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Horizon Newsletter

on Sexual Abuse & Deviancy

Assessment of sexual abuse & deviancy

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Sponsored by The Sexual Abuse Treatment, Research, Resource, and Referral Website

The Horizon

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The Sex Offender Recovery Faking Scale

By Mark S. Carich, Ph.D.

INTRODUCTION

An ongoing concern for professionals assessing, treating, and supervising a sex offender is trying to determine if the offender is internalizing change and maintaining recovery. Recovery is the capability to maintain abstinence from offending given that there is no cure (Carich, 1991a, 1997a, 1997b, 1999a, 1999b). My concept of recovery is based on dynamic (changeable) risk factors. Likewise, most treatment objectives and plans consist of dynamic behaviors.

Given the amount of defenses, maladaptive coping responses, cognitive distortions, levels of psychopathy and/or antisocial behaviors, and reluctance of many to be straight forward in an offender's responses; evaluating phoniness is an ongoing concern. Methods of evaluating phoniness have been previously discussed by Carich (1991b, 1997b).

There are a variety of ways to detect phoniness. A list of ways to detect faking, without the use of the polygraph and phallometric equipment, are provided below:

- Jumping from topic to topic and not focusing on or staying with one topic.
- Provides much verbal garbage or verbiage as if he/she is trying to impress others, avoids issues or presents phony self.
- The client keeps shifting stories, demonstrating contradictions.
- Distorted, twisted information compared to reports.
- Taking long verbal trips to nowhere or not being relevant.
- When information must be pulled out and is not volunteered.
- Inconsistency in behavior in the past and present.
- Scanning other group members for appropriate responses or cues on how to respond.
- Client scans room looking for any type of confirmation and reinforcement.
- Client answers questions by asking questions, as indicated by the client's nonverbal (voice-tone, pitch, rate, volume) behavior in order to get confirmation.
- Agreeing on every topic or response.

(NOTE: these are just a sample of an entire list developed by Dr. Carich)

Since much of the offender's life is consumed with concealing information and behaving superficially; it is important to discern the amount of phoniness from genuineness, in order to evaluate an accurate recovery level. It is presumed that the more anti-social or psychopathic the offender is, the more likely a "faking" situation can occur. A faking scale by Dr. Carich is provided below, but has yet to be statistically validated (entire scale is located on page 4).

Research Forum

The National Mental Health Association, in 1999, cited that as many as 20% of students with emotional disabilities are arrested at least once before they exit the school system. Moreover, the N.M.H.A. state that as many as 60 to 75% of incarcerated youth have a mental disorder, and 20% have a severe mental disorder. The N.M.H.A. has launched its Justice for Juveniles' Program to assist in identifying these and similar issues, as well as creating a plan of action. **(Source: Natonal Mental Health Association)**

Finkelhor, Mitchell, and Wolak (2000), in their published study, *Online Victimization: A Report on the Nation's Youth*, found that 19% of regular Internet users between the ages of 10-17 years received unwanted online requests to engage in sexual activities or to provide intimate sexual information (n=1501). In 15% of such incidents, the solicitor attempted to contact the youth in person, over the telephone, or by mail. The authors termed these dynamics "aggressive solicitations". Although none of these youth in this study actually suffered sexual abuse or a sexual assault as a result of these solicitations, nearly 25% reported being very frightened or upset. Moreover, 25% of the youth in the study reported being exposed to unwanted online pornography within the last year. A quarter of the unwanted pornography came in the way of emails or instant messages that the children opened. The report emphasized the need to better educate families and young people about the sources of help and ways to protect against online victimization. You can obtain a full copy of the report by calling 1-800-843-5678.

The National Institute of Justice, and the Centers for Disease Control and Prevention, published their report, "Extent, Nature, and Consequences of Intimate Partner Violence" (2000). The study revealed that 25% of women reported that they have been raped and/or physically assaulted by a current or former spouse, cohabitating partner, or date at some time in their life. In comparison, only 7.6% of men reported similar violence. The study consisted of telephone interviews with 8000 women and 8000 men about their experience with various forms of violence, including intimate partner violence. The report estimates that nearly 1.5 million women are raped and/or physically assaulted by an intimate partner each year in the United States. To obtain a full copy of this report, visit The National Institute of Justice website at:

www.ojp.usdoj.gov/nij/welcome.html

Bonner, Walker, and Berliner (2000) assessed and treated children from 6-12 years of age with a broad range of sexual behavior problems, and developed a typology system for such children. Moreover, the authors examined the effectiveness of two primary types of group therapy—cognitive behavioral and play. The authors developed three typologies with regard to the children they assessed: sexually inappropriate children; sexually intrusive children; and sexually aggressive children. Both approaches to treatment were found to be effective in reducing children's inappropriate or aggressive sexual behavior. Finally, by the end of the two year follow up, 17% of the children had relapsed.
(Source: National Clearinghouse on Child Abuse, 2000)

Center for Restorative Justice and Peacemaking

Committed to the development of community-based restorative responses to crime and violence which strengthen community safety and social harmony. This organization is an affiliate program of the University of Minnesota, and offers a tremendous amount of resources, training, information and contacts.
Visit them online at:
http://ssw.che.umn.edu/rjp/default.html
Or contact them at 612-624-4923.

The Net Addiction Website

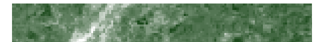
Net Addiction lists high-risk behaviors, types of Internet addictions, and even includes a self-test to assist in determining if someone may be addicted to the Internet. This website also lists numerous resources and treatment options.

www.netaddiction.com

Assessing and Treating Violent Youth and their Families
By Kathryn Seifert, Ph.D.

Violent youth often have a variety of problems in school and the community with peers and at home (Bilchik, 1998). Tolan and Guerra (1994) found that multi-faceted assessment and treatment for juveniles with severe behavioral problems can be effective, especially when used within a community setting, while targeting younger children and their families. The greatest intensity of services should be reserved for the youth that are at the highest risk for severe aggressive and sexual acting out behavior. Low-risk youth will often do well with minimal services. Treatment should target the child's needs (Loeber and Farrington, 1998). Having an easy-to-use tool to determine risk and the services needed can be very useful. The CARV (Child & Adolescent Risk for Violence) is such an (cont. on pg. 6)

"Having an easy-to-use tool to determine risk and the services needed can be very useful."



Legal News

High court upholds sexual assault conviction. In July of 2000, the Wisconsin Supreme Court , in a 4-3 decision, let stand Edward A. Hammer's Racine County conviction for the second-degree sexual assault of a 14-year-old and the fourth-degree sexual assault of a 16-year-old, both of which occurred during an overnight visit at his parents' home in June 1997. At trial, Hammer attempted to introduce evidence that his alleged victims had engaged in conduct among themselves that was similar in nature to what Hammer was accused of. But Circuit Court Judge Gerald Ptacek excluded that testimony under the state's rape shield law. However, Ptacek allowed prosecutors to introduce testimony about a sex-related incident that supposedly occurred five years earlier, even though Hammer was a juvenile at the time. The supreme court justices found the testimony about Hammer's earlier sexual conduct to be relevant and proof of Hammer's method of operation. He also found that the court's use of the rape shield law to exclude evidence of the teenagers' alleged behavior did not deprive Hammer of a fair trial.

(Source: Milwaukee Sentinel, July, 2000)

Seattle, Washington's, "Two Strikes Your Out" law, designed to incarcerate 3rd conviction sexual offenders for life, is being applied inconsistently because the statutes wording leaves judges to interpret what counts as a "strike". Recent cases demonstrate the unreliability of the law, as the defendants had prior sex offense convictions that were not listed as "strikes". Older statutes, changed statutes, and juvenile convictions are among the most common causes of the confusion.

(Source: Associated Press, July 2000)

Presidential candidate Al Gore is announcing a new Crime Victims' Bill of Rights. The Crime Victims' Bill of Rights will ensure that the rights of victims are fully protected throughout the criminal justice process; will allow victims to take leave from work without fear of losing their jobs; will expand programs to help victims of domestic violence; and will crack down on hate crimes. This set of initiatives will cost $685 million over ten years.

(Source: U.S. Newswire, July, 2000)

In Quebec, Canada, a judge ordered that a man convicted of molesting 19 boys give a DNA sample that will be part of new national databank of Canada's worst criminals. Justice Department official Michael Zigayer stated that the databank will help solve past crimes as well as future crimes.

An Ohio man's foot fetish results in a five year prison sentence. A man who lured a girl to a secluded part of a Worthington library to satisfy his foot fetish was sentenced in July to five years in prison and might be labeled a sexual predator for life.

Sexual Addiction: Assessment and Treatment Considerations

By Karen Engebretsen-Larash, Psy.D.

While there are some behaviors that may be considered normal in most people, these very same behaviors can be highly addictive for others. To give a diagnosis of Sexual Addiction for anyone requires an appropriate psychological assessment of the individual.

In general, *sexual addiction* can be described as a destructive relationship with sexual activities that deviates from mainstream experience within the expected boundaries of the particular sexual culture (i.e., heterosexual, gay, bisexual, lesbian, transgender). This drive for sexual gratification then becomes central in the addict's life and he or she relies on sex for nurturing, comfort from pain, and relief from stress. The basic characteristics of addiction include: a) a powerlessness to stop at will; b) harmful consequences if the behavior is maintained; c) an inability to manage other areas of one's life; and, d) withdrawal symptoms upon trying to quit.

So, how do individuals determine if their sexual experiences are "normal" or "addictive?" Several questionnaires have been developed to determine the need for Sexual Addiction treatment. For example, Robert Weiss, LCSW, Clinical Director of the Sexual Recovery (cont. on pg. 7)

Legal Information Institute

The Legal Information Institute offers a diverse collection of U.S. Supreme Court rulings and decisions. Visit the Legal Information Institute on-line at: www.supct.law.cornell.edu.supct.hermes.search.html

DETACH

As a child I learned a way, to disappear one stressful day, even better than hiding my face, I would float away to a safer place...

I eagerly embraced the arrival, of this special tool of survival. A gift to me by saving grace, it brought me to a sacred place…

Where I could leave behind the pains and woe, of the world I lived in down below. I could rise above and be gone, oblivious to the goings on.…

From the horror that was to come, I could separate and go numb. Further and further I'd go reeling, 'till I was just an observer with no feeling.…

Later in life some would say, my gift was not a special way, but an illness that had to leave, so I could face the truth and grieve…

The hardest thing I ever faced, was letting the numbness be replaced, and facing all the hurt and fears, engrained in those early years…

Though I am now grown and healing, sometimes yet I get that feeling. In times of stress I can will myself to safety even still…

By
Angelmz@aol.com
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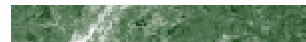


The Sex Offender Recovery Faking Scale

By Mark. S. Carich, Ph.D.

Name:__________________________ ID Number:_____________________ Date:___________________

Instructions: Rate (from None, Low, Moderate, High) each offender according to the degree or magnitude that each behavioral item was demonstrated throughout interviews, group, treatment, etc. Then tally up the ratings and average the score.

SCALE 1=None 2=Low 3=Moderate 4=High

Item				
1. Jumping from topic to topic and not focusing on or staying with one topic.	1	2	3	4
2. Provides much verbal garbage or verbiage as if he/she was trying to impress others, avoids issues or present a phony self, taking long verbal trips to nowhere or not being relevant.	1	2	3	4
3. The client keeps shifting stories, demonstrating contradictions.	1	2	3	4
4. Distorted, twisted information compared to other reports.	1	2	3	4
5. Pulled out information; is not volunteering it.	1	2	3	4
6. Inconsistency in behavior in the past and present.	1	2	3	4
7. Scanning other group members for appropriate responses or cues on how to respond. Looking for any type of confirmation and reinforcement.	1	2	3	4
8. Incongruence in verbal and nonverbal behavior in the here and now.	1	2	3	4
9. Incongruence between cognitive/affective/behavioral/psycho-physiological and social-domains of experience.	1	2	3	4
10. Cutting off feelings or showing bland or blunted affect.	1	2	3	4
11. Intellectualizing (this is also considered a disowning behavior as the offender demonstrates a lack of recognition).	1	2	3	4
12. Mimicking responses with no meaning associated with responses.	1	2	3	4
13. The "Chameleon Effect"—changing feelings, behaviors, or joining you or the group by mimicking what he/she thinks you want to hear. The changes have no meaning and are superficial at best.	1	2	3	4
14. Playing the middle or being non-committed in responses.	1	2	3	4
15. Agreeing on every topic or responses (i.e. to look compliant).	1	2	3	4

Formula Total__________________ / (divided by) 15=______________________

Raw Score:

46-60 Appears to be strongly faking
31-45 Appears to be somewhat faking
16-30 Appears to be slightly faking
0-15 Appears to be genuine, real, and authentic responses

Score Keys:

3.5-4.0 Appears to be strongly faking
3.5-3.4 Appears to be somewhat faking
1.5-2.4 Appears to be slightly faking
1.0-1.4 Appears to be genuine, real, and authentic responses

Concluding Comments

Detecting phoniness has always been of interest to professionals working with sex offenders. Sex offender specialists are concerned with offenders faking treatment or authentically making changes. The faking scale was designed with the goal to actually measure the degree the offender is phony versus real or authentic.

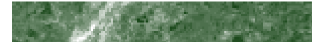
Carich, M.S. (1999a). Evaluation of Recovery: 15 Common Factors or Elements. In M. Calder (Ed.) Assessing Risk in Adult Males Who Sexually Abuse Children. Dorset, England: Russell House Publishing Limited, p. 279-281.

Carich, M.S. (1991a). The Recovery of Sex Offenders: Some Basic Elements. INMAS Newsletter, 4(4), 3-6.

Carich, M.S. (1991b). Evaluating and Detecting Phoniness of Clients. INMAS Newlsetter, 4(2), p. 13-14.

Carich, M.S. (1999b). Utilizing the 15 Factor Sex Offender Recovery Criteria: A Manual for Professionals. Unpublished manuscript.

Carich, M.S. (1997b). Toward the Concept of Recovery in Sex Offenders. The Forum. 9(2), 10-11



Rosenberg Historical Risk Assessment

In *Understanding, Assessing, & Treating Sexual Offenders*

Name: ______________________________ **Date:** ____________________

BD: _______________ **Months in Tx:** ____________________

Chronicity of problem

1. First documented sexual offense: 0
2. Two documented sexual offenses: 1
3. Three or more documented sexual offenses: 2
4. Prior allegations of sexual offending: 2
5. No developed pattern of offense behavior: 0
6. Client vaguely planned offense: 1
7. Client planned entire offense with desired outcomes: 2

Total:___________

Severity of denial

8. Client denies all involvement in current sexual offense: 2
9. Client accepts partial responsibility for current sexual offense: 1
10. Client accepts full responsibility for current offense: 0
11. Client is willing to take polygraph test if requested: 0
12. Client is unwilling or shows resistance to talking the polygraph: 2
13. Client is willing to explore the dynamics of offense: 0
14. Client is willing to explore dynamics of offense, but with resistance: 1
15. Client is unwilling to explore the dynamics of the offense: 2
16. Client attends therapy sessions on a regular and consistent basis: 0
17. Client occasionally misses therapy sessions with or without notification: 1
18. Client misses numerous therapy sessions without notification: 2
19. Client is willing to discuss his or her sexual history without significant resistance: 0
20. Client has demonstrated deception when disclosing sexual history: 1

Total:____________

Abuse history

21. No history of being sexually abused: 0
22. Client has history of being only sexually abused: 1
23. Client has history of being both physically and sexually abused: 2
24. Client has no history of substance abuse: 0
25. Client has history of substance abuse: 1
26. Client has history of substance abuse and was using during the offense(s): 2
27. Client has history of torturing/abusing animals: 2
28. Client has significant history of firesetting behaviors: 2
29. Client demonstrated severe problems with elimination (feces and urine): 2

Total:____________

Other antisocial behaviors

30. Client has little or no behavioral problems at school/work: 0
31. Client has some notable behavioral problems at school/work: 1
32. Client has chronic behavioral problems at school/work: 2
33. Client demonstrates severe transience in school and/or work: 2
34. Client has prior violent and non-violent criminal history: 2

(***cont. pg. 8***)

Assessing and Treating Violent. . .

(cont. from pg. 2) evaluation tool developed and field-tested by Dr. Kathryn Seifert, founder of Eastern Shore Psychological Services (ESPS).

The early results of CARV field-testing are promising. Initial findings are that youth with no history of aggression have the lowest scores; youth with moderate problems with aggression have moderate risk scores; and seriously aggressive and chronic offenders have the highest scores. Divided into two segments, the test assesses both *risk factors* and *protective factors* with 46 questions that are easily completed by reviewing interview documentation, knowledge of the youth, and the youth's file. Both static and dynamic factors are used. *Dynamic factors* like anger management skills are those that may respond to treatment, while *static factors,* such as past abuse, will not change over time. Additionally, the form provides a treatment-planning tool based on the responses. The significance of the development of a tool, such as the CARV, is widespread and offers an opportunity for school and mental health professionals to access a reliable tool for determining the need for additional testing and for specific treatment protocols. In about 40 minutes, a teacher, mental health professional or trained caregiver can accurately determine the type and intensity of services that are needed for the youth.

Among adult actuarial risk tools, the more risk factors that an adult offender has, the greater his or her risk for recidivism. The CARV is constructed in a similar fashion. Risk factors include violent family background, past assaults, youth abuse or neglect, harm to animals, enuresis, psychiatric problems (Briscoe, 1996), belief in the legitimacy of aggression to solve problems, school problems, and firesetting. Resiliency factors include a nurturing, stable caregiver with consistent, non-harsh disciplinary techniques; school success; and, prosocial peers. More risk factors result in a higher risk score. Resiliency scores are subtracted from the risk score.

For high-risk youth, multi-faceted treatment is essential (Bilchik, 1998). A treatment model developed by ESPS focuses on the entire family unit and services are designed to address multiple needs when they are identified. Through traditional individual and group therapies and in-home and in-school services, such as therapeutic mentoring, psychiatric rehabilitation services, and prevention/intervention specialists, families are treated as a whole unit. Collaborative efforts of all available services within a community are supported through interagency treatment teams. With a continuum of care, services and monitoring can be increased when the youth is unable to exert his or her self-control and begins to act out. They are decreased when a youth has had significant treatment and is doing well. The treatment team can increase or decrease services. Coordination with parole and probation is also essential.

For information e-mail drkathy2@cswebmail.com. Dr. Seifert can also be reached at ESPS 28761 Ocean Gateway Salisbury, MD 21801 410-334-6961 or fax - 410-334-6960.

Bilchik, S. (July, 1998). Mental Health disorders and substance abuse problems among Juveniles. OJJDP Fact Sheet #82. Washington, DC: Office of Juvenile Justice and Delinquency Prevention

Briscoe, J. (1996). A collaborative effort: Examining Juvenile offenders with mental impairments. Corrections Today. 58(6), 106-136.

Loeber and Farrington. (1998). Serious and violent juvenile offenders: Risk factors and successful interventions. Thousand Oaks, CA: Sage Publications, Inc.

Tolan, P. and Guerra, N. (1994). What works in reducing adolescent violence: An empirical review of the field. Boulder, CO: Institute for behavioral Science.

Rosenberg & Associates

Matthew Rosenberg, MSW, CSW, editor in chief of The Horizon Newsletter, will be planning his Spring 2001 public appearance/training schedule in the coming months. If any individual or agency is interested in his trainings on sexual abuse and deviancy, please call him directly at 248-210-4498. He and his associates will travel throughout the United States, and will personalize each training to meet the specific needs of each agency.

"In about 40 minutes, a teacher, mental health professional, or trained caregiver can accurately determine the type and intensity of services. . ."

Center for Sex Offender Management

The Center for Sex Offender Management's (CSOM) goal is to enhance public safety by preventing further victimization through improving the management of adult and juvenile sex offenders who are in the community. Visit CCOM at:

www.csom.org

Or call 301-589-9383

The Rape Recovery, Help, & Information Page is an informative website that offers an extensive amount of resources, support options, and information. This website also contains book reviews, links to similar websites, newsletter information, and links to On-Line police agencies, and much more.

Visit this site at:

www.geocities.com/hotsprings/2402

Sexual Addiction: Assessment and Treatment. . .

(cont. from pg. 3) Institute, Los Angeles, CA has a brief 15 question survey, which can be used to determine whether further evaluation is needed. Dr. Patrick Carnes and Robert Weiss, LCSW also created a gender-specific sexual screening test for men (G-SAST) and one for women (W-SAST).

In most cases, treatment for sexual addiction involves the same concepts that are used to treat other forms of addiction (e.g., chemical dependency, eating disorders, etc.). The process is intended to help individuals break through their denial system by taking an honest look at the consequences and damage these unhealthy choices have caused. Therapy also includes involvement of the family and significant others so that co-dependency and other issues can be addressed.

Conceptually, I believe that the core of all addictive disorders, including sexual addiction, has to do with abandonment issues. Intense fear and anxiety arise in the face of perceived betrayal and rejection, and attempting to bury themselves in one addictive (numbing) behavior after another only serves to reinforce the emptiness inside. Often, individuals run from one relationship or sexual experience to the next to fill that gaping wound, only to realize that once again, looking to external sources has left them feeling unfulfilled and wanting. Unfortunately, sometimes therapists end up being so focused on examining the individual's "brokenness" that they fail to adequately address the immediate relationship(s), which seem to be perpetuating the unhealthy attachment to others.

Exploring these sometimes deep-seated issues can be a very painful process. Therefore, making the decision to enter psychotherapy for sexual addiction (or, for that matter, any presenting problem) is very courageous. It suggests a willingness to explore alternatives and a realization that sexual addiction is probably a symptom of a much bigger issue. In fact, research has demonstrated that there is a strong correlation between sexual addiction and history of an unresolved trauma. For therapy to be effective, a thorough examination of trauma-related experiences (sexual and non-sexual) will be a necessary part of the process.

The development of an effective therapy relationship is dependent upon the right therapist-patient mix as well as, the type of services individuals wish to obtain. In general, clinicians tend to practice and utilize techniques based on their training and areas of expertise. The therapist's theoretical orientation will also play a role in the choice of technique since the theory is used as a template to understand human behavior and relatedness.

In sum, there are many factors, which affect the assessment and therapy process, regardless of the presenting problem. The complexities associated with the myriad of dysfunctional life experiences can reveal a complicated clinical picture. Therefore, it is essential that a mutual respect between the therapist and patient be established early so that an atmosphere can be created whereby patients can feel safe enough (over time) to unravel the past and hopefully experience the emotional release needed to break through the sometimes massive barriers to intimacy.

Karen E. Engebretsen-Larash, PsyD, PA, DABPS, DNBAE, FACAPP, CDVC, MAC, is a licensed clinical psychologist in private practice in South Florida and specializes in treating trauma-related disorders and sexual addiction. She is also a member of the National Council on Sexual Addiction and Compulsivity. For more information, she can be reached via website at

www.drkaren.com

or by phone at 954-779-2855.

"Exploring these timetimes deep-seated issues can be a very painful process."

Fast Fact:

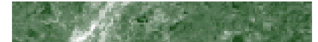
In a recent study focusing on children in foster care, researchers found that 90% of the children studied had at least one parent incarcerated or arrested at some point in the child's life.

Source: Center for Children of Incarcerated Parents. "Children of Criminal Offenders and Foster Care

Safer Society Foundation

The Safer Society Foundation is a tremendous resource for professionals and the public. The foundation's publication division, **The Safer Society Press**, has published dozens of workbooks and other materials on sexual abuse and sex offender treatment. The foundation's website announces dozens of national conferences and seminars. Moreover, The Safer Society has a nation-wide database of sexual abuse and sex offender therapists.

Safer Society Foundation, Inc.
PO Box 340, Brandon Vermont 05733
PHONE: (802) 247-3132
www.safersociety.org



Rosenberg Historical Risk Assessment

35.	Client has prior non-violent criminal offense history:	1
36.	Client has no prior criminal history:	0
37.	Client did not use physical force/threats during offense process:	0
38.	Client used or allegedly used some physical force/threats during offense:	1
39.	Client threatened or inflicted great bodily harm during offense process:	2
	Family support	Total:__________
40.	Family shows some resistance in the therapy process:	1
41.	Family engages in the therapy process as expected:	0
42.	Family is disengaged in the therapy process altogether:	2
43.	Client has no family support:	2
44.	Family acknowledges client's sexual deviancy:	0
45.	Family denies client's sexual deviancy, but is willing to explore the possibility:	1
46.	Family denies client's sexual deviancy and is unwilling to explore the possibility that deviancy exists in client:	2
	Empathy/remorse	Total:__________
46.	Client has ability to empathize with victim and shows remorse over the offensive behavior:	0
48.	Client expresses little empathy/remorse over the offensive behavior:	1
49.	Client is unable to empathize or show remorse and blames the victim for the reported offense:	2
50.	Client's affect/mood appears to be inappropriate under the context of treatment:	1
51.	During offense period, client demonstrated psychosis or mood disorder:	2
		Total:__________

TOTAL SCORE FOR ALL SIX DOMAINS:_________

LEVEL OF RISK TO THE COMMUNITY FOR A REOFFENSE

LOW	MODERATE	HIGH
0-5	**6-10**	**11+**

The Rosenberg Historical Risk Assessment is a static risk assessment that assists the therapist in determining the level of risk an untreated offender may pose for a reoffense. This tool breaks down the risk categories into six domains to further assist the therapist in determining what areas are producing the behaviors, which are of significant concern (these areas should be added to the treatment plan). The Rosenberg Historical Risk Assessment is just one of the many tools featured in Mr. Rosenberg's workbook, Understanding, Assessing, & Treating Sexual Offenders: Tools for the Therapist

Child Abuse Prevention Network

The Child Abuse Prevention Network is the Internet nerve center for professionals in the field of child abuse and neglect. Website includes research, tools, prevention methods, articles, resources and much more.

http://child.cornell.edu/

National Clearinghouse on Child Abuse and Neglect Information

The N.C.C.A.N.I. offers an extensive amount of free information, research, and resources. You can obtain their full catalog of publications, prevention information, and more by calling 1-800-FYI-3366, or emailing *nccanch@calib.com.* **Finally, visit the N.C.C.A.N.I. on the Internet to obtain an extensive amount of information, including their database information, at:**

www.calib.com/nccanch

Survivors' Corner

Survivors' Corner is a new feature in The Horizon Newsletter, and will highlight articles written by survivors of sexual abuse. If you would like to submit an article for publication, please email:

namaste5@bellsouth.com or write to Elden Phillip Owens at 2810 Wildwood Crossing, Birmingham, Alabama, 35211. Articles may be submitted anonymously, and all articles are subject to editorial review. You may also submit questions, comments, or concerns you may have that you would like addressed.

Victims' Reaction to Sexual Assault:
Gender Neutralized
By Elden Phillip Owens

People who become victims of sexual/physical assault typically experience the victimization as a traumatic event. There are typical or common reactions to this kind of trauma or shock; but at the same time, each person responds in their own unique way.

Below are some of the common responses to sexual assault. These reactions are experienced at different intensities and levels.

- After a sexual assault, many people fear that they are losing control over their lives. They have been forced to participate, even though in some instances it may have been a passive participation, in an act that was against their will. They have lost control over their lives at the time of the assault. This sense of a loss of control may endure for months or years following the actual assault.
- Victims also may re-experience the assault in their thoughts and dreams. When this happens, it is almost as though the assault is actually occurring again. This re-experience of the event is called a flashback.
- Sexual assault victims may find that they have trouble concentrating on things. It is as though they cannot keep their minds on what they are doing. This is certainly a frustrating thing to have happen and adds to the sense of loss of control.
- Feelings of guilt may be present. Guilt, if present, may be related to what the victim had to do in order to survive the assault. In some instances, feelings of guilt result from the fact that others may have been seriously harmed even more than the actual victim. This is sometimes referred to as "survivor's guilt." Another potential source of guilt (and by far the most common) is the result of self-blame. The victim tells him/herself such things as, "I should not have been out that late," or "I should have been dressed differently". Most of this self-blame is a reflection of our society's tendency to place some responsibility on the person who has been sexually assaulted.
- Self-image frequently suffers as a result of the assault. Many people report feeling "dirty" and may take frequent showers in an effort to feel clean.
- A sense of sadness, or feeling "down" or depressed, may be omnipresent. There may be feelings of hopelessness and despair, frequent crying spells, frequent out bursts of anger, and sometimes even thoughts of suicide. Often associated with the sense of sadness is a loss of interest in activities and people. Nothing seems like it is fun anymore.
- A disruption in relationships with others can be quite common. The disruption is in part a result of the withdrawn behavior that frequently accompanies sadness and depression; also there can be a sense of embarrassment and or shame, which contributes to the disruption in relationships. At the same time, the support of friends and family plays an important role in the victim's recovery from the trauma of sexual assault. (cont. pg. 10)
- After an assault, the victim may experience a significant loss of interest in sexual/physical activities. It is understandable that the trauma from the assault may lead to an avoidance of sexual/physical activities. There may be other factors involved. For instance, it is common for people who are depressed to experience a decrease in sexual/physical activities.

To summarize, victims of sexual assault may experience any combination of the following reactions to the trauma created: *sense of loss of control over their lives; flashbacks, or re-experiencing the traumatic event; difficulty concentrating; feelings of guilt;* *(cont. pg. 10)*

Fast Fact:

In a recent study of teenagers who use the Internet, only 17% of youth and 10% of their parents could identify an authority in which to report sexual offenders on the Internet.

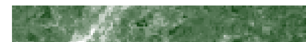
Source: *Online Victimization: A Report on the Nation's Youth, by Finkelhor, Mitchell, and Wolak, 2000*

Kathy's Essential Information on Abuse, Assault, Rape & Domestic Violence

This website includes information on physical, sexual, and psychological abuse, with a significant focus on domestic violence. There is a tremendous amount of resources and information on this website.

www.mcs.net/~kathyw/abuse.html

"There may be feelings of hopelessness and despair, frequent crying spells, frequent outbursts of anger, and even thoughts of suicide."



Victims' Reaction. . .

(cont. from pg. 9) *negative change in self-image; sadness or depression; disruptions in relationships; decrease of interest in sex; decrease of interest in physical activities; fear responses.*

The most common victim reaction to sexual assault is fear. At the time of the assault, the overwhelming experience is fear—fear of being physically injured, and, for many, fear that they will be killed. For many people the fear response (to certain sights, sounds, smells, thoughts) associated with the assault persists for weeks, months, or even years. People who have been assaulted typically avoid anything that reminds them of the assault. Some people become so fearful that they greatly restrict their activities; and, indeed, some people become so fearful that they are unable to leave their homes or are unable to be left alone.

Some of these reactions are connected with each other. For some people, having flashbacks, for example, may increase their concern about losing control of their lives and may even intensify the fear responses. Of these ten categories of reactions, fear is probably the most common and appears to be the most debilitating. For this reason, I will focus on this very normal and very predictable response to being sexually assaulted. I want to emphasize, in fact, that all of the ten reactions listed here are normal responses to experiencing any traumatic event.

Fear and anxiety are difficult to distinguish from each other. In general, fear usually has a specific object (person, place, situation, etc.) that is identified as the feared object. Anxiety (worry, uneasiness, distress, etc.) on the other hand, usually is more vague. Victims of sexual assault may experience both fear and anxiety reactions. Weeks or even months after the assault, victims may describe a feeling of uneasiness or jitteriness (a feeling, at times, that something bad is going to happen). This would be anxiety.

Long after the assault, the fear response may continue to persist. This fear response may be triggered by any number of things. The trigger (the stimulus) for a fear reaction may be anything that reminds you of the event. The triggers or stimuli might be certain features of the offender, such as skin color, facial hair, or the way he or she may smell. The stimuli might be related to the situation or the setting in which the assault took place, like dark nights, country roads, even your own home.

People react to any kind of fearful situation on three different levels: physical, mental, and behavioral. Our physical reactions are automatic. For instance, our heart begins to beat faster and harder and our blood pressure increases. These physical reactions come from our "flow of adrenalin." This automatic response is sometimes referred to as a "fight" or "flight" response (which is best exemplified in the animal kingdom). Victims of sexual assault may physically experience the fear and anxiety reaction. The reaction occurs first at the time of the assault, and later it often occurs in a similar form when something reminds the victim of the assault.

Fear is also experienced in the mind. It is not unusual, for example, for an assault victim to wonder if the assailant will come back and harm them again, or the fear being alone. Sometimes certain people, places, or circumstances will trigger these thoughts (i.e. darkness). At other times, the thoughts simply enter the minds of the victim, apparently without any clear stimuli. It is important to know that these are normal, yet stressful and traumatic reactions.

A third way that trauma victims respond to the fear and anxiety is on a behavioral level, where they try to control or avoid the fear response itself. In other words, they try to avoid the intense discomfort associated with the physical and mental aspects of fear and anxiety.

The physical, mental, and behavioral responses or reactions to fear and anxiety may occur separately. Most often, however, they occur all at once; that is, they influence or interact with each other. For example, having thoughts or flashbacks or even dreams (mental reactions) about the traumatic event usually triggers or stimulates physical reactions, such as rapid breathing, increased heart rate and muscle tension. These reactions, in turn, may lead to behaviors, which help avoid stimuli that trigger the mental and physical reactions. A sexual assault victim may see a person on the street that reminds him/her of the offender. Just seeing this person may trigger a fear response both mentally (they think about the attack) and physically (body tenses, heart rate accelerates, etc.) As a result, the victim may avoid walking down the street alone.

The Sexual Abuse Treatment, Research, Resource, & Referral Website

This informational website is geared towards both professionals and the public. Included are theories for deviancy, articles, research, links, online polls, specialized therapist contacts, forensic and legal referral information, topic of the week, chat room, online consultation and supervision, links, and much more.

www.angelfire.com/mi/collateral/index.html

The Fall issue of The Horizon will focus on Juvenile Sexual Offenders. The issue will include clinical writings from experts and specialists, resources, research, and much more. Two of the issues that we would like to address include: the number and types of juvenile offenders and the difference between juvenile and adult offenders. If you would like to contribute to this issue, please email Mr. Rosenberg at: Mrosen8693@aol.com

Literature and Resources

Health Journeys presents the "Image Paths" systems. Health Journeys uses guided imagery, via audio tapes and compact disks, to assist with a number of disorders and problem areas. Of particular relevance to sexual abuse is their audio program, "Healing Trauma" (PTSD). For more information, contact 800-800-8661 or www.healthjourneys.com.

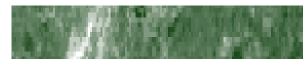
In Cabin Six: An Anthology of Poetry by Male Survivors of Sexual Abuse (Impact Publishing, 2000), edited by Jill Kuhn, M.A. This anthology examines survivors' relationships with men and women, loss of childhood, self esteem, numbing, blame, and confronting the abuser, to name a few. It is not recommended for minors under the age of 18.

Understanding, Assessing, and Treating the Sexual Offender: Tools for the Therapist, by Matthew Rosenberg, MSW, CSW; edited by Debra Pawluck, MSW. This 180 page workbook includes clinical essays, assessment measures, risk measurement/assessments, treatment tools, training tools, and more. To order, call 248-210-4498.

Treating Child Sex Offenders and Victims, by Anna Salter, Ph.D. (Sage, 1988). Salter's book provides the reader with a concisely written guide to diagnosing and working with both sex offenders and their victims.

Assessment and Treatment of Adolescent Sex Offenders, by Perry and Orchard (Professional Resource Exchange, 1992). This is a solid, comprehensive book for practitioners who have recently begun to work with sexual offenders.

The Psychological Assessment of Abused and Traumatized Children, by Francis Kelly (Lawrence Erlbaum, 1999), Offers a clinical paradigm for assessing abused children.



If you have any comments on the articles or other material featured in the Horizon, please write to the author, care of The Horizon Newsletter. Also, please write with any topical themes you would like to see addressed in upcoming editions of The Horizon.

The Horizon

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Subscription Form

A one year subscription to The Horizon Newsletter is currently running at the promotional rate of $15.00 per year. $1.00 from every subscription will go directly to a victims of sexual abuse charity. The subscription will include four issues of The Horizon, and may entitle professionals to be listed on the Sexual Abuse Treatment, Research, Resource, and Referral Website referral page:
www.angelfire.com/mi/collateral/index.html

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Send this, along with your check or money order to Mr. Rosenberg at The Horizon:

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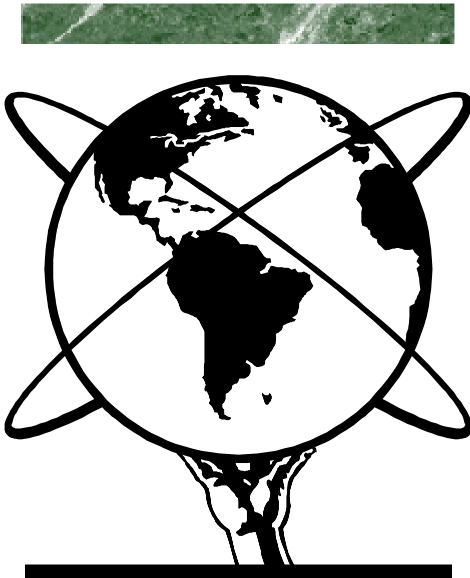
810-447-2282

Fast Fact:

20% of students with emotional disabilities are arrested at least once prior to leaving school.

Source: Office of Juvenile Justice and Delinquency Prevention, 2000



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Conferences, Trainings, & Seminars

Juvenile Delinquency: Violence & Aggression, Substance Abuse, & Sexual Offending, September 25, 2000, in Detroit Michigan. Featuring George Vanderbossche, M.A., and Sean Menifee. For more information, or to register, call 248-210-4498.

Sexual Offenders: Profiles, Victimology, Assessment, & Treatment, a 3-day series, October 20th, 27th, and November 10th, 2000, in Detroit, Michigan. Featured speaker is Matthew Rosenberg, MSW, CSW. Guest speaker includes Steven Miller, Ph.D., forensic psychologist. Registration fee includes the workbook, Understanding, Assessing, & Treating Sexual Offenders: Tools for the Therapist. For more information, call 248-210-4498.

Honoring the Past, Challenging the Present, and Changing the Future, the Maryland Domestic Violence/Sexual Assault Conference, will be held on November 3, 2000. The conference will be held at Chesapeake College, Wye Mills, Maryland. For more information, call 301-352-4574.

The Association for the Treatment of Sexual Abusers 19th Annual Conference, will take place November 1-4, 2000, in San Diego, California. This conference offers symposia, workshops, poster sessions, discussion groups, and advanced clinical groups relating to issues for both victim and offender research and treatment. Call 503-643-1023 for information and registration.

The Massachusetts Association of Guardians ad Litem, Inc., is having its Fall conference in Boston on November 10 & 11, 2000, featuring Janet R. Johnston, Ph.D. The conference, part of In the Best Interest of the Child Series, is entitled Alienation and Estrangement in High Conflict Families: Clinical and Legal Perspectives. More information and registration materials can be found at www.magalinc.org. You may also contact MAGAL at conference@magalinc.org or by telephone, 781-329-9729