Clinical Update

California Society for Clinical Social Work

Volume XLIV Number 3, October 2012

INSIDE Update

Sexual Offenses Against Adults and Children: What Every Clinician Should Know

By Ken Katz, LCSW, CTS and Anne Petrovich, Ph.D. LCSW

This article presents information about sex offenders and victims. Sex offender characteristics, typology, motivations and methods of operation, as well as the range of sexual abuse of both adults and children are described. Internet crimes against children and current laws regarding sex offenders are also discussed.

Who is a Sex Offender?

There is no such thing as a typical sex offender profile. With respect to age, some are young, some are married, some are middle-aged, and some are more elderly. Although females are known to commit sex offenses, the vast majority are male; male offenders outnumber females 8:1. While we may think of offenders as being adult males, studies have revealed that 60% of adult sex offenders began offending as adolescents. Most often the person who sexually abuses children is a heterosexual male ranging in age from adolescence to middle age. Sex offenders can come from any socioeconomic class or background. Some have mental health problems, such as depression, anxiety, or other disorders; but these difficulties do not cause them to commit a sex offense. Many, if not most, do not have a mental health diagnosis.

Relevant Characteristics and Behaviors of the Sexual Offender, and the Context of the Offense

Sex offenders have secretive and manipulative lifestyles. Although many of their sexual assaults are well planned, they may appear to occur without forethought. Frequently offenders are accomplished at presenting to others a façade designed to hide the truth about themselves;

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District Meetings

GREATER SACRAMENTO DISTRICT:

Coordinator: Stephanie Brodsky
Coordinator Phone: 916- 384-7458
Coordinator Email: StephanieBrodsky@msn.com
Date: October 20, 2012
Time: 1:30 pm to 4:00 pm (1:30 – 2:00 Socializing & Networking; 2:00- 4:00 Presentation)
Presenter: Myles Montgomery, JD, LCSW
Topic: **Emotionally-Focused Therapy**
Location: Friends Meeting House, between H & J St, 890 57th Street, Sacramento, CA

Emotionally-Focused Therapy (EFT) was originated by Dr. Sue Johnson and her colleagues in Ottawa, Canada, circa 1998. EFT is a short-term form of couples' and family therapy, which is heavily based on attachment theory. This therapy is also described as incorporating experiential Rogerian techniques and structural systemic strategies. The overarching goal of EFT is to strengthen the emotional bonds among couples and families, by moving through nine steps and three change events. The office EFT website (www.iceeft.com) notes studies, which have demonstrated that 70-75% of couples experience reduction in relational stress, while 90% report "significant improvements." Dr. Johnson authored two books about EFT, "Hold Me Tight: Your Guide to the Most Successful Approach to Building Loving Relationships," and *The Practice of Emotionally Focused Marital Therapy: Creating Connection*. Both books are used as texts in educational settings.

Myles Montgomery, JD, LCSW currently runs a private practice in Davis, CA, and is working on how to combine his law and social work degrees. He is on CSCSW's Board of Directors, and is chairperson for our Code of Ethics committee.

CSCSW members earn 2 CE credits at no cost. Non-member LCSWs and MFTs may obtain credits for $10.00 per unit. Non-members are welcome at no charge, no CEU certificate. Everyone is invited and we especially encourage MSW students to attend. Course meets the qualifications for 2 hours of continuing education credit for MFTs, LPCCs, and/or LCSWs as required by the California Board of Behavioral Sciences. PCE Provider #1

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District Meetings (cont'd)

MID-PENINSULA DISTRICT:

Coordinator: Virginia Frederick LCSW
Coordinator Phone: 650-324-8988
Date: Friday, October 19, 2012
Time: 12:20 PM to 2:00PM
Presenter: David Smith, MD
Topic: **Through the Eyes of A Psycho-pharmacologist: Looking at Anxiety with a Focus on Diagnostic Criteria, Use and Misuse of Medications and Clinical Examples**
Location: Stanford Department of Psychiatry, 401 Quarry Road, Room #1206

"America the Anxious" was the title used in an article written by David Frum in August's Newsweek. We seem to live in a society where anxiety is a growing part of the cultural norm. Dr. David Smith will present a look at anxiety focusing on the diagnostic criteria and medications used as well as the medications frequently misused. He will present clinical cases as a way to illustrate the issues he is confronted with. This presentation is planned to leave plenty of time for discussion and answer questions facing clinicians.

Dr. David Smith is a leading psycho-pharmacologist in our area and is in private practice in Palo Alto. He is a generous and exceptional presenter. He did his internship and residency at Stanford Department of Psychiatry where he was the Chief Resident. He is an outstanding teacher. Join us for this first meeting of the 2012-13 program.

Meetings generally take place on the third Friday of the month with the exception of February which will be the forth Friday. Other programs this year will include – November 16, - **The Meaning of Therapeutic Leaks in Psychiatry: Why Psychotherapists Gossip** (PhD Dissertation at Sanville Institute), January 18 – TBA, February 22– **A Clinical Case Presentation**, March 2 –**Law & Ethics focusing on internet communication and cyberspace** (6 CEU's) March 15– **Resilience in the Face of Trauma**, April 19 – TBA and May 17 – TBA.

NAPA SONOMA DISTRICT

Coordinator: Laurel Marlink Quast, LCSW, BCD
Coordinator Phone: 707-696-3148
Coordinator Email: Laurelmq@yahoo.com
Call Laurel M. Quast for details and to RSVP.
Date: Saturday October 6, 2012
Time: 1-3pm
Topic: **Projective Identification - Getting Pulled into Being Stuck**
Presentor: Mick Rogers, LCSW, BCD (and CSCSW Board President)
Location: **4827 Kieran Ct, Santa Rosa, CA 95405**

Projective Identification (PI) can seem confusing because it is an interactive defense. Mick Rogers, LCSW BCD will make it understandable as he discusses, with case examples, how PI presents in a variety of clients: (1) normal PI with parent and baby; (2) Classic PI with clients who 'make use' of their therapist's ego to process difficult feelings; (3) clients with pre-verbal trauma; and (4) clients who experience prejudice, but do not feel comfortable directly talking about it in psychotherapy. When therapists do not identify this interactive process in clients who use PI as a defense, therapists are at risk of acting out and of missing the opportunity to help their clients with this important, destructive relationship pattern.

Mick Rogers LCSW BCD is a psychotherapist and training coordinator at CSUS' Counseling & Psychological Services. He is also a PhD student at Smith College School for Social Work's Clinical Social Work program. Mick's more than 30 years of experience as a clinical social worker includes Sutter Counseling Center's Child Guidance Clinic, St. Louis County's Child Guidance Clinic and Dorothea Dix State Mental Hospital's Adolescent Treatment Program. Mick is the President of the California Society for Clinical Social Work.

Members earn 1.5 CE credits at no cost. Credits for non-members are $10.00 per unit. Non-members are welcome and may attend at no charge (no CEU certificate). MSW students are encouraged to attend. Course meets the qualifications for 1.5 hours of continuing education credit for MFTs, LPCCs, and/or LCSWs as required by the California Board of Behavioral Sciences. PCE Provider #1

Inside the Institute

News from the Sanville Institute for Clinical Social Work and Psychotherapy

A Message from Whitney van Nouhuys, PhD
Academic Dean

Students and faculty begin the new year attending mentorship meetings, clinical consultations, seminars; writing papers and dissertations; and getting together for our Fall Convocation – these are the activities that characterize The Sanville Institute's unique program.

In June our two recent graduates, Jean Kotcher, PhD, MFT and Lonnie Prince, PhD, LCSW, presented on their dissertation research to the Sanville community. As it happens, both research studies address controversial clinical questions and contribute to a fuller appreciation of the complexities involved. Jean studied psychoanalytically oriented therapists' experience of long-term (15 years or longer) psychotherapy. Lonnie looked at "Why Therapists Gossip," referring to the common phenomenon of casual disclosures about clients.

The recently formed Sanville Community Alliance will promote collaboration with other organizations – beginning with the Smith School of Social Work alumni – and sponsor continuing education programs. It will also re-establish a "service arm" for the Institute with volunteer therapists providing direct services for selected groups, such as low-cost therapy for MSW and MFT students.

Speaking of continuing education programs, we have several in the works. In the south:
October 25 (evening) at ICP in Los Angeles: Valerie Sinason "Key Findings in Psychoanalytic Treatment of Adults and Children with Intellectual Disability"
November 10 (morning, address TBA): Gloria de la Cruz Quiroz, "Family History Taking"
January 26, Winter Convocation at The Sportsmen's Lodge in Studio City
April 21, 6th Jean Sanville Day with presentation by Pat Ogden

In the north, in November we will present a video showing and discussion of his original play with Berkeley therapist and author David Shaddock, PhD, MFT, straight from the Spoleto Festival in Italy. Check our website and stay tuned. We are a state-approved educational institution with centers in Berkeley and Los Angeles offering PhD and certificate programs in clinical social work, open to social workers, MFTs, and psychiatric nurses with a master's degree in their field. For further information please contact The Sanville Institute office at 510-848-8420 or at admin@sanville.edu

Do You Know??

Do you know that five new preventive services are now covered by Medicare?

Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse – Effective 10/14/11
Screening for Depression in Adults – Effective 10/14/11
Intensive Behavioral Therapy for Cardiovascular Disease – Effective 11/8/11
Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to Prevent STIs – Effective 11/8/11
Intensive Behavioral Therapy for Obesity– Effective 11/29/11

Learn more about Medicare coverage of mental health care by visiting Medicare Interactive.

Meet your Board Member

Leah Reider, LCSW
President Elect

I am beginning my sixth year as a board member of CSCSW and will be the board president beginning in June, 2013. I remember that I began my first term on the board with some trepidation, as I was a bit intimidated to learn that several board members were professors at various schools of social work. I wasn't sure what I would have to contribute. However, my fears were soon put to rest when I met a lovely group of very dedicated colleagues. I feel privileged to serve on the board with wonderful, bright, dynamic people who work tirelessly to represent our profession.

I must have been destined to enter this field because the results of a vocational test I took in the eighth grade (don't ask why such a test was given in the eighth grade) showed that I should become a social worker. I majored in psychology at Wellesley College and received my MSW from UC Berkeley in 1971. I have continued my professional education to this day and, in addition to taking numerous courses, have been a member of many consultation groups, including one in which I currently participate. One of the things I love about our profession is the ongoing opportunity to learn and to challenge oneself.

Prior to beginning my private practice in Palo Alto, I worked for Jewish Family and Children's Services for 15 years. I like to have variety in my practice and have always worked with both children and adults. I'm very interested in attachment issues and enjoy my work with adopted children. Other areas of interest include divorce, loss of a parent, relationship issues, depression, anxiety, and parent/child conflict. I love to do play therapy, but also enjoy my work with adolescents and adults. In addition, I have served as an adjunct consultant to MSW students for many years.

I am originally from the Midwest, but have lived in California since 1969. I have two adult daughters. One has a master's degree in environmental science and lives in New Zealand, where she set up and is running an organic farming network. The other has followed in the family tradition and is a first year student at Smith College School for Social Work. She just began her field placement in the schools in San Francisco.

I love traveling and hope to be able to have many more trips to interesting places. Of course, I have taken yearly visits to New Zealand, which is an incredibly beautiful country. I like to hike, but also enjoy museums, plays, and concerts. The past two summers I took theater courses in London, where I was lucky enough to see some wonderful productions.

We are fortunate to have a wonderful executive director and administrative assistant who have worked very hard to revitalize our Society and have been successful in recruiting several hundred new members. There are numerous ways in which members can be involved in the Society. As chair of the Mentorship Committee, I work to match mentors with newer social workers or those who want to change the direction of their careers. If you are interested in being a mentor or mentee, please contact me. I'd also love to hear from you if you have questions about CSCSW or are looking for ways to be involved, I can be reached at lreider@clinicalsocialworksociety.org.

California Society for Clinical Social Work

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Jewish Family Services
8804 Balboa Avenue
Room #198
San Diego, CA 92123
Free parking Use west lot (by the Counseling Center) and enter lobby

Tuition:
CSCSW Members $100
Non-Members $130

Registration begins at 8:30
Program begins at 9:00
Drop in Registration – subject to availability $110 mem/ $140 non
A boxed lunch will be provided

To register complete form below or contact Cindy Esco, 916-560-9238 cesco@clinicalsocialworksociety.org

100% **refund** if notified within 48 hrs of program. Less than 48 hr notice no refund.

CEU's provided by **CSCSW** - PCE #1
This course meets the qualifications for 6 hours of continuing education credit in Law & Ethics for MFTs, LPCCs, and/or LCSWs as required by the California Board of Behavioral Sciences

California Society for Clinical Social Work Presents

Providing Mental Health Services Legally and Ethically In the Age of Cyberspace

Presenter:
Carole Bender JD, LCSW
Saturday, October 13, 2012 9:00 A.M.

Digital technology and the World of Social Networking are entering our treatment rooms in a variety of ways e.g. e-mails and text messaging between clients and psychotherapists; internet psychotherapy sessions; and invitations from clients to be their friend on Facebook, MySpace, LinkedIn, Twitter or other social networking sites. Since our Professional Code of Ethics were developed before the "Age of the Internet", this presentation will explore the ethical and/or legal issues of privacy, confidentiality, transparency, self disclosure, and dual relationships in this brave new world of Social Networking. This six -hour workshop will be both informational and interactive by utilizing different scenarios and small group discussion. The workshop will also review the following areas: Scope of Practice and Competence, Professional Standard of Care, Informed Consent, Privileged Communication, Reporting Laws and Record Keeping.

Participants will be able to discuss what happens to the patient's expectation of privacy or confidentiality and to the Psychotherapist- Patient Privilege when use of the Internet enters the treatment room. Participants will be able to explain when Patient Targeted Googling (PTG) can be clinically justified and when it is not. Participants will be able to describe which questions to ask themselves when faced with a request by a patient to be their friend on Facebook. Participants will be able to describe what their Professional Code(s) of Ethics say about providing mental health services via electronic media (such as computer, telephone, radio and television). Participants will be able to differentiate between the concepts of "Confidentiality" and Privileged Communication". Participants will be able to articulate the different mandatory reporting requirements for child abuse and elder abuse.

Carole Bender, a Licensed Clinical Social Worker and Attorney, is a former Director of the UCLA Department of Social Welfare's Center on Child Welfare and a member of the Field Faculty, and is Past President of the California Society for Clinical Social Work.

Ms. Bender has presented training on law and ethics to mental health clinicians in hospital and agency settings as well as at national and state conferences. She has held Adjunct Clinical Faculty teaching appointments at the USC School of Social Work, the UCLA School of Medicine Department of Psychiatry and the Albert Einstein College of Medicine Department of Psychiatry.

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CSCSW Member? Yes/No Interested in Becoming a Member? Yes/No (Circle One)

Sexual Offenses Against Adults and Children: What Every Clinician Should Know
By Ken Katz, LCSW, CTS and Anne Petrovich, Ph.D. LCSW

(Continued from Page 1)

they are often highly functioning people who use their social skills to commit crimes and can spend a good deal of time grooming their victims by slowly gaining the victims' and their family members' trust through apparently kind, attentive behavior, accompanied by a variety of special favors. Sex offenders almost universally justify, rationalize, minimize, or deny their sex offending behavior. During the course of their lifetimes, they may commit a wide range and large number of sexually deviant acts, and show a continued propensity to re-offend. Although there is a high prevalence of sexual or physical abuse in the histories of samples of sex offenders, research does not support the notion that being a childhood victim of abuse actually causes sex offending. Most childhood abuse victims do not grow up to become offenders.

Many sex offenders commit their illegal acts while under the influence of alcohol and drugs, but substance abuse is not an indicator of sexual offending. Alcohol and drug use is significant, however, because the use of substances tends to reduce impulse control and to blur appropriate boundaries between adult and child. This has a disinhibiting effect on the behavior of the perpetrator, allowing him to act out thoughts and impulses that were previously controlled.

Social, interpersonal, and intimacy deficits are common among sex offenders. Many have ineffective communication skills, are socially isolated, have general social skills deficits and problems in intimate relationships. Although they may be superficially empathic to their victims, aware of the victim's susceptibility to love and attention, they lack empathy for the powerlessness, fear, and shame experienced by their victims. In the service of rationalizing their behavior, offenders engage in distorted perceptions and thinking about their victims, experiencing the victim as wanting or enjoying, not being harmed by, or even inviting and initiating the abuse.

Sexual Offenders vs. Predators: the Distinctions

These terms may overlap and are variously understood by clinicians and law enforcement, but the distinctions are important in understanding the psychology and context of these offenses. A sexual offender is a person who has committed a sexual offense, whereas the term sexual predator is often used to refer to a person who habitually seeks out sexual situations that are deemed exploitative. However, in some states, the term sexual predator is applied to anyone who has been convicted of certain crimes, regardless of whether or not there is a history of similar behavior. Sexual offenders usually commit one crime, have only one victim who is a member of the family, are a limited threat to the general public, are not considered to be psychopathic, do not usually have other dysfunctional sexual behaviors, such as paraphilias (to be described later), and are more amenable to treatment, with the ability to gain control over their aberrant sexual behavior. Sexual predators, in contrast, are habitual offenders who commit many crimes with multiple victims, have more psychopathic traits, and are much less amenable to treatment and to relinquishing control over their behavior. Sexual predators develop stalking and grooming techniques and are more likely to have paraphilias that drive their behavior. The focus of treatment with sexual predators is relapse prevention; cure is impossible.

The Role of Paraphilias

As noted above, these aberrant sexual behaviors are relevant in the history and motivation of many sexual offenders, especially the predators. Defined in the DSM IV T R, a paraphilia is a sexual disorder characterized by recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors that occur over a period of six months and cause marked distress or interpersonal difficulties. Few paraphilics can gain sexual gratification without paraphilic behavior, and many engage in what would be considered exaggerated forms of sexual

activity. The source of arousal or fantasy may be non-human objects, the suffering or humiliation of oneself and/or another person, or children and other non-consenting adults. More males suffer from paraphilias than females, and paraphilics frequently have more than one (up to 3-4) paraphilias. Common paraphilias are *exhibitionism* (exposure of one's genitals, breasts, or buttocks to unsuspecting others for one's pleasure); *voyeurism* (observing unsuspecting people in normal daily activities or sexual behavior, commonly called, *Peeping Tom*); *fetishism* (sexual arousal to a non-living object, usually involving masturbating or engaging in sex while holding, smelling, or rubbing the object); *beastiality* (sexual interest or activities with animals); *partialism* (sexual arousal to body parts); *frotteurism* (rubbing of body parts against unsuspecting others); *pedophilia* (sexual attraction to children); *masochism* (arousal to pain, to suffering, or to being humiliated, either by oneself or others); *sadism* (sexual arousal or gratification in response to another's suffering); and *transvestitism* (deriving sexual pleasure from dressing in the clothes of the opposite sex). There are innumerable other less known and less common paraphilias.

Paraphilias typically have slang names associated with them (*golden showers, S&M).* A sex industry manufactures and sells related paraphernalia and props, such as restraining devices, dolls, adult-sized baby clothing. There are elaborate support networks for persons with paraphilias, such as the North American Man/Boy Love Association (NAMBLA), Internet newsgroups, and chatrooms in which participants can share tips on how to groom potential victims. A body of literature, in the form of newsletters and forms of pornography, also thrives to support and reinforce paraphilic behavior.

It is extremely important to remember that not everyone suffering from paraphilias is a sexual offender and that not all sex offenders suffer from paraphilias (although many do). Individuals suffering from one or more of these paraphilias can limit their behavior to engaging in fantasy and masturbation, or they can act out their fantasies with objects or consenting partners. On the other hand, they can act out their fantasies and impulses illegally with non-consenting and/or underage partners.

Paraphilias, Methods of Operation (MOs and Rituals)

The MO is a pattern of behavior, involving thought and deliberation, intended to ensure success, protect identity, and facilitate escape from detection. Most offenders change and improve their method over time and with experience. The presence of paraphilias often means highly repetitive and predictable behavior patterns focused on specific sexual interests that go well beyond an MO. An MO, for example, may involve blindfolding the victim so he or she cannot identify the offender, whereas ritualistic behavior, such as using blindfolding or bondage as a part of the paraphilic fantasy, is repetitive behavior required for the sexual gratification of the offender, and is known as the *sexual ritual.* The ritual is necessary to the offender but not to the successful commission of the crime. Ritualistic behavior increases the odds of identification, apprehension, and conviction because it causes the offender to make need-driven mistakes. Sexual ritual, with its resultant behavior, is determined by erotic imagery, is fueled by fantasy, and can often be bizarre in nature. Offenders sometimes find it difficult to change and modify their psychological, cultural, spiritual, or sexual rituals, even when experience tells them they should or when they suspect law-enforcement scrutiny.

Cognitive Distortions, Attachment and Sexual Offending

Also known as thinking errors or rationalizations, cognitive distortions are thoughts that seem logical to the offender but are not realistically rational. Typically reported beliefs by sexual offenders are the following: "I feel it, so it must be true." "There was no injury, no crime, or no harm done." "It isn't me – it's the alcohol doing it." "She came on to me." Disturbances in attachment are also common in sexual offenders, especially due to the integration of the need for power and control with attachment. Sexual offenses are often influenced by attachment issues or deficits. Past

traumas can impact the ability to form sexual attachments; and some offenders, notably psychopaths, have difficulty forming any meaningful relationships. Psychopaths, in particular, have above average intelligence, are social chameleons able to control their underlying anger and rage, are less often convicted of their crimes, and are more dangerous in the way they are able to control others and avoid detection. With respect to attachment, their goal is to be in control of their relationships. Sociopaths, on the other hand, are more impulsive, more explosive, have average intelligence, limited social skills, a longer history of criminal behavior and an inability to learn from past mistakes. Because they control their emotions less well, they are more often arrested.

A motivational typology of rapists delineates those driven by power/reassurance needs, power assertive needs, retaliatory anger, and anger excitation (sadism).

Legal definitions of sexual offending

Non-contact sex offenses include exhibitionism, voyeurism, the viewing (not producing) of child pornography, pimping, and pandering. Rape and physical abuse are usually associated with pimping. Exhibitionism involves the desire to be seen and accepted in the absence of the social skill or self-esteem to satisfy these needs in a more socially acceptable way. The exhibitionist uses the behavior as a means of controlling the response of his victim, is thrilled by the response, and later uses the victim's reaction to fantasize and masturbate. This behavior involves multiple offenses, is compulsive in nature, and is highly correlated with voyeurism. The perpetrator is sexually naïve and may have learned about sexuality through pornography. Voyeurs (peeping toms) have poor social skills, relationship deficits, low self-esteem, similarly perceive their behavior as a form of attachment and control, and have a tendency to progress to other paraphilias and sexual offending behavior, such as frotteurism.

Contact sexual offenses involve touching the victim. Frotteurism increases the risk of harm to others as it involves leaving the realm of fantasy and makes the contact physical (by rubbing against the unsuspecting victim). Frotteurists have low self-esteem, poor or absent social skills, are tentative in their approach to others, and perceive their behavior as a form of attachment.

Rape is defined as sexual intercourse, or other forms of sexual penetration by one person (the accused or the perpetrator) against another person (the victim*)* without the consent of the victim. Rape is variously defined in some laws as sexual intercourse with a woman by a man without her consent and chiefly by force or deception. A motivational typology of rapists delineates those driven by power/reassurance needs, power assertive needs, retaliatory anger, and anger excitation (sadism). Power reassurance rapists (the rapist gentleman*)* are characterized as very paraphilic, surprise their victims, most commonly assault strangers, are often apologetic and not interested in degrading the victim (for example, they may politely ask the victim to take her clothes off), use only enough force to gain compliance from the victim, and have few sexual partners. The power reassurance rapist does not feel manly and has a need to prove his masculinity, is socially isolated, often keeps a journal of his behavior, takes trophies or souvenirs from his victims, frequents porn shops, and compulsively masturbates. This offender has a likely history of exhibitionism and voyeurism, a tendency to stalk his victims until he feels safe, forms an attachment to his victim, about which he frequently fantasizes, often victimizes his victim at night in her bedroom, and engages in the cognitive distortion of believing the victim will like him. Eighty-five percent of rapists are this type. The power assertive rapist has no doubt about his masculinity, is exercising his perceived prerogative as a man (That's what she's here for), uses rape to express his virility and dominance, and fantasizes that she's looking for it. His control is obviously more overt; seven percent of rapists are this type.
Anger/retaliatory rapists (5%) use sex to express anger and rage. Their aggression may range from verbal abuse to murder, and their victims represent the hated individual, either real or imagined. The most dangerous rapist is the anger/excitation type, who is expressing

sadistic/aggressive sexual fantasies, is aroused by the sexual suffering of his victim, and is primarily motivated by inflicting pain that elicits fear and total submission. This rapist views his victim as mine to do with as I want. This rapist is methodical, plans his crime in advance, may record his behavior. He is often intelligent, married and considered a good family man. He is often well educated, is compulsive in personal appearance or possessions (such as the type of car he drives), is knowledgeable about police investigative techniques, and probably has no prior arrest history.

Sexual offenders are also characterized as situational vs. opportunistic. Situational offenders may arrange, set up, or create situations to offend. Opportunistic offenders take advantage of situations in which they find themselves in order to offend; for example, encountering a woman alone during a robbery or home invasion. Both may involve the use of alcohol or drugs.

Most pedophiles become aware of their sexual attraction to children during puberty and begin offending as teenagers.

Child Sexual Abuse

Sex offenses against children happen in every strata of society all over the world. Unlike the well-known stereotype of a creepy man in a trench coat hiding in the bushes, the great majority of offenders are known to the victim and present to the rest of society as likable, good citizens whose crimes would be unthinkable to those who know them in social contexts outside of or sometimes even inside of the home. It is estimated that one in every five girls and one in every ten boys is sexually abused by the end of the 13th year. Ninety percent of these children are abused by a family member or close family friend; stranger abduction is quite rare. We all like to believe that we are good people and a good judge of character; but since one in every 20 men is a sexual predator, the chances are you interact with at least one every week. It is impossible for most people to believe that their children can be abused without their knowledge. Denial and disbelief are characteristics that sex offenders depend on in order to carry out their crimes undetected.

Child molestation is a legal term defining any behavior that exposes a child to the risk of psychological interference in his/her sexual development. This includes touching or intercourse with the child, coercing the child into touching the adult, photographing a child for sexual purposes, masturbating or being sexual in front of a child. Pedophilia, on the other hand, is a clinical diagnosis, usually made by a psychiatrist or a psychologist and is not a criminal or legal term. While all pedophiles are child molesters, not all child molesters are pedophiles. Pedophiles are considered a preferential type of sexual offender, with specific attractions characterized by age, sex, hair color, race, height, or other characteristics. Pedophiles groom their victims and may establish relationships with women to gain access to their children. Others may seek paid or volunteer positions that enable them to get in closer contact with potential victims by virtue of the authority or trust placed in them. Many use toys or animals to entice children and may furnish a special room in their houses oriented to children. Pedophiles identify with children and are sexually attracted to children, usually under age 13, express love for them, and form an attachment to them. Pedophiles distort their perceptions of children and of themselves because they want the encounter to be consensual (she wanted it; I can't help it – I was born this way); and they seek support from previously mentioned groups like NAMBLA to reinforce these distortions. They less frequently have intercourse with children, but engage in touch and masturbation with them. Pedophiles are less likely to offend against children due to situational stress. Most pedophiles become aware of their sexual attraction to children during puberty and begin offending as teenagers. They commit 95% of child sexual offenses, and cannot be cured, but can learn to control their urges. Most are situational offenders (responding to opportunity) and offend at higher rates in later years than other types of sexual offenders.

Child molesters who are not pedophiles are typically married and have sex with adults, although their relationships may be highly conflicted. Many have their

own children, whom they often don't molest; however, some will molest their own children, and stepchildren are at especially high risk. These child molesters are not emotionally attached to their victims but are motivated by power and control and tend to victimize in order to escape feelings of powerlessness, loneliness, and poor self-esteem. Their behavior is a maladaptive attempt to meet emotional needs; and they tend to have multiple victims, sometimes as many as 600 or more. These child molesters are more opportunistic and more coercive and antisocial than pedophiles.

Incest, is a subcategory of pedophilia. A child molester or pedophile can be an incest perpetrator as well as an extra-familial perpetrator. Five distinct types of incestuous fathers have been identified: sexually preoccupied, adolescent regressive, instrumental sexual gratifiers, emotional dependent offenders, and angry retaliators. Federal data show that 27% of all sexual offenders assaulted family members. Fifty percent of offenses committed against children younger than six years were committed by a family member; 42% of sexual offenses were committed against children 6 to 11 years old, and 24% against children 12 to 17 years old. The incest perpetrator chooses a family member as his victim due to easy accessibility; often these perpetrators are cousins, boyfriends, uncles, grandfathers or stepfathers. Often frustrated in his relationship with a wife or girlfriend, he can more easily exercise control and authority over the younger family member who is not likely to reject him.

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Treating child molesters vs. pedophiles

Child molesters know their behavior is wrong whereas pedophiles don't feel that way. Pedophiles assert that it is not my fault because it's the way I was made, and surround themselves with like-minded communities of support. This is facilitated in the prison setting because we isolate this group from the rest of the population. Rapists and child molesters have a higher degree of psychopathology and therefore find confrontation by therapists and law enforcement as "part of the game" in a battle of wits. Incest perpetrators are the most amenable and responsive to treatment, as they are more attached to their victims and live in the context of a web of family relationships that are, to a greater or lesser degree, important to them. Incest perpetrators, after they are caught and prosecuted, are more likely over time to respond to therapeutic efforts to challenge their cognitive distortions, correct their failures of empathy with their victims, and improve their communication skills and ability to form more successful adult to adult sexual relationships.

The Female Offender

Female sexual abuse of adolescent and adult men may go unnoticed from a legal perspective because the offense is often incestuous in nature, and children may be reluctant to report sexual contact with a parent on whom they are dependent. A typology of female sexual offenders includes the teacher/lover, the male-coerced/male-accompanied, and the pre-disposed. The teacher/lover acts as the initiator of the sexual abuse of an adolescent, usually a male. She seeks the expression of love in her interactions with the victim, feels no hostility toward him, was usually the victim of severe emotional and verbal abuse as a child, and has a history of sexually abusive relationships with her lovers. The teacher/lover female abuser engages in cognitive distortions, convincing herself that her sexual favors are an act of kindness and a positive expression of her love. When confronted, she is defensive and commonly engages in denial, minimizing the impact of her behavior on the victim. It is likely that she also has a drug and/or alcohol problem.

The male-coerced or male-accompanied female abuser is influenced by a male to participate in the sexual abuse, often of the male's biological child. She is usually in the position of homemaker, dependent on the male/mate as the breadwinner, and feels powerless in their interpersonal relationship. She has a low to average IQ, is under assertive, has little self-esteem, is fearful of her male partner, and often abuses alcohol and/or drugs. Male-coerced females are reluctant to

participate in the abuse but fear punishment; male-accompanied females usually participate more actively in the abuse.

The predisposed female abuser independently initiates the sexual abuse. She is usually the victim of severe sexual abuse as a child and has been abused by family members, strangers, and acquaintances throughout her life. Sexual abuse is common throughout her family history, her self-esteem is low, and her victims tend to be her own family members and often their children as well. She will tend to abuse her victims physically as well as sexually and is motivated by sadistic fantasies triggered by anger. Her offenses are more violent, fueled by alcohol and drug dependence; and she is often chronically suicidal and self-injurious.

Diversity Issues

Some sexual offenses may be acceptable in the country of origin outside of the United States. This behavior may be reinforced by the family and ethnic support system of the perpetrator, and this support may be used as a rationalization or defense. These behaviors may vary considerably, and the understanding of sexual behavior in the cultural context is an important area of investigation and exploration.

Sexual Offenses and the Developmentally Delayed

Persons with developmental delays are overrepresented among child sexual abuse cases. This is likely due to the inability of the developmentally delayed individual to connect with adults his own age, as well as to sexual naïveté. Treatment and supervision of these individuals requires more assistance.

Sexual Exploitation

Sexual exploitation is another form of child abuse including child prostitution, sex tourism involving children, on-line enticement of children for sexual acts, unsolicited obscene material sent to a child, misleading domain names, words or digital images on the Internet; and the possession, manufacture and distribution of child pornography. Preferential sex offenders in general tend to collect theme pornography and/or paraphernalia related to their sexual preferences. Situational-type child molesters might also collect pornography but not with the same degree of predictability as the preferential child molester. The material collected can often be of a violent and degrading nature.

Internet Crimes Against Children (CAC)

This is an exponentially growing public health problem. Forensic investigations focus on monitoring offenders' computers, phones, email, and on general monitoring of social media sites (sexting, etc). In 1999, it was determined that 25% of minors (age 10-17) saw unwanted sexual materials on the Internet. By 2008, this figure had increased to 34%. This was in spite of a 22% increase in the use of filtering and blocking software. The Department of Justice has reported that one in every 25 minors is asked for sexually explicit photographs of themselves while online. Approximately 61% of 13-17 year olds have a personal profile on a social networking site such as MySpace, Facebook or others. Seventy-one percent of these minors have received messages on line from a stranger, 45% have been asked for personal information from a stranger, 30% have considered meeting a stranger in person, and 14% have actually met a stranger offline. Even if a person uses a fake name with no identifying characteristics, a predator can still find out your name, address, and other personal information, due to the fact that everything you type online is searchable.

Twenty-two percent of teens believe it is safe to share personal information online, while 37% believe personal information will not be used inappropriately. Teens whose parents talk to them about Internet safety are much less likely to instant-message, post pictures of themselves, or talk to strangers online. It is important also to remember that someone online may not be who he says he is. Someone who says that "she" is a 12-year-old girl could really be an adult male sexual predator.

Vulnerable teens may seek out attention online that they do not feel they are getting at home or from loved ones or friends. They may falsely believe that

interacting on the Internet gives them an element of anonymity. Children and adolescents are naïve about the risks associated with the Internet. Most often they believe that it could not happen to them.

Current Laws Related to Sexual Crimes Against Children: Megan's Law, Jessica's Law (Proposition 38), and Chelsea's Law (AB 1844)

Megan's Law, effective as of 9/24/04, required the Department of Justice (DOJ) to create a website for the purpose of providing public awareness of sex offenders in the community. It was hoped that identifying the whereabouts of these offenders would allow unsuspecting members of the public to protect themselves via this knowledge. Access to information varies by nature of the offense and is organized into categories. For more serious offenders, the home address may be posted; the presence of others may be indicated by zip code.

Jessica's Law, passed by California voters on November 7, 2006, requires sex offenders who have been convicted of a felony sex offense to be monitored by GPS devices while on parole and for the rest of their lives. It also prohibits any person required to register as a sex offenders from living within 2,000 feet of a school or park, broadens the definition of certain sex offenses, and extends the length of parole for specified sex offenders, including habitual sex offenders.

Chelsea's Law (AB 1844) was signed by the governor on September 9, 2011. The law is named for Chelsea King, a 17-year-old who disappeared in February of 2010. John Gardner sexually assaulted and killed both Chelsea, in 2010, and Amber Dubois, a 14-year-old, who disappeared in February, 2009. Gardner was a discharged parolee and registered sex offender who had been imprisoned after being convicted for the violent molest of a 13-year-old girl in 2000. The enactment of Chelsea's Law was facilitated by the arrest of Philip Garrido, in August, 2009. Garrido, another parolee, had kidnapped Jaycee Dugard on June 10, 1991, held her captive for 18 years, raped her and fathered two children with her. Chelsea's Law increases penalties for sexual assaults with specific intents against persons under age 18 and enacts life sentences (some without possibility of parole) on sexual assault with specific circumstances. This law is relevant for the conviction of sex traffickers. Especially notable, Chelsea's Law also mandates the treatment of sexual offenders on probation or parole and ongoing risk assessments, describes a model for the management of sex offenders, and certifies sex offender treatment providers and treatment programs. It further establishes Sexual Assault Felony Enforcement (SAFE) teams, clarifies mental health civil commitment evaluations and procedures with respect to sex offenders, and restricts sex offenders who have committed crimes against persons 14 years old or younger from public parks.

Conclusion

Hopefully the information in this article will help clinicians with treatment decisions for both perpetrators and victims. For perpetrators, decisions about treatment goals and whether, when and how to treat should be informed by assessing their typology, motivation, emotional development, cognitive distortions, ability to form attachments, use of alcohol and drugs, and level of psychopathy. For victims, knowing the prevalence of sexual abuse and identifying the type of abuser, as well as his motivations, methods of operation and cognitive distortions may help them to comprehend and process their trauma. Understanding the risks of sexual abuse to children from people they know, as well as from the anonymity of the Internet, can enable adults to better protect them.

Vicarious trauma is a risk for clinicians, law enforcement officers, and others who deal with sexual abuse perpetrators and their victims. Also referred to as "secondary trauma" and resembling burnout, it is the dual experience of feeling traumatized by the victims' pain and the offender's history of offending. Clinicians and others may find themselves experiencing similar symptoms of trauma as do their victims, including emotional numbness, hyperarousal and hypervigilence, problems in their relationships, and the general inability to enjoy life. Self-care through rest, play, and exercise are important coping skills, but equally important is an

institutional, or agency commitment to the wellbeing of staff members through training and careful monitoring of case loads and work expectations. Clinicians working with victims, perpetrators or both are performing a critical service to our communities and deserve both to take excellent care of themselves and to be cared for by the institutions for which they work.

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