child accepts his or her sex and has pride both in the sexual and nonsexual aspects of the self.

In Ames, 1966 studies, the number of stories featuring some kind of violence ranged from a low of 63 percent for boys at two years to a high of 88 percent of boys at three and a half years. The most common theme was aggression. Ames also found boys to be much more violent in their expression than were girls. In general, Ames found spanking to be strong in the early age as well. Ames concluded, "If it should be that they absorb the violence from the culture, then such absorption must be considered a rather universal phenomenon expressing itself as early as two years of age" (Ames 1966:390).

Researchers wanted to find out what were the themes that related to the sensory and sexual experiences of life, intimacy, kindness and eroticism. Ames, 1966 found that though kind of friendly stories were not very common at any age from two to five years old, they sometimes occurred at two and three years of age. Pitcher and Prelinger, 1963 found that girls sometimes referred to love, courtship, and marriage. The girls were more likely than the boys to express emotion and effect around a parental figure, particularly a mother. The boys displayed an extraordinary lack of interaction with either mother or father. Pitcher and Prelinger found that it was rare that the phenomenon of excitement

and of aggression between a man and a woman took placed in the stories. They attributed this in part to the taboo on sexual knowledge for children in the United States and the fact that adults keep most aspects of their own sex life secret. The younger infants appeared at times to make transparent references to the issue of pregnancy in their stories, but the connection of the various details tended commonly to be illogical or poorly motivated. Gardner, 1969 agreed with Ames and Pitcher and Prelinger that the conscious fantasy life of the normal child at this age contains little overt sexual material. But Gardner found that from about age eight and onward, sexual fantasies might take any form know to adults. It may be a phase-specific theme that the culture does not allow or encourage to be more specific and accurate among younger children. But Pitcher and Prelinger, 1963 did not rule out the possibility that manifestations of unconscious or less conscious preoccupation with sexuality are prevalent in many of the stories of young children.

Borneman, 1983 gathered information about the content of forbidden riddles, songs, verses, and games in Austria. He reported what he regarded to be an inordinate number of verses about brother-sister incest and a fair number about parental intercourse, all of them in stories appealing to children between ages six and seven. This may reflect cultural differences in the exposure of children to sexual knowledge and sexual experience, but it more likely reflects a difference in methods of soliciting information from children.

Wormer and Levin, 1967 distinguished between two kinds of erotic fantasies, erotic fantasies in general and masturbation fantasies in particular. Erotic fantasies consist of all types of fantasies of a sexual nature, including those that could become

reality if the person being fantasized about were available as a participant with the one who is fantasizing. Masturbation fantasies, on the other hand, are sometimes of a kind that could not be fulfilled in any reality relationship with another person. In addition, the aim of masturbation fantasy is self-gratification, and the person masturbating may have little or no desire to translate his or her masturbation fantasy into action. In the masturbation history of a healthy person, masturbation fantasies tend to undergo a variety of changes as the person passes through different phases of psychosexual development. First masturbation for young, innocent children is apt to be accompanied by fantasy content that, as described by one young man in the study, is "either very innocent or erotic concepts or very sadistic and violent through ignorance.

Not all persons who masturbate fantasize. In the Kinsey, et al. 1953 sample, just about half of the females reported that fantasies had occurred almost always in connection with most of their masturbating, at least during certain periods of their life, with another 14 percent fantasizing some of the time. For a fair number, masturbation fantasies had not begun until some years after they began to masturbate; fantasies were least common for the younger females. For males, 72 percent had almost always fantasized while masturbating and another 17 percent fantasized some of the time. For some, fantasizing is a necessary concomitant of successful masturbating.

Comparison between the Sexual Life of Children in Sweden and the United States

As one expert on sexually victimized children wrote, "we know more about sexual deviance than we do about sexual normality… We hardly know how they come to have sexual experience at all." We have "a vast ignorance of the forces governing the development and experience of sexual behavior in general" (Finkelhor, 1979).

One question that has not been seriously considered or asked is: How do children get a sexual life? One answer could be that they appear to get it naturally and unobtrusively by being alert to the many influences around them. But that method is not sufficient in a society where pains are taken to keep as much sexuality hidden from children as possible. In such a society, if we want children to know about sexuality, we need to supplement natural assimilation with instruction (Martinson, 1994).

In their book "Children Sexual Thinking (1982), Goldman and Goldman (1982), provided a "natural environment" on the need for sexual education. They were Australian educators who set out to look for the best in sexual education materials and methods. They developed a system whereby they could determine the value of sexual education programs by interviewing a sample of five- to fifteen-year olds in four countries, Australia, England, Sweden, and the United States. Goldman and Goldman found that children's sexual thinking is not confined to thinking about sexual intercourse and that it embraces a much broader universe of experience than that. Goldman and Goldman used the broadest meaning of sexuality in order to plan and complete their research. They also found that children are sexual thinkers from birth. Children constantly seek for sex information by whatever ingenious method they can with their exploring sexual topics increasing as their age increases. They seek this information until they feel they have a fairly complete set of answers. If they do not get the answers they need they simply invent them. In addition they looked at the fact that children in the United States were the least and the latest to receive sexual education while in Sweden sexual education was provided to children from the first grade, age seven and on. Here they found a natural experiment showing one country with the least and the latest sexual

education, and another country with the earliest sexual education. What differences did Goldman and Goldman (1982) find between children in the two countries?

Results showed that Swedish children were capable of understanding complex biological concepts much earlier than had been believed. They were two or more years ahead in sexual knowledge and understanding than children from the United States. They found that children in the United States were retarded in their sexual knowledge three or more years and were the most retarded of all four countries. Goldman and Goldman were convinced that the American children were inadequately prepared for sexual adulthood. For example, American children up to and including eleven years of age gave nonsexual responses to parent roles in procreation. Many older children knew the facts of sexual joining, but few could put the facts together to make a satisfactory explanation, even by age fifteen. It was noted that only an estimated 10 percent of American high school students receive comprehensive sex education before they graduate from high school today.

In addition they also found that the home was the most cited major source of sex information for children, in the person of the mother. It could be suspected that silence in the school is matched by silence in the home as well. Sears, Maccoby, and Levine (1957) conducted a study in England which bears this fact out. It is amazing the ingenious means mothers utilized to thwart the attempts of their young children to engage in sex play and to ask sex questions. Not one of the parents was completely free and opens in the discussion of sex with their children. One reason for this was the fear that any attention called to the subject of sex might awaken the child to erotic activity. In contrast, the parents in the Berges (1991) study never brought up the subject of orgasm

with their children. The reason being, they did not believe that their children had any understanding of what orgasm was. It is also interesting to note that orgasm is not a topic commonly discussed in books on sex education prepared for parents of children in United States society (Martinson, 1992).

Beginning in the 1800s, U.S. society built a wall around children to protect their innocence and to protect them from their won sexual inclinations. Keeping children sexually innocent became firmly established and has continued to be a feature of American culture. This means that teenagers have to look elsewhere for their final sexual instruction. Their peers are a major source from whom they learn what passion and orgasm is, and the joy, the fear, the excitement of sexuality. They also learn the status that sexuality can bring them.

Comparisons between Sex Education in the United States and Sweden

Sweden took a different course than the United States; it introduced sex education in 1942 and made it compulsory in 1956. After further studying its sex education program in the 1970s, Sweden again reduced the age at which each topic was offered to children. Children between the ages of seven and ten learned the difference between the sexes, where babies come from, the father's role in conception, developments before birth, the process of birth, and many other topics. The Swedes were still not satisfied with their program and introduced a more difficult subject of sex education, namely, teaching children the art of loving. They reasoned that sexuality is not a bad habit to be discarded and that sex education is important for a happy life. Therefore, sex is not a secret in Sweden. Sex education is a totally open program based on faith in young people and this faith has caused young people to respond (Goldman & Goldman , 1982).

According to Schwartz, 1993, because young people understand about sexuality at an early age the rate of sexual intercourse is not down but the rates of venereal disease and abortion are. Sweden's abortion rates are lower than the latest figures for Australia, the United States, and England and Wales (Goldman & Goldman 1982).

Engaging in premarital sexual intercourse has become statistically normative for American youth. Fifty-four percent of ninth through twelfth graders and 72 percent of high school seniors have had sexual intercourse (Haffner, 1992). Haffner also estimated 30 percent of sexually active adolescents become pregnant.

Unfortunately, sexual intercourse is a moral issue for some adults, and this is a problem when it comes to sexual education. Sexual education has focused almost grudgingly on helping young people avoid the negative consequences of bad decisions that could lead to contracting sexually transmitted diseases, unplanned and unwanted pregnancies, school dropouts, early marriage, and a life of poverty. However, in contrast, the Swedes see sexuality as a matter of health, not illness, and try to help people accept and enjoy their overall mental and social health and well-being. It is argued that a major source of public schooling should be to teach children how to reason, to question, and to accept responsibility; to teach them how to think, more than what to think. (Martinson, 1994).

Public Education and Sex Education Curriculum

Public education has an obligation to present a variety of ideas that reflect the perspectives of the entire community and to address the needs of all pupils, starting in kindergarten (Sedway, 1992). Public education has introduced a K-12 curriculum. On the other side of this issue, there are groups, often referred to as the far right or religious

right, who promote a narrower curriculum. Their curriculum eliminates the discussion of controversial topics, such as birth control, AIDS, and abortion, and focuses almost exclusively on sexual abstinence as the only behavior that can be supported for moral or practical reasons. These groups also are introducing curricula, and they are small but fervent and zealous in their efforts. We can agree with Udery, 1993, who stated that sex research "is not a battle between the forces of good and evil, nor is it a battle based on some misunderstanding that can be made to go away by more communication. On the contrary, it is a genuine and legitimate political battle between two groups and the population who hold diametrically opposed policy views."

For the almost twenty-five years, the attention of scholars in America, and incidentally, most of the research money, has been concentrated on a much smaller but not inconsequential problem, that of child sexual abuse. Unfortunately, the problem appears to be exacerbated by the public's concern over the naiveté of our youth caught up as they are in a much larger political and religious issue, an issue not of their making. Our youth are also being blamed for sexual issues that are not of their making either. For example, we use the perspective of victimology in judging sexual cases. Victimization predicates victims and perpetrators. The perpetrator is a human being who must be segregated from society or otherwise disciplined. We have begun to use this paradigm in dealing with child sexuality and have written it into the law. Behavior that is treated as child sex play in Scandinavia, at least up until 1984 was treated as perpetrator-victim behavior in the United States (Aigner and Centerwall, 1984).

Effects of Using the Victim and Perpetrator Paradigm

The following are examples of the effect of the use of the victim and perpetrator paradigm in dealing with children. The state of Minnesota in 1991-92, reported 1,110 cases of sexual harassment and ninety-five cases of sexual violence in its schools, and these were only the cases that were actually reported (Hotakainen, 1993). It is alleged that many more were not reported. More than 1,000 children in the city of Minneapolis alone were suspended or expelled on charges of sexual harassment (Shalit, 1993). Cases such as the following were classified as sexual harassment: telling dirty jokes, spreading rumors about sexual behavior of individual girls, exposing oneself, snapping bras, wearing offensive T-shirts, and yelling sexual innuendoes during sporting events. Cases classified as sexual violence, the more serious cases, included rape, forced fondling and touching, forced oral sex, "depantsing" (removing another's pants as a joke or as punishment), and "sharking" (biting body parts, such as breasts). Punishment for such offenses, besides expulsion, included transfer to another school, writing essays, apologizing, undergoing counseling, and serving time in detention. The attorney general of the state of Minnesota has warned Minnesota children that such behavior can result in costly litigation. Minnesota is viewed as a national leader in fighting sexual harassment. Sue Sattel, a specialist for the Minnesota Department of Education, reported what she regarded as an open-and-shut case of sexual harassment involving a five-year-old boy as predator and a five-year-old girl as victim. She reported, "the boy led the girl into the art resource room. He pulled her pants down. He pulled his own pants down. He jumped on top of her and began to simulate intercourse." Sattel then went on to say "Something very, very serious is going to happen to that little boy" (Shalit 1993). She is right, for this

is a sexual offense in most states. Minnesota's anti-sexual-harassment law covers all children down to and including the kindergarten age. A publication provided by the Minnesota Department of Education, Examples of Hostile Environmental Sexual Harassment, provides a glimpse into what supervisors are looking for on the playground. Here is a partial listing: Sexual gestures (e.g., boys grabbing their groin when a girl passes by); Students "rating" other students; students teasing other students about body development, either overdevelopment or underdevelopment; males bragging about or indicating the size of their penis. Proponents of Minnesota law say tough penalties for offenses like these are the wave of the future, (Shalit, 1993).

Children appear to get a sexual life naturally and unobtrusively by being alert to the many influences around them. Children come to an age when they are concerned about their own identify and how to relate to members of the opposite sex. In the fumbling attempts to relate, they often perform badly. It is a moot question whether such behavior should be handled punitively, with more expulsion and more detention and at younger ages, or whether we should try another perspective, such as teaching the art of loving and the respect for others. (Martinson, 1993).

CHAPTER 5

Social Responsibility Therapy for Preteen Children

The news media today increasingly airs stories pointing out the lack of social responsibility and multiple forms of abusive youth behavior which consistently continues to tear at the moral fabric of our society and threaten the civil rights, safety and security of our citizens. Social Responsibility Therapy was designed to help develop social responsibility in youth with multiple forms of abusive behavior from multiple cultural backgrounds whose antisocial behavior impacts the future quality of living in our society (Yokley, 2004).

Social Responsibility Therapy is a research-informed treatment that applies best practice procedures to help those with abusive behavior develop a social responsible lifestyle that is no longer harmful to self and others. Social Responsibility Therapy uses a Structured Discovery approach to target five basic types of abusive behavior (i.e., sexual, physical, property, substance and trust abuse) across settings (i.e., treatment, home school, community), and time (i.e., 24 hours a day, 7 days a week). Social Responsibility Therapy also addresses: the target behavior problem (i.e., the referral form of abuse is not usually the only form of abuse); the negative social influence problem (i.e., from peers, partners and parents) and; the dose-response problem (i.e., expanding the agents of change to include significant others at home, school and the community which provides better coverage of the youth's behavior during the day).

Social Responsibility Therapy has a multicultural premise which states, "We are our brother's keeper" and it is our social responsibility to respect diversity by caring for

ourselves, caring for those who grew up with similar cultural influences and caring for those who did not. (Yokley, 2004).

The target behavior problem is a developmental psychopathology/labeling issue, the constricted referral problem and increased relapse risk resulting from not targeting all forms of abuse on the treatment plan). The target behavior is critical because youth can be incarcerated for any type of abuse not just their referral type of abuse. A youth who completed treatment for sexual behavior problems and exhibits no further sexually abusive behavior but gets re-arrested for physically abusive behavior can be considered a sexual behavior treatment success. However, they can not be considered a community safety or cost success because their other forms of abuse behavior continue to make them both a danger to others and a community tax burden.

Social Responsibility Therapy avoids diagnostic labels that diminish responsibility and focuses instead on the severity and impact of the behavior on "{The Abuse Behavior Continuum". Social Responsibility Therapy uses a social learning experience approach to develop appropriate social behavior control and addresses multiple forms of abusive behavior by teaching prosocial alternatives to antisocial abuse.

Social Responsibility Therapy is the most logical treatment approach for parenting youth with abusive behavior as it teaches social responsibility and multicultural values as competing responses to abusive behavior. This makes it easily accepted and integrated into ongoing behavior management by parents. In addition, Social Responsibility Therapy helps the youth and their parents/foster parents understand how the abusive behavior was acquired, what maintained it and how it generalized into other problem areas. One of the strong points of Social Responsibility Therapy is its

supervision protocol. Electronic communication, behavior tracking and monitoring technology are utilized along with twelve basic foster home safeguards and twelve basic community safety/supervision procedures that target the client and negative peer associates. In Social Responsibility Therapy, youth develop a socially responsible, positive lifestyle in three basic program phases: learning social responsibility; maintaining social responsibility and developing a socially responsible lifestyle. The TASC Forensic Foster Care program for youth with multiple forms of abusive behavior was founded in March of 1988 and is currently operating in Ohio and Florida, (Yokley, 2004).

Youth sex offender risk assessment is in its early development stages. There are presently no empirically validated, assessment instruments to estimate the risk of adolescent sexual reoffending. Actuarial risk scales (i.e., with items weighted to develop the best statistical cut off scores between offenders and non-offenders) are not yet available. The field is moving from the subjective clinical interview stage to the use of objective structured protocols based on known re-offense risk factors. The purpose of these protocols is to aid in the systematic review of identified risk factors that been associated with sexual and criminal offending. The documented limits of these assessments allow the "mitigating circumstances" latitude needed for juvenile court judges and human services clinical supervisors to make important decisions balancing the rights of youth to the least restrictive treatment setting and community safety. Currently there are two relatively well developed structured youth sex offender risk assessment protocols in use, (Yokley, 2004)..

Juvenile Sex Offender Assessment Protocol

The "J-SOAP-II, which was developed by Prentky & Righthand (1994), is a youth sex offender risk assessment which is still in its early stages of development. There are presently no empirically validated assessment instruments to estimate the risk of adolescent sexual reoffending. Actuarial risk scales (i.e., with item weighted to develop the best statistical cut off scores between offenders and non-offenders) are not yet available. The field is moving from the subjective clinical interview stage to the use of objective structured protocols based on known re-offense risk factors. The purpose of these protocols is to aid in the systematic reviewed of identified risk factors that have been associated with sexual and criminal offending. The documented limits of these assessments allow the "mitigating circumstances" latitude needed for juvenile court judges and human services clinical supervisors to make important decisions balancing the rights of youth to the least restrictive treatment setting and community safety.

The J-SOAP which has had more time for clinical development than the ERASOR, is designed for boys ages 12-18 and may be used to assess re-offense risk for adjudicated or non-adjudicated youth. The original J-SOAP version was developed in 1994 based on literature reviews covering clinical and risk assessment/outcome studies of juvenile sex offenders, adult sex offenders, general juvenile delinquents and mixed populations of adult offenders. The majority (62%) of the original 26 J-SOAP questions tapped static risk factors. The J-SOAP-II has expanded to 28 items with changes made in all four of its scales. An important contribution to the area of juvenile risk assessment was the addition of the "Caveat" section in the J-SOAP-II which clarifies the limits of these assessments. The J-SOAP-II has 12 identified dynamic items (17-28), with the majority

(57%) of its questions tapping static risk factors. J-SOAP-II also consists of the 12 dynamic risk factor items on that protocol should be reassessed at 6 month intervals and sooner if risk-relevant changes have occurred.

The Estimate of Risk of Adolescent Sex Offense Recidivism

The ERASOR 2.0 is designed to assist evaluators estimate the risk of a sexual reoffense only for individuals aged 12-18 who have previously committed a sexual assault. The ERASOR 2.0 was developed using an empirically guided clinical judgment approach in a similar fashion to the Sexual Violence Risk-20. The ERASOR 2.0 has 9 identified static items (5-13), with a majority (64%) of its questions tapping dynamic risk factors. All ERASOR 2.0 scales except the "Historical Sexual Interest Scale", which consists of the 9 identified static risk factor items on that protocol should be reassessed at 6 month intervals and sooner if risk-relevant changes have occurred.

The J-SOAP-II and ERASOR 2.0 exhibit some differences on their emphasis of static versus dynamic risk factors (Yokley, 2000).

- The J-SOAP-II may be slightly better suited for a forensic evaluator conducting a one time risk assessment for juvenile court or human services recommendations during pre-sentence investigation or placement determination of the initial level of treatment care.
- The ERASOR 2.0 may be slightly better suited for a treatment program therapist conducting repeated risk assessments during treatment to evaluate treatment progress and determine when a recommendation for step down to a less restrictive treatment setting is appropriate.

Social Responsibility Therapy Treatment Components

1. **Stopping Abusive Behavior:**
    - By developing self-control and social-emotional maturity as competing responses to abusive behavior.
2. **Understanding Abusive Behavior:**
    - Including the Abuse Development Triad on how abusive behavior was acquired, maintained and generalized.
3. **Developing Prosocial Behavior:**
    - Including assertiveness, empathy, age-appropriate social interaction ability and emotional restitution.

Abusive Youth: Who are these people?

- Abusive youth typically have a history of juvenile court involvement, counseling and placement failure.
- Most youth abusers are multiple abusers
    - The referral type of abuse is not usually the only type of abuse.
    - Many youth abusers exhibit more than one type of abuse on "The Abuse Behavior Continuum" that requires treatment (i.e., sexual, physical, property, substance and trust abuse) (Yokley 1996).

Understanding Abusive Behavior through the Abuse Development Triad

- Helps abusers, treatment staff and caretakers understand how abusive behavior was:

  - Acquired through, **The Chain of Events that led to abuse**

  - Maintained – by Stress-Abuse Cycle and

- Generalized (to other problems) – by the Anatomy of Social Maturity Components

- In order to help interrupt further abuse behavior
- **"**If you don't know where you came from you're doomed to return there."

Note, the Abuse Development Triad includes cognitive contributors to abuse formulated by Albert Bandura, Samual Yochelson and Stanton Samenow.

The Chain of Events that led to abuse

Describes four basic factors or links in a chain which help explain how the initial abuse behavior was acquired. In other words, what led up to it, what were the primary contributing factors?

Link 1: Past Permanent Problems which consist of biopsychosocial disadvantages, abuse, neglect, rejection and other predisposing factors that could not be controlled. In summary, Past Permanent Problems are predisposing historical factors associated with the development of abuse.

History of Being Abused:

- The childhood experience of sexual abuse has been associated with juvenile sex offending, (Fenrenbach, et. al., 1986; Kahn and Chambers, 1991).
- Vampire Syndrome – Approximately 80% of adult pedophiles were molested as children, (Yokley, 2003).
- 19% to 81% of adolescent sexual abusers were previous victims of sexual abuse, (Becker, Kaplan, Cunningham-Rathner & Kavoussi, 1986).
- 75% of female street prostitutes were raped as children, (Yokley, 2002).

- Childhood experiences of being physically abused, being neglected, and witnessing family violence also have been independently associated with sexual violence in juvenile offenders, (Yokley, 2002).
- 75% of violent adolescent sex abusers report having been physically abused compared to 29% of other delinquents (Yokley, 2002).

History of Witnessing Abuse:

- There is a strong relationship between being abused by parents and/or witnessing aggression between parents and battering an adult partner.
- 79% of violent juveniles were exposed to extreme violence in their family.
- This was true for only 20% of less violent juveniles.
- Only 1 of the 14 juveniles sentenced to death in the United States was not physically abused as a child.
- 12 were exposed to extreme violence in the home, (Yokley, 2002).
- Males who observed parents attack each other were three times more likely to have assaulted their wives, (Yokley, 2002).

It is important to note that the abusive experiences of juvenile sex offenders have not consistently been found to differ from those of other juvenile offenders. For example, 44-47% of chemical abusers were victims of incest.

Other factors such as family instability, disorganization, and violence have been found to be prevalent among juveniles who engage in sexually abusive behavior. 59% of adolescent sex offenders come from families with serious problems and 38% of those homes evidence sexual deviation. Parental conflict, poor parental supervision, neglect, separation from parents and lack of parent affection are predictors of juvenile

delinquency. Marital discord and parent hostility directed towards the children appear to play a role in the development of adolescent conduct disorder. Many juvenile sex offenders have experienced physical and/or emotional separations from one or both of their parents (Yokley 2002).

He also found that the effects of inadequate parenting are far stronger on later delinquency, than was marital discord. Also a lack of appropriate supervision, neglect and parental rejection are associated with the seriousness of a child's delinquency. Recollection of paternal rejection is a strong contributor to an abusive personality. It was found that over one third of the mothers and half of the fathers of adolescent sex offenders were judged to be rejecting. 60% of parents are indifferent and 32% are hostile/rejecting of their delinquent youth.

Link 2: The Chain of Events that led to abuse: Low Self-Efficacy and Social Maturity:

Feeling ineffective, incompetent and helpless, low self-confidence, social-emotional immaturity, e.g., lacking honesty, trust, loyalty, concern, responsibility, self-control and empathy are all examples of low self-efficacy (Yokley 2002). Juveniles with low self-efficacy show signs of learned helplessness depression.

Research repeatedly documents that juveniles with sexual behavior problems have significant deficits in social competence which lead to involvement with deviant peers that afford an alternative means of self-enhancement. Inadequate social skills, poor peer relationships, and social isolation are among the difficulties identified by juvenile sex offenders. Research found that 46-65% of adolescent sex abusers evidence serious social isolation. This is significantly higher than the 17% of juvenile delinquent controls who are loners. 86% of adult rapists and 74% of adult child molesters report few or no friends

as youngsters. Adolescents with conduct disorder and depression also experience interpersonal difficulties with family and peers.

Pathological social immaturity and character disorder reflect deficits in honesty, trust, loyalty, concern and responsibility and criminal pride. Many youth sex offenders suffer from "pan immaturity" in emotional/social adjustment (Yokley, 1993). Aggressive or hostile adolescents are more likely than their non-aggressive peers to believe that aggressive behavior enhances their self-esteem and helps them having a negative image among their peers.

Link 3: High Risk Situations:

High risk situations are situations that set the occasion for, increase the risk of or trigger abuse behavior. Compensation situations, (feeling "one down" makes you want to be where you feel "one up"). High risk situations include people, places and things that allow or trigger abuse behavior such as associating with other abusers or victims; being in a place that sets the occasion for abuse or where abuse has occurred in the past; experiencing abuse trigger emotions. 18-36% of substance abusers report relapses associated with social pressure, e.g., "I have to use to get acceptance from other users". Marital and relationship problems are common with abusers and involve sexual, physical and substance abuse. Abusive youth have to stay away from control and power situations, situations that trigger emotions, pornography and substances (Yokley, 1993).

Link 4: Maladaptive Thinking:

Cognitive distortions which support abuse behavior are thoughts, beliefs, attributions and perceptions which disinhibit self-control or set the occasion for abuse. Cognitive distortions such as blaming the victim are associated with sexual reoffending

juveniles. Cognitive distortions biases and errors are correlates of both adolescent conduct disorder and depression. Cognitive distortions (i.e., attitudes, attributions, thoughts and irrational beliefs) that mediate emotional arousal and behavior choices are one of the most widely accepted factors in partner aggression (Yokley, 1993).

Maladaptive thinking examples:

- Justifying actions based on feelings:
    - Batterer's example: "she made me angry" is the most common excuse for violence heard when (battering) men first enter counseling.
- Failure to put self in the place of others:
    - Incest child molester example: "I did it to relieve myself at the time", "There was not love, no feelings, there was no nothing – it was just sex and that's all it was" and "it was mechanical. I just wanted to have a blow job. There were no feelings or anything like that".
- Depersonalization of the abuse victim:
    - Viewing others as objects not human with feelings.
    - Objectifying is also seen in depersonalization of the abuse victim with devaluing words.
    - Justifying raping them because they were prostitutes and deserved it.
- Blaming the abusive behavior on circumstances:
    - Blaming the responsibility for the abusive behavior on provocation by the victim.

- 31% of convicted rapists present their victim as not only willing but the aggressor, a seductress who lured them, unsuspecting into sexual action
- 30% of incest child abusers suggest that their daughter actually initiated the activity but none of their daughter concurred (Yokley, 1993).

- Comparing the abuse to more serious violence:
  - Batterer feels that because he is less violent than the man who beats a woman with his fists because he only slapped her with an open hand. Rapists who detest child molesters and alcoholics who detest drug addict.
- Minimizing and Normalizing abusive behavior
  - "It was just a mistake and I only did it one time".

  Normalizing abusive behavior – depicting the abusive behavior as a common or a socially acceptable occurrence.

  - "All my friends are doing sexual things to girls at parties so why shouldn't I?
  - "It's OK to use drugs", "Everybody gets high"

Link 5: Fall and Relapse:

The gratification reaction:

- After eating the entire box of donuts Jane felt terrible. In giving into her urge she let herself down and began to think what others would say. As she drove home she considered lying to cover up the fact that she did not feel like eating

dinner with the family. She failed herself again and felt depressed, disappointed and afraid others would notice.

- The gratification reaction sets the occasion for Negative Coping (e.g., lying and entering into the Stress-Abuse Cycle.

Why Abusers with extensive treatment experience continue to need staff guidance

1. Because social immature abusers have not developed enough honesty, trust, loyalty, concern and responsibility to succeed on their won and
2. Staff have developed enough social maturity to succeed on their own and
3. Social maturity can only be acquired through social learning experiences taught by the socially mature and reinforced through practice.

In summary, it is important that professionals and parents are able to understand the difference between a sexually reactive child and one who could be considered a sexual offender. This knowledge will save a child a lifetime of stigmatization and labeling as a sexual offender, when in fact they were innocently experimenting with the idea of sex and were not engaging in criminal activity.

As mentioned earlier in this paper, childhood sexuality begins very early in life, with some notable professionals stating as young as 12 months old. Sex and sexuality are, to a large degree, learned behavior. Society must therefore keep in mind that children will experiment with their sexuality and with sexual behavior towards other children. Children today live in a sexually saturated society and begin to learn about sex and sexuality from a diverse set of informational sources: television, parents, peers, music, self-exploration, babysitters, and so forth.

It is very important for parents and professionals to understand the concept of presexualization. Presexualization refers to a child who has been sexualized prematurely in life. Nearly all of the adult and adolescent sex offenders' studies have been pre-sexualized. Presexualization can take various forms such as, being overtly or covertly sexually abused, being exposed to pornography, and witnessing adult sexual behavior in the home, are among the most common forms of presexualization. It is important to emphasize that being pre-sexualized, however, does not necessarily imply that the child is or will become a sexual offender. Rather, it may indicate that the child may act out what he/she has been exposed to. This is what we call a sexually reactive child.

A sexually reactive child, for example, may be best illustrated in the following scenario. Tommy is a 9-year-old male, who was exposed to video pornography at the age of 3 onwards. Because his mother had a substance abuse problem, he would be cared for by his mother's sister. His aunt would have boyfriends come over the house regularly, and would engage in sexual intercourse. Though the door to the bedroom was closed, Tommy hearing strange noises found a crack in the door and witnessed the sexual activity. At first Tommy felt very strange, he thought his aunt was being hurt and he felt scared. After witnessing the sexual activity a number of times, he began to feel what we may call "horny" or sexually excited. He began to masturbate at the age of 6 by rubbing his penis on pillows and against the bed. One day, when Tommy was 9, he was left along for the day with his 8 year-old female cousin. They began to play various games together. Tommy noticed a sexual scene on a television soap opera, and became sexually aroused. He then asked his cousin if she wanted to

try something he had seen his aunt do in the past. The female cousin agreed, and Tommy got on top of her and began to "hump" her. While they were doing this, Tommy's aunt came in and witnessed what Tommy was doling. She was so upset and confused, that she phoned the police. The police entered a report, and Tommy and his aunt were referred to a sexual abuse/offender clinic in a nearby town.

Is Tommy sexually reactive, or a sexual offender? Many untrained people may erroneously state that Tommy is a sexual offender. He asked his cousin to partake in the activity. He initiated the activity. It appeared to be an advanced act of carnal knowledge.

Let's re-examine his story for clarification of the facts. Tommy was prematurely exposed to various sexual activities by witnessing his aunt having sex with numerous men, and by viewing pornography. At first he became scared, but then he became eroticized. He began to masturbate at a young age, most likely thinking about what he witnessed. The day of the incident, Tommy's sexual arousal was triggered by witnessing a love scene from a television program, and wanted to try what he had seen with his female cousin. No penetration occurred, and the act was unsophisticated.

Again, Tommy would be considered a sexually reactive child. If Tommy is treated like a "sex offender" by his family and by professionals, he will develop an increasingly higher level of shame over his behaviors and himself. This shame will not facilitate change for him, as he cannot understand that what he did was "wrong". This shame will affect Tommy's life in a number of disastrous long term ways.

Some of the differentiating signs between a sexually reactive child and a sexual offender are the following:

- Did there appear to be a conscious knowledge of sex and sexual behavior, or was the behavior triggered by external stimuli?
- How sophisticated was the incident?
  - Did penetration occur?
  - Was it a planned out offense?
  - Did the child/adolescent have a goal in mind (i.e., ejaculation)?
- How many times has the child/adolescent engaged in such behavior?
  - Is this likely the first, second, or third incident, or
  - Has the child/adolescent exhibited this behavior for an extended period of time?
- Does the child/adolescent make up a deliberate lie to cover their tracts, so to speak? or
  - Does the child/adolescent appear greatly confused and ashamed over the incident?
- Does the child/adolescent typically hang around with or associate themselves with children significantly younger than themselves (i.e., Tommy was 9, are all his playmates 5 and 6?).

These are just a few of the differentiating data that may separate a sexually reactive child from a sexual offender.

It is extremely for professionals and parents to note that much of the shame and psychological damage that occurs, not only with child victims of sexual abuse, but also

with sexually reactive children, stems from the reactionary behaviors of adults. For example, in Tommy's case, his aunt phoning the police may have created a significant trauma in his life that may have created more problems and difficulties for him. Parents and adults should attempt to remain calm in the presence of the children, and phone a specialist or mental health professional immediately. Parents should talk to the child, without expressing anger, and inquire about where the child learned the behavior. During this time the parents should also discuss how many times this may have occurred. It would not be appropriate to punish, hit, or whoop the child, as the child may not have known what he/she was doing wrong. This would only result in an intense level of shame which will carry over for years to come.

CHAPTER 6

Conclusion

As social workers, therapists and childcare workers, care must be taken not to become caught up in the sexual hysteria hype which is being created by the current mass media. Society today is inundated with sexually explicit material every where we look. Nothing is hidden from our children; sex is all around them, on the TV, in magazines, on billboards, advertisements, movies and video games. Boys are even secretly watching their parents' pornographic videotapes, another example of the effects on children of their exposure to the sexual stimuli that surrounds them.

Today, movies allow their viewers to witness sexual acts, the only restriction being that one cannot observe a penis going into a vagina. (Penises and vaginas not involved in the act of copulation are still permissible.) Those interested in viewing this aspect of a sexual encounter can easily find theaters showing X-rated movies or view pornographic home videotapes. Accordingly, both parents and children have their sexual titillation easily available.

With regard to the containment of sexual urges stimulated by external stimuli, there is a continuum (as is true for most things in this world). At the one end of he continuum are those people with very powerful suppressive (conscious) and repressive (unconscious) psychological mechanisms, with the result that they are able to block from conscious awareness their titillation. However, they may have to resort to the utilization of various complex psychological mechanisms that allow release (symbolically or vicariously) without conscious awareness that pent-up sexual needs are being gratified. At the other end of the continuum are those who are driven to seek every possible sexual

gratification because of the bombardment of stimuli that they are continually being exposed to. Children are no exception to this principle. A newborn infant can be brought to orgasm if an adult chooses to masturbate the child (a practice which is not recommended). Obviously, the greater the intensity of the stimuli, the greater the frequency; the greater the excitation, and the greater the likelihood of acting out. In the world in which we live, the ubiquity of sexual stimuli is causing many children- even those at the highly suppressed end of the continuum, to exhibit sexual interest and excitation. And providing a false sex abuse allegation is one possible and increasingly available route for release (Gardner, 1991).

Compounding the difficulty of identifying children with sexual behavior problems, most American child protective services agencies are not legally empowered to investigate or intervene when sexual behavior problems are identified in children, unless the child first came to their attention as a possible victim of some form of maltreatment (e.g., neglect on sexual, physical, or emotional abuse). In Vermont, if a child under age 10 is found to have acted abusively, the Child Protection Services Agency cannot intervene with the maltreating child. This lack of power differs dramatically from the legal mandate that Child Protection Services Agencies function as therapeutic referral services for children with sexual behavior problems; these agencies are bereft of the ability to provide follow-up even if the family has requested it (Cantwell, 1988). Thus, relatively few records about children with sexual behavior problems are maintained within Child Protection Services Agencies or any other agency.

Fortunately, even in the absence of a legal mandate, several Child Protection Services Agencies have opened their case files to examine the number of substantiated

cases of child sexual abuse that are the result of other children's misbehaviors. In 1991, Vermont's Child Protection Services Agency held 135 open cases on children and adolescents whose records demonstrated that they had engaged in sexually abusive behaviors against others. Of the 135 youths, 51 (37.8%) were between 6 and 12 years old. These 51 children were responsible for 13.2% of all child sexual abuse cases substantiated in Vermont in 1991. It must be noted that 36 of the 51 children (70.6%) were known victims of sexual abuse before the onset of their own sexual behavior problems (Gray & Pithers, 1993).

Currently more than 40% of known child abusers in Vermont are under age 20 (Social and Rehabilitation Services, 1995). In 1994 alone, in a state with fewer than 640,000 residents, more than 125 children were sexually abused by a child less than 14 years old, with one third of these abuses being performed by a child less than 10 years old. Reported sexual abuse performed by children under the age of 14 has increased 300% within the last 10 years in Vermont (Gray, et al. 1997).

Utah has yielded data remarkably similar to that of Vermont. In Utah, 43% of all sexual abuse perpetrators are youths under age 18 with 18% being youths less than 13 years old (Utah Governor's Council on Juvenile Sex Offenders, 1990). In Washington, two case file reviews have been conducted to determine how many children with sexual behavior problems are in state custody (Office of Children's Research, 1992). In both reviews, the daily census ranged between 650 and 700 children.

The limited information available from Child Protection Services Agencies is powerfully confirmed by juvenile court data. Between 1980 and 1995, juvenile arrests for

general crimes committed by children ages 12 and younger increased 24%. In dramatic contrast, the arrest rate for children less than 12 years old has escalated 125% for sex offenses (excluding rape) and 190% for forcible rape. Of all juvenile arrests for children under age 12, 18% are for sex offenses (excluding rape), and 11% are for forcible rape. Because children of this age constitute only 9% of all juvenile arrests, the proportion of their arrests resulting from sexually abusive behaviors must be psychologically staggering to anyone whose heart holds compassion for children (Butts & Snyder, 1997).

The relationship between child maltreatment and adult criminality has been the topic of speculation for many years. It is now clear that although most maltreated children do not engage in criminal acts as adults, childhood maltreatment is associated with increased risk of arrest for a variety of antisocial behaviors, including sex crimes, throughout adolescence and adulthood. Juveniles who were maltreated during childhood have a higher rate of criminal arrests (26%) than juveniles not abused as children (16.8%). Even in adulthood, abuse survivors have a significantly higher rate of criminal arrest (28.6%) than adults who were not abused during childhood (21%). Sexual abuse was not associated with any greater degree of criminality in adulthood than other forms of child maltreatment. Thus, any form of maltreatment increases the risk of adult criminality (Widom & Ames, 1994).

Using odds ratios (i.e., calculating the odds that a person who has experienced a certain event as a child will engage in a specific behavior as an adult), it was found that sexually abused children were 4.7 times more likely than nonabused children to be arrested for a sex crime as an adult. Physically abused children were 4.1 times more likely than nonabused children to be arrested as an adult for a sex crime. Physically

abused children were 7.6 times more likely than nonabused children to be arrested for rape or sodomy. The similarity in the odds ratios of adult arrest rates for a sex crime across types of childhood maltreatment suggests that the etiologically significant factor in the emergence of abusive sexuality is exposure to trauma, not a unique associate of sexual victimization. Data from a study conducted by Widom 1995 suggests that childhood maltreatment is a distinct criminological factor. However because maltreatment does not function as a criminogenic factor in all children, it may be vitally important to define the debilitating factors that promote antisocial conduct and the protective factors that foster a prosocial adaptation by maltreated children.

The families of these abused children possess exactly the characteristics associated with parents of early-onset conduct disordered youth. Research on children with sexual behavior problems has shown that they can make clinically and statistically significant change after only 16 weeks of specialized treatment. Taken together, these data demonstrate the need to respond to families of children with sexual behavior problems and the ability to do so effectively.

Given these findings, state legislatures of Child Protection Service Agencies must be charged with creating the conditions that permit a meaningful response to the families of children with sexual behavior problems. Statutes need to be revised to enable children who have engaged in problematic sexual behavior to receive services that are demonstrably effective. Child Protection Service Agencies must work to provide services to families in a manner that is not experienced as primarily coercive and faultfinding, but as a method of building on a family's strengths to promote an abuse prevention lifestyle. Should society neglect to quickly provide effective services to these

children and families, the available research demonstrates that there is an increased likelihood that they will require much more costly services after delinquency hearings or criminal trials.

Clinical experience with adult sex offenders has shown that the collaborative efforts of health care and probation professionals result in more favorable outcome than the isolated effort of either profession alone. For children with sexual behavior problems, although the professional partnerships differ, the same principle holds. Effective treatment of these children and their families must involve collaboration among treatment providers, school personnel, Child Protection Service workers, and other social services agencies. Through this collaborative support, the children and family will be given the greatest opportunity to demonstrate an abuse prevention lifestyle day by day.

Respond to Individuals not Stereotypes

Within the current social climate, it seems that when an individual has engaged in a sexually abusive behavior, he or she is permanently branded a perpetrator and considered les than human. We seem to have lost sight of the fact that even though sex offenders have engaged in inhumane acts, they possess al the qualities and potential found among people who have not engaged in sex offenses: hatred and love, cowardice and courage, coldness and compassion. In some American states, the social misperception of sex offenders has led to imposition of some criminal sanctions that appear, at least to us, to be quite inhumane themselves (e.g., mandatory castration or “two strikes” legislation). Given that the children with sexual behavior problems have a mean of two victims, we are grateful that no one has attempted to extend “two strikes”

legislation on them. From this perspective, it may be time to rethink legislation that automatically imposes a sanction exclusively on the basis of a predetermined number of victims or convictions. Such social policies ignore one of the most defining elements of American society: recognition that everyone is an individual. Sentencing practices for adult sex offenders and dispositions for juvenile abusers should fully consider each individual's strengths and weaknesses, as well as the needs of their victims.

We are particularly concerned that the tendency to dehumanize adult sexual offenders not be extended to children with sexual behavior problems. Childhood is a time of boundless potential. It is the responsibility of adults who care for children to take measures to ensure that the potential of childhood is nurtured into a strong sense of personal ethics and social responsibility of adulthood. When society identifies children who are engaging in behaviors destructive to others and themselves, it must fulfill its social contract to act responsibly and provide interventions that will inspire these children to become adults with a strong sense of personal ethics. Labeling these children in a manner that even remotely implies that they may have lifelong problems with sexual assaultiveness (e.g., child sex offenders) and that denies their potential to make amazing contributions to the social good is simply wrong and should never be done.

In an era when society has recognized the importance of conserving precious natural resources, all of us must also recognize that children are the most precious resource in our world. Everyone must accept the challenge of demonstrating respect for the preciousness of children, place value in nurturing their boundless potential, and work to alter conditions that impair it. When harm has already been done, resources must be

dedicated to reclaim the hope for a better future offered by every child's life. The loss of one child's ability to nurture unlimited dreams for their future, limits society as a whole.

Finally, because child maltreatment has reached epidemic proportions in America, it may be time for governmental agencies, such as the Centers on Disease Control and Prevention, to demonstrate leadership in supporting implementation of health promotion strategies to prevent child abuse. Such efforts have yielded positive results with other risk behaviors (e.g., smoking cessation or seat belt use).

APPENDIX I

The Abuse Behavior Continuum: Selected Abuse Examples

Primary Area of Impact

ABUSE IMPACT SEVERITY	**Abuse of Self**	**Abuse of Self and Others**	**Abuse of Others**
	Compulsive Injury of Self Food Abusers (binge, purge, starve) Nicotine Abusers		
	(Single)	Workaholics (with partners and family)	
	(Self-destructive relationship dependent type)	Codependents (Abuse behavior enablers)	
	(Compulsive deviant masturbation)	Sexual Compulsives (Unprotected sex, affairs)	
	(Single Shopaholics)	Money Abusers (Compulsive Gamblers)	(Embezzlers, Credit Fraud)
	(Single alcohol and drug abusers)	With partner/family) Substance Abusers (Alcohol and drug abusers with partners/family)	(Drunk drivers, drug dealers)
		Responsibility Abusers (Work Neglecters)	(Child Neglecters)
		Trust Abusers (Partner cheating)	(Professional con artist)

Abuse Behavior Continuum (Cont'd)

Verbal Power Abusers

Property Abusers

Physical Abusers

Sexual Abusers

Contract Killers

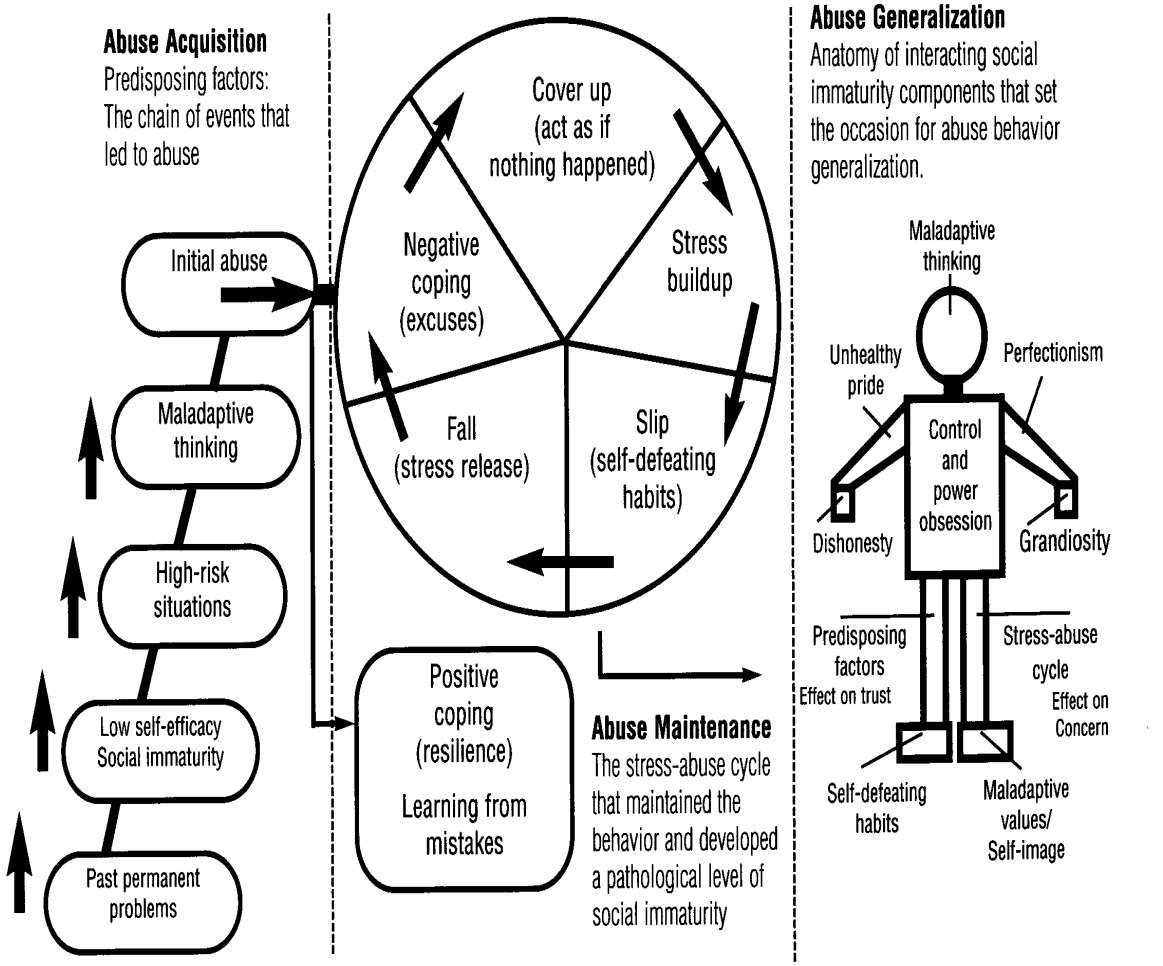
Lust Murderers,

Serial Killers

Compulsive Injury of Others

APPENDIX II

Figure 1- The Abuse Development Triad:
How Abuse was Acquired, Maintained & Genelalized to Other Forms



DEFINITIONS

Sexual Behavior Problems (SBP)

Children with sexual behavior problems engage in developmentally expected sexual acts; however, they also engage in more unexpected and intrusive acts than other children.

It understandably may be difficult to accept that children can engage in sexual behaviors that might be harmful to others and to themselves. Childhood is supposed to be a time of protected innocence. However, even at a logical level, little reason exists to believe that children are less likely to experience problems in sexual development than with any other behavior. Fortunately, one need not rely solely on logical analysis. The fact that children can engage in sexually problematic behavior is confirmed by two lines of date: (a) scores on an observational rating instrument of children's sexual behaviors and (b) the proportion of substantiated child sexual abuse in which the perpetrator was less than 12 years old.

The national prevalence of problematic sexual behavior in children is difficult to estimate. Criteria for identifying problematic sexual behavior in children are defined imprecisely (e.g., differences in stature or sophistication). Given the use of vague criteria for defining problematic sexual behaviors in children, it cannot be surprising that such behaviors are often misperceived or reported inconsistently. Because a highly normed measure (i.e., the Child Sexual Behavior Inventory-3) now exists that distinguishes the extent to which children engage in developmentally expected and unexpected sexual behaviors, it may be a preferable strategy for health care professionals to begin using this

measure to objectively define the existence of behavioral problems (National Adolescent Perpetrator Network).

Oppositional Defiant Disorder (ODD)

The essential feature of Oppositional Defiant Disorder is the recurrent pattern of negativistic, defiant, disobedient, and hostile behavior towards authority figures that persists for at least 6 months and is characterized by the frequent occurrence of at least four of the following behaviors: losing temper, arguing with adults, actively defying or refusing to comply with the requests or rules of adults, deliberately doing things that will annoy other people, blaming others for his or her own mistakes or misbehavior, being touchy or easily annoyed by others, being angry and resentful, or being spiteful or vindictive. To qualify for Oppositional Defiant Disorder, the behaviors must occur more frequently than is typically observed in individuals of comparable age and developmental level and must lead to significant impairment in social, academic, or occupational functioning (American Psychiatric Association, 2000).

Conduct Disorder (CD)

The essential feature of Conduct Disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. These behaviors fall into four main groupings: aggressive conduct that causes or threatens physical harm to other people or animals, nonaggressive conduct that causes property loss or damage, deceitfulness or theft, and serious violations of rules. Three or more characteristic behaviors must have been present in the past 6 months. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning. Conduct Disorder may be diagnosed in individuals who are

older than 18 years but only if the criteria for Antisocial Personality Disorder are not met. The behavior pattern is usually present in a variety of setting such as home, school, or the community.

Children or adolescents with this disorder often initiate aggressive behavior and react aggressively to others. They may display bullying, threatening, or intimidating behavior; initiate frequent physical fights; use a weapon that can cause serious physical harm (e.g., a bat, brick, broken bottle, knife, or gun); be physically cruel to people or animals; steal while confronting a victim (e.g., mugging, purse snatching, extortion, or armed robbery); or force someone into sexual activity. Physical violence may take the form of rape, assault, or, in rare cases, homicide.

The most current conceptualization of conduct disorder has proposed two distinct subtypes that linked by their developmental pattern and course: early-onset life persistent and adolescent-limited. The early-onset type is marked by onset of behavior problems before age 10, including physical aggression and disturbed relationships with peers. This type is more likely to have pervasive conduct problems that persist into adulthood, becoming antisocial personality disorder (American Psychiatric Association, 2000).

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