Cognitive - Behavioral Treatment with Intrafamilial Incest Perpetrators.

by

Edward Reid Hartry

A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of: Master of Social Work

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Table of Contents

Table of Figures

Table of Tables

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2 ABSTRACT

A review of the literature suggests that men who sexually assault their children, are individuals with multi-problematic profiles.

This study systematically evaluated a cognitive behavioral treatment program, which was designed firstly, to identify and correct inappropriate beliefs, secondly, to aid the participants in gaining control of in-appropriate arousals and finally, to increase factual appropriate sexual knowledge.

The overall goal was to give the men more control over their day to day behavior.

The participants in the program were three men referred to the Psychological Services Center, University of Manitoba, by Manitoba Probation Services.

The study employed the A-B basic single system design (Bloom & Fischer, 1982), to monitor for observable changes. The effectiveness of the study was evaluated by four instruments.

The clients beliefs were measured by the Cognition Scale (Abel et al, 1984), which was administered repeatedly at specified intervals throughout the baseline therapy and at followup. The Hudson Index of Self Esteem (Ise, Hudson 1982), was administered at similar times to monitor client functioning, and development of self esteem. The clients' sexual knowledge was checked specifically with the Sexual

Knowledge Questionnaire (Abel et al, 1984) pre and post, that portion of treatment. A client satisfaction questionnaire was used to acquire participants perception of the helpfulness of the therapy.

The results of the study indicate that the program was successful in the identification and restructuring of a number of inappropriate beliefs. The results also showed an increase in the clients' personal sexual knowledge and feeling of self control. The program was not however adequate in eliminating all of the clients actual and perceived needs.

Recommendations for future programs include:

1) Inclusion of modules to increase social skills;

2) develop assertiveness skills, and;

3) marital functioning intervention, where appropriate. The suggestion is also made

4) to use stronger, more specific scales and questionnaires and,

5) perhaps incorporate the use of the lie detector and plethysmograph, as additional evaluation instruments. Finally,

6) that the courts and crown attorneys be consulted

regarding possible disclosure of unreported assaults and the effect that this required notification of authorities may have on treatment.

3 INTRODUCTION

Introduction

In recent years, public awareness has resulted in increased numbers of intra family incest cases appearing before the courts. Research suggests that this problem is not, suddenly, occurring more frequently. Instead, increased use of public education and prevention programs is seen as the factor which accounts for increased reporting. (Sexual Offences against Children, 1984). In reality, when one examines historical documentation on the phenomenon, we see that children have been sexually exploited throughout history (Finklehor, 1979, Rush 1980)

3.1 Gender of Perpetrator

A significant point throughout the literature is that, for the most part, perpetrators are predominantly male. The research suggests, that perhaps other factors need to be examined. Nicholas Groth, in his work with perpetrators has seen few women in comparison to males. In one case load review he indicated there were only three females in a sample of 253 adult perpetrators (Finkelhor, 1984). A majority of clinicians who are involved with perpetrators believe that these numbers are less than accurate. The lack of significant numbers of female perpetrators is linked to a number of issues (Finkelhor, 1984). Females may "mask"

offending behavior through the guise of bathing or dressing. The fact that the perpetrator may be the victim's mother suppresses disclosure because of the child's perceived and or real need, to have their mother available for nurturance. (James & Nasjleti, 1983). Myths - like the male myth of 'introduction to sex by a adult female as an ultimate fantasy - are all contributing factors (Groth, 1979, Plummer 1981). All of these factors help to explain the low numbers of identified female offenders. This study dealt mainly with the population of perpetrators currently before the courts - that being males. The reality is, that there are many more cases of mother-son incest than are currently reported in the literature and to authorities.

3.2 Incidence of Child Sexual Abuse

Until recently, the sexual abuse of children has retained the status of an isolated social problem. Many professionals believe that it is the success of prevention and public education programs - and not an increase in the occurrence of offences - that has resulted in a flood of disclosures by children (Giarretto, 1982, Dawson, 1982).

Not everyone views increased sex education and street proofing children as a positive path for society to follow. These individuals believe, that this type of information

will lead to sexual permissiveness and experimentation. The opposite to that view, is the view that being educated about sexual matters allows the child to recognize and disclose inappropriate adult child sexual contact. (Bagley, 1984, Feeling Yes, Feeling No, 1983).

A major reason for not having an even more dramatic increase in reports, is the effects disclosure has on the family unit (Renvoize, 1982). In fact, many feel that, at times, this allows the abuse to continue (Renvoize, 1982). The perpetrator can, in some instances, use this consequence, of discovery, as a way of maintaining the secret. The victim is made aware of what will happen to dad, and how it will be the victim's fault, for what happens to him and the rest of the family (Burgess, Holmstrom, McCausland, 1978).

3.3 Current Treatment

In the past, services for dealing with this social problem have been extremely limited. Work is now being done to provide more services for the current victims (Berliner, 1983; Conte and Berliner, 1981; Sgroi, 1982) and the adult survivors of childhood sexual abuse (Jehu, Gazan and Klassen, 1985; Herman and Schatzow 1982).

Areas that have received less attention by researchers and therapists are - work with the siblings, spouses and the perpetrators themselves. This study examined and dealt with the perpetrators of sexual offenses against children.

Perpetrators are usually men who are seldom motivated to self report or plead guilty, especially because the alternatives to incarceration are non existent, and the impact on themselves and the rest of the family is so devastating (Renvoize, 1982, Groth, 1978). They perceive themselves, and often with just cause, as having nothing to gain and everything to loose.

The purpose of the present study is to present a treatment model that meets the needs of the perpetrators for a readily implemented and effective alternative or adjunct to incarceration. Upon examining characteristics of the perpetrator, it is clear that we are dealing with an individual with a multiproblematic makeup. Perpetrators, involved in family abuse situations, are not totally motivated by sexual needs. As well, the picture of a sex crazed dirty old man, also does not fit many of the identified perpetrators (Groth, Hobson Gary, 1982). Researchers are instead identifying a population of perpetrators whose problems are multifaceted - involving the abuse of power, trust, and control, in the family setting

(Finklehor, 1979; Groth, 1979; Sgroi, 1982). Finkelhor's Four Factor Model, is an effective model for explaining pedophilic behavior (Finklehor, 1979, 1984). That enables us to explore possible causes and other areas of focus during treatment. Realizing, that the perpetrator is not a voluntary client, the issues worked on were clearly stated (Summit, 1980).

The target group for the study was chosen from men convicted and sentenced for having had sexual contact with their children. The study involved men charged with offences which, by definition, were best described as being Intrafamilial incestuous contact (Kempe and Kempe, 1984). For the purpose of this study, it included both birth parent and parent substitute, and again the abuse that occurred was sexual in nature.

A cognitive behavioral model has been utilized because the model lends itself to focus on behavior and on the issues of increased control and responsibility. The program was twenty weeks in length, and addressed a number of issues. One area of concern to be addressed was the cognitive restructuring of faulty beliefs and attitudes. Another focus was the use of covert sensitization to suppress and control deviant sexual urges and replace them with age appropriate and socially appropriate urges. A third

focus was to ensure a sound knowledge base in the area of sexuality. These three sections were followed by a focus on helping the perpetrator develop his individual control plan used to prevent reabuse.

The effectiveness of treatment was evaluated by means of the following measures:

1) Attitude Scale (Inventory) (Abel, Becker, Cunningham-Rather, Rouleau, Kaplan, Reish, 1984);

2) Hudson Index of Self Esteem (SEI), Hudson, 1982;

3) Sexual Knowledge Scale. (Abel, Becker, Cunningham - Rather, Rouleau Kaplan, Reish, 1984).

4) A check of police and court records, to find any reinvolvement in similar offenses.

The study utilized a single system design, having assessment and treatment phases, plus a six month follow-up.

The first two measures were administered during assessment, and at the beginning and end of each treatment phase. The sexual knowledge scale was administered before and after the sexual knowledge treatment, to check for improved knowledge and understanding of human sexuality, an area deemed lacking in most men who are sexually inappropriate.

An analysis of the data collected was used to evaluate any impact the treatment process has on the client.

4 Literature Review

4.1 Impact on family

The perpetrator of child sexual abuse within the family can be an extremely resistant and difficult client to work with. The steps we as a society take, upon disclosure, can, at times, allow the abuse to continue. The belief is, that disclosure totally destroys the family unit, and the victim often sees herself as the cause of its destruction. Therefore, the perpetrator can be protected from detection even if the victim hates the abuse and knows it is wrong, because keeping the secret is viewed as more desirable than disclosure. The destruction of the family unit can, at times, be a factor in why the abuse also continues after the victim's initial family disclosure. Again it the consequences of disclosure that the perpetrator may share with his victim which acts as a block to the victim seeking help (Sgroi, Blick, Porter, 1982). Much of the impact of sexual abuse disclosure arises out of the role the victim plays in the disclosure process. She accuses a family member of a serious criminal offense - sexual assault (Summit, 1980). At the point of disclosure, the victim is often left without any functioning adult ally in the family (Sgroi, 1978). In fact, the victim may be subject to further abuse by being totally disbelieved or even blamed for the familial disruption (Sgroi, Blick, Porter; 1978). The victim is often

blamed for causing the problem and for bringing the matter into the public arena. This is especially true with adolescents (Finklehor; 1979). The court process is very pressure laden, the victim must confront and accuse her parent in a public courtroom (Criminal Code of Canada; 1986). All of these factors can help a perpetrator pressure the victim into maintaining the secret (Summit; 1983). This coerced silence, is one of the factors which deflates the self-esteem of the victim (Bagley; 1984).

4.2 Client Motivation

The literature consistently argues that perpetrators are not motivated to self report or plead guilty. Some of the major reasons are; the lack of alternatives to incarceration, the reality of prison life for a perpetrator, and the effect the disclosure will have on the total family network (Finklehor; 1979, Groth et al 1982).

A review of the literature suggests that identifying high risk populations, is impossible. The perpetrator of acts of sexual abuse against children exists in every population, race and religion (Groth et al, 1982).

4.3 Age of Victim

The age at which the abuse normally begins is prior to adolescence. The perpetrator often begins with his victim at a very young age, yet limits his type of assault (Groth et al, 1982; Quinsey, Chaplin, Currigan, 1975). The indication is - the severity of the assault tends to increase as the age of the victim rises.

4.4 Response to Disclosure

The literature suggests that one factor which can effect work with the perpetrator is the response to disclosure. Society's response can, at times, reinforce the perpetrators involvement with the victim. Some believe, that the hostile and punitive response to this behavior, results in the perpetrator closing off his world. Perpetrators rationalize that by avoiding normal adult contacts and maintaining an interest in children, they can better control their social network (Groth et al, 1982, Finklehor, 1979, Kempe and Kempe, 1984).

4.5 Clientele

Another point made clear during the literature review, is the fact that we are dealing with a multiproblematic

client whose behavior is linked to external factors like alcohol, family pressure or job stress. While it is important to realize that these are not causes, each may have a role in the perpetrator's history.

Alcohol, although involved in a majority of reported cases of sexual offending, is a disinhibitor not a cause. (Groth et al, 1982, Renvoize, 1982, Virkkunens, 1974).

Other important factors included the fact that incest perpetrators do not qualify for a psychiatric diagnosis. (Ellis, Hartry et al)

The nature of the assault is also unique. The offence is rarely a singular occurrence; it is normally of extended duration. Also of note is that the recidivism rates are lower than other sexual offenders. In a 1965 study of 1512 adjudicated sexual offenders the incest offender had a six year follow up reinvolvement rate of 10% compared to other sexual offenders involving adult rape and child molesters, which had rates of 22% for heterosexual offenders, and 35% for homosexual offenders. (Frisbie, & Dondis, 1965)

Another notable point is that that these men themselves are usually victims of abuse. Not always sexual abuse, it also includes high rates of emotional and physical abuse. In

looking specifically at sexual victimization, the study by Earl, Bouchard and Laberge (1984) was examined. They were much more likely to have been victims of sexual aggression as children and adolescents (53 per cent).

In looking specifically at incest cases, a major difference is the extended nature and duration of the sexual relationship (DeFrancis, 1969). As mentioned, it is rare that it occurred only once or twice, often beginning when the female approached puberty and continued until she was 15 or 16. The assaults themselves usually began as fondling and progressed as the daughter grew older to intercourse. The disclosure of relationship is often precipitated by the father's jealousy of the daughters contacts with male peers. (DeFrancis, 1969)

Heterosexual incest is a phenomena which is much more frequently reported than is homosexual incest. (Quinsey, 1977)

Above all it is clear that the incest perpetrator is a multiproblematic client. It is for this reason that Finkelhor's Four Factor model fits so well. One cannot look for a singular cause for this behavior.

4.6 Myths and Fallacies

The reviewed data strongly suggests that it is time to reevaluate our response to this client population. Until now, the response that has been used, does not appear to be working, even though it was founded on some basic, sound principles - those being, to protect our children from further abuse and to make the perpetrator accountable for his behavior (Summit, 1980). We must do more than punish. Incarceration is not enough of a deterrent to end this behavior.

Greer and Stuart, 1983, express some important points and note some societal beliefs which may present problems in working with perpetrators.

> "1) Incarceration is seen as non-productive time, during which, there is little opportunity for perpetrators to receive help or insight into the underlying cause of the the abuse.
>
> 2) There is a disincentive to obtaining treatment following incarceration due to the feeling that the debt to society has been paid.
>
> 3) Incarceration is more costly than outpatient treatment, while doing little or

> nothing to prevent perpetrators from later establishing another dysfunctional family in which children can be exploited.
>
> 4) The necessary financial and emotional hardship on the rest of the family (occur) regardless of whether or not they choose to try and rehabilitate the family as a unit. (p. 212)

The author wishes to express his belief with respect to the use of incarceration with incest offenders. This position is shared with others involved in direct service delivery to this client population. It is that a touch of jail is useful to clearly state society's position regarding their behavior. However lengthy incarceration can often make this client population impossible to work with. It is often the threat of a longer return to jail, should he refuse to participate in treatment, that motivates involvement (Dreiblatt, 1985).

The reviewed data clearly shows us our previous failures with this client population, and the many myths we have about abuse and perpetrators. We must clear up any myths about child sexual abuse that exist. The myth - that the perpetrator is usually a stranger - must be laid to rest. The reality is that the victim usually knows the perpetrator, and it is often a close relation (Finklehor, 1979, Kendell, Tackett & Simon, 1987). As well the image of

the "dirty old man", is incorrect. Most perpetrators are young adults between 20 and 40 years of age (Finklehor, 1984 Groth et al, 1982, Reinhart, 1987).

When examining the current response of society to disclosure, the value and usefulness of incarceration needs to be evaluated. Greer and Stuart, argue that the deterrent value of incarceration is a very poor answer, and support for this approach within the treatment community is weak. The literature strongly suggests, that it is time to do a total reevaluation of our response with some perpetrators.

> "If we are genuinely concerned about combating the sexual victimization of children, we must be humanistic in our attitudes towards the offender, so that we don't inadvertently perpetuate the problem (Groth, et al, 1982).

The current heavy use of incarceration serves two clear and obvious needs of society at large. The first being the legal responsibility as interpreted by the Criminal Code and the judicial system. There is a strong belief that the Criminal Code of Canada demands incarceration as a disposition when dealing with abuse cases. The other is the reality that the judicial system feels responsible to protect society - specifically its children. What better way than to isolate the perpetrator from his victim.

4.7 Prognostic Factors

The author would clearly state that not all perpetrators can be seen as candidates for outpatient treatment. Research clearly shows, that each case should be fully examined and evaluated. When looking at the case, we must examine the effect on victims, method of disclosure, etc. Many of these issues, as well as the response of the perpetrator when discovery occurs, give us an indication of the potential for considering outpatient treatment. (Dreiblatt, 1984, Finklehor, 1984).

The one factor that at times demands isolation or incarceration is the use of violence towards the victim. The dangerousness of an offender, at times, demands his isolation from the community (Groth, 1978). Section 688(b) of The Criminal Code of Canada addresses this issue, and allows for the detention of such perpetrators for indeterminate periods of time. However, the same code also includes a section that authorizes the automatic return of the perpetrator to the community after two thirds of his sentence is satisfied. Prior to being released on his mandatory date, a perpetrator does not have to show any reasons why he should be viewed as a candidate for release.

Release will occur regardless of whether or not he has done anything about the behavior that placed him behind bars (Criminal Code of Canada, Section 672, 1987).

Drawing from the experience of a consortium of professionals working with child molesters and incest offenders, Dreiblatt (1985) has identified the following factors that are felt to predict a safe and positive prognosis for community, non-institutional treatment: has committed non-violent offenses, is experiencing first apprehension, has had offending pattern interrupted, accepts modicum of responsibility for offence, has had some motivation for change, has some life stability and investment in same, has focused problem with risks definable and manageable, is basically honest, has ability to tolerate treatment and willingness to tolerate treatment, has supportive community resources available. (Ellis, et al, 1987).

Research dealing with intrafamilial child sexual abuse strongly suggests that, although work must be done with the total family unit, the total responsibility must be accepted by the perpetrator (Finklehor and Araji, 1983; Rowan and Rowan, 1985).

4.8 Four Factor Model

The author of the study incorporated the concepts expressed in Finkelhor's (1984) Four Factor Model to identify those areas of the perpetrators behavior which warrant intervention. The model allows an individual examination of the perpetrator's behaviors in order to identify probable causes for his involvement with children. This framework was developed after careful review of all relevant literature in this area. Instead of explaining the behavior in terms of a single cause, Finkelhor felt that a much wider approach needed to be used. He saw his four factors for sexual interest in children as complementary processes, and felt that many were present in each perpetrator's repertoire. These four factors are: emotional congruence; sexual arousal; blockage; and, disinhibition.

The factor called Emotional Congruence explains why a perpetrator would find relating to a child gratifying. This factor includes such issues as arrested social development, low self esteem and male socialization to dominance.

The factor called sexual arousal explains why a perpetrator would be sexually aroused by a child. This factor includes such issues as reliving an arousing childhood experience, and child pornography.

The factor called blockage attempts to explain how or why a person is blocked in efforts to obtain sexual and emotional gratification from more normatively approved sources. Finkelhor identifies issues like fear of adult females, traumatic experiences with adult sexuality and repressive social and personal norms about masturbation and extramarital sex.

The last factor Finkelhor addresses in his model is disinhibition. This factor is concerned with the reasons a person would not be deterred by the conventional social restraints and inhibitions against having sexual relationships with a child. Finkelhor identifies such issues as impulse disorder, senility, alcohol problems and psychosis. (Finklehor and Araji, 1983, Rowan and Rowan 1985).

The model presents an organized and comprehensive view of the sexual offence against children that includes not only the role of the perpetrator but also the role of the victim and the environment of the offence. With reference to the perpetrator, the model incorporates all the many factors identified as relevant to sexual perpetrators into a comprehensive formulation that focuses on key issues that predict sexual offending.

The position taken is that the intrafamilial perpetrator is normally not predestined to offend, or as Nicholas Groth states, is not "a fixated pedophile" (Groth, 1978). Instead - as explained by using Finkelhor's model - the perpetrator is an individual who, in addition to being lacking in many areas, also reacts sexually in a totally inappropriate way with his children. These men lack many social skills and are misinformed in the areas of male/female relationships and sexual matters. All of these factors can result in a sense of low self esteem, and in turn a lowered resistance to becoming involved in offending behavior (Finklehor and Araji, 1983, Abel et al, 1984).

In earlier literature, perpetrators were also found to be lacking a positive nurturing relationship from their family of origin.

> "Weiner concluded, incestuous fathers to have a disturbed relationship with their own fathers, who were harsh authoritarians. The sons both hated and admired their own fathers, resulting in passive homosexual feeling for him paradoxically satisfying their longing through the incestuous relationship with their own daughters. (Weiner, 1962).

One can see how this fits into much of the current literature, including the work of David Finklehor and Sharon Araji.

This program focused on some of the issues mentioned in the literature as potentially problematic (Finklehor, 1984, Abel et al, 1984). Those factors covered included dealing with the cognitive distortions which have allowed the abuse to begin, and continue in the man's family (Abel et al, 1984, Rowan and Rowan, 1985), and with enhancing inhibitions against offending and with reducing blockages against appropriate sexual behavior.

4.9 Cognitive Restructuring (5 weeks)

In cognitive restructuring it is believed that if the therapist openly confronts the inappropriate beliefs that support sexual offending and in turn aids the perpetrator to reframe new beliefs to better the societal laws and morals, then the therapist in fact is reshaping the individuals personal belief system (Finklehor, 1984; Rowan and Rowan, 1985). Attempts were made to break any misconceptions the perpetrators held about the lack of effect their actions have had on the victim, as well as clearing up any misconceptions about the role of the victim in the assault (Sgroi et al, 1982).

The reality of a victim's plight was shown to the perpetrator by using two video resources, (Untold Secret, 1984, and, Men who Molest; 1985) both of which clearly illustrate these points. The major uses of the video material was to show the perpetrator the massive impact his actions have on the victim, and to illustrate the way other perpetrators rationalize their behavior (Finklehor and Araji, 1983).

4.10 Covert Sensitization (4 weeks)

Covert sensitization involves getting the perpetrators to use fantasy to help control their deviant arousal patterns to children. Research has shown that often these men have used fantasy about sexual involvement with children to break down the barriers preventing actual abuse (Groth, 1978). By using covert sensitization a therapist can re-educate the perpetrator about the realities of his inappropriate behavior (Abel et al, 1984, Rowan and Rowan, 1985).

Covert sensitization is the process whereby the perpetrator is first put at ease and then asked to develop a picture of his deviant chain of arousal. Once this is identified, he is instructed to break the chain early in the arousal pattern by imagining an extremely psychologically

painful discovery scene. These aversion scenes are drawn from ones identified by the perpetrator as being personally painful. Continual linking of the deviant arousal to the aversion scene makes it clear that inappropriate arousals result in personal pain upon discovery. The aversion scene and the pressure it places on the perpetrator is relieved by using a escape scene. The escape scene is usually a pleasant scene, involving sexual contact with a consenting adult partner, which therefore links arousal to an consenting adult rather than a child. When repeated often, this process is found to be an effective tool in working with sexual perpetrators by helping the therapist lower the perpetrator's drive to reoffend (Abel at al, 1984, Rowan and Rowan, 1985).

The therapist spent the four weeks going through each scenario repeatedly to directly confront the deviant arousal scene with an aversive discovery scene that has been personally selected by each perpetrator (Abel et al. 1984). As well, each perpetrator was given the assignment of repeating the exercise at least twice during the week into a tape recorder. This allowed selective checks of the process by the therapist to insure compliance and understanding (Abel et al, 1984). It is the use of multiple sessions, and the focused nature of the exercise, which was seen as

important in helping the perpetrator to appreciate and internalize the inappropriate nature of the sexual contact with the child (Langevin, 1983).

4.11 Sex Education (4 weeks)

The next focused area of intervention is sexual education. The literature argues that inappropriate knowledge, or total lack of knowledge, can often be seen as a contributing cause of some sexual misbehavior (Abel et al, 1984, Rowan and Rowan, 1985, Groth, 1982). The intention was to provide the perpetrator with factual information on issues of sexuality. The issues covered included anatomy, sexual life-styles, sexual dysfunction, conception, and contraception (Abel et al, 1984). The film, "Am I Normal" was also shown, to demonstrate normal sexual experiences. The anatomy discussions were aided by diagrams of both sexes. The men were also given reading assignments each week on human sexuality.

4.12 Control Plan

This package was drawn together over the two weeks following completion of the previous material. The major purpose was to develop a personal control plan for each man. The literature clearly states that it is control of the

offending behavior which is the aim of intervention with incest perpetrators (Abel et al, 1983; Dreiblatt, 1985). The plan shared with the perpetrator, was one proposed by Gene Abel and associates (Appendix 1). The aim was to get each man to use this plan as a guide in developing one which fits his own situation.

The hypothesis being presented is that the incest perpetrator can be taught to monitor and control his deviant urges to offend. The literature suggests that, if the perpetrator has taken some ownership of the problem, and if the therapist has the power of the court to ensure involvement, then positive movement is possible (Abel et al, 1983, Rowan and Rowan, 1985). The literature points out that the perpetrator is a man who is often lacking in both personal strength and knowledge. During both assessment and intervention phases the therapist attempted to identify and lessen these weak areas. Identification and clarification aided the perpetrator in their personal plan to control sexually inappropriate urges. The use of Finkelhor's framework gives the therapist an opportunity to: evaluate each man as a unique individual; identify the areas of concern; and, focus the intervention to fit each perpetrators situation (Finklehor and Araji, 1983). This in turn was used to provide the perpetrator with the

information he needed to develop his own personal control plan. The ultimate aim of the intervention was to give the perpetrator the skills to break his offending cycle (Dreiblatt, 1985). This allows the offending behavior to end, thereby lessening the likelihood of the family system turning to, or continuing in, a pattern of multigenerational abuse (Gelinas, 1983).

4.13 Conclusions

In conclusion, the perpetrator is an individual who has abused his position of trust and responsibility within the family. However, if the perpetrator is able to accept responsibility for the abuse, he can be taught to control his deviant arousal to children. If so motivated, his skill and knowledge level can be enhanced. He must then make this a part of his day to day behavior for the rest of his life. We are not saying that he will offend again. However, having acted inappropriately, the risk of reinvolvement is much higher unless he continuously monitors himself.

The other important point is that in dealing with an involuntary client, the therapist needs the support of the court to ensure compliance and attendance during the intervention (Groth, 1978, Finklehor, 1984). These are men who must be monitored for as long as the law of the land

allows us. In Canada, community monitoring through probation supervision lasts a maximum three years. The negative behavior has usually been part of the perpetrator's life for a period longer than three years, therefore reconditioning him, may take years. As community agents we must make effective use of the time we have. The development of this type of intervention strategy is a direction the community should be taking.

5 Rationale

RATIONALE

The behavioral techniques used in this study have been designed to promote behavioral change in perpetrators of child sexual abuse. This was done by confronting inappropriate beliefs, increasing factual knowledge, and controlling inappropriate behavior (Abel et al, 1984).

The use of the techniques decided upon for this study have been shown by other researchers and clinicians to be appropriate intervention tools in dealing with this social problem (Dreiblatt, 1985, Abel et al, 1984, Rowan and Rowan, 1985).

It must be made clear, that in this study, only selected techniques are being used, which meet only a part of the therapeutic needs of this multiproblematic client population (Abel et al, 1984, Finklehor, 1983).

5.1 Cognitive Restructuring

Cognitive restructuring has been used successfully with this client population, both in inpatient programs and community based programs in the United States and with

increasing frequency in Canada. The focus of this technique is to cause the perpetrator to first identify, then acknowledge, the distortions of reality he has incorporated into his belief system and which in turn lowered his inhibitions to offend.

Cognitive restructuring is a mainstay of the treatment process in most of the programs where it is used (Abel et al, 1984, Rowan and Rowan, 1985).

The therapist uses confrontation to cause the perpetrator to see how his beliefs have allowed the abuse to occur and continue over time. The perpetrator was made to realize, that he alone is responsible for the abuse. This may stem from individual beliefs he has about himself, based on childhood experiences or other factors discussed in Finklehor's, Four Factor Model, (Finklehor, 1984,) all of which, have resulted in the sexual assault of his child - an act which contradicts all culturally dictated ways of treating our children.

5.2 Covert Sensitization

Covert sensitization is a behavioral technique that is included in many of the treatment modules currently used with this client population. The focus is to help the

perpetrator gain self control of his arousal patterns through aversive conditioning. The first stage of treatment is to get the perpetrator to identify his own offense cycle and arousal cues. In applying the behavioral techniques used by Abel and associates, the perpetrator's arousal is attacked as his offense cycle begins by having him verbalize and expand on the feeling of being discovered by a significant adult. The use of multiple repetitions, both during treatment sessions and taped homework sessions, has been shown to reduce the arousal to the inappropriate stimuli he may previously have acted upon (Abel et al 1984, Rowan and Rowan 1985).

5.3 Sex Education

The lack of factual sexual knowledge is a consistent problem identified in men who sexually abuse. This study will offer a structured curriculum, which will deal with all relevant areas of human sexuality. In other treatment models this again is seen as an area of major significance and need (Abel et al, 1984, Rowan and Rowan, 1985).

5.4 Court Mandate

This writer contends that the client's involvement must be mandated by the court, prior to enrollment in the program. As noted in other offender programs, the client is not a voluntary participant (Dreiblatt, 1985).

5.5 Individual vs. Group

Because of limitations in time and referrals, the decision was made to offer programming on a one to one basis. It should be noted however, that except for the aversive conditioning module the components fit well into a group model. In examining other programs, use of both group and individual are seen as appropriate (Dreiblatt, 1985, Abel et al, 1984). The writer's intention is to utilize these techniques in other situations in a group format with a female co-therapist.

6 Assessment and Evaluation Procedures

6.1 Objective

The overall purpose of this study was to help men, who sexually abuse children in their family, to gain control of their inappropriate behavior and to appreciate the damage incurred by their victims. The specific goals of the intervention were as follows; (1) to get the men to identify the rationalizations they used, which allowed them to offend, (2) to understand and identify their own offense cycle and teach them to break their arousal through a aversive behavioral technique; (3) to dispel, through a sex education curriculum, any myths the perpetrator may have internalized in this area, and; (4) to help them increase their own self esteem by feeling in control of behaviors which previously have caused pain to themselves and their families.

6.2 Subjects

The subjects were three men, who were referred to the Psychological Services Center, University of Manitoba, for this therapy by their Probation Officers. The participants ranged in age from 26 to 36 with a mean age of 31. Of the three men referred, all completed the full term of therapy.

This perhaps can be linked to the fact all three were carefully screened, and each had a condition attached to his probation order that required involvement in such a program.

Admittance to this treatment modality was based on the following criteria identified from the literature as predicting positive prognosis and safe community management.

1) The individuals had to be referred by their probation or parole officer, and attendance had to be a condition of a court disposition of a sexual assault by the perpetrator against a child in an intra familial relationship.

2) The individual must have accepted at least a modicum of responsibility for the assault.

3) The perpetrator must not have a criminal history of similar sexual assaults.

4) The perpetrator would reside in the community, and not be incarcerated.

5) The perpetrator must be free from any drug and alcohol dependence.

6) The offense could not include physical injury to victim or the use of physical force against the victim in the commission of the offence.

7) The participant agrees to sign all release forms as required by the therapist and the Psychological Services Center.

8) The perpetrator understand that failure to complete the program would result in a referral of the matter back to the probation officer, and perhaps the court.

6.3 Assessment Procedure

Prior to implementation of the intervention, a four week assessment period was completed with each individual. The protocol used (appendix 2) gathered relevant history around the development of clients' sexual knowledge and attitudes. Issues identified included: "Where was sexual knowledge gained?"; "Was the client a victim of abuse or early sexualization?"; and, "What were the roles of significant family members and siblings in developing his relationships and sexual knowledge base - either through observed behavior or direct involvement?". A similar examination was made of the relationship he had with his partner and children at the time of the abuse.

Two key issues also had to be dealt with during assessment and intervention. The first was the perpetrators attitude towards sexual behavior involving children. The second was his attitude towards himself.

The Attitude Inventory (A.I.), used by Abel and associates, 1984 Appendix 3) was administered to identify specific beliefs which required modification during intervention. The attitude towards self was measured through use of the Hudson Index of Self Esteem (ISE), (Appendix 4) to track clients perceived image of self.

6.4 Variables Evaluated

The variables examined during the study were: the attitude of the perpetrator towards the offense and its impact on victim, and the perpetrator's own self image - often seen as a contributing factor to an offence. Each of these variables were evaluated both during assessment and intervention phases. During assessment, assessment instruments were administered on three occasions, and during intervention before and after each component of the module.

The final variable to be evaluated was the client's sexual knowledge. This was checked through a sexual

knowledge checklist (Appendix 5) administered before and after involvement in that portion of the intervention package.

6.5 Measures

The Attitude Inventory (AI), (Abel et al, 1984), a type of self anchored scale (Bloom and Fischer, 1982), was used as one of the repeated measures.

As Bloom and Fischer state, self anchored scales must be based on the clients perceived desired outcome. Although these men are required to attend, they all have accepted at least a portion of the responsibility for the offense and want to gain control of their behavior. This scale, because it addresses issues common with most men who are sexually inappropriate with children, was therefore seen as an appropriate tool to use. Bloom and Fischer regard self anchored scales as appropriate measures, which appear to be sensitive to change.

6.6 Reliability and Validity

In examining these issues in relation to this scale validity and reliability data on Abel et. al. scale are not reported and were not available. Bloom and Fischer identify

a number of specific points in examining the face validity of self anchored scales. Firstly, this type of scale must be seen to have face validity. Secondly, they must measure things "only the client can report on, and so they represent his or her most accurate portrayal of the circumstances, thoughts, or feelings" (Bloom and Fischer, p. 169). As the Abel scale fulfills these criteria, they can be seen to have face validity according to the Bloom and Fischer definition.

6.7 Limitations

The weakness of this type of scale is certainly its lack of established reliability and validity checks. It is with limited statistical confidence that one can draw inferences from the data gathered from such instruments. Another weakness is possible reactivity based on the self report nature of scale. Because the perpetrator is very aware of the social desirability of his answers, he may use some which fit the norms of society. These in turn may effect the information gathered and bias any observed outcomes (Bloom & Fischer, 1982). It is argued however that with proper instruction as to its use and purpose, these types of scales are the only ways we can get a real picture of clients' thoughts and beliefs (Bloom & Fischer, 1982). As well, the

client is advised that honest responses will make the data collected useful for him during treatment for the identified problem.

6.8 Hudson Index of Self Esteem (ISE)

This standardized measure (Hudson, 1982) was used to evaluate the impact of the intervention program. The perpetrator often has an extremely low level of self esteem. This is seen both as a contributing factor prior to abuse, as well as a significant factor on his functioning once the confrontive nature of the intervention begins to break down his individual defenses. These defenses often allowed him to become active in the negative behavior of the past.

The instrument is comprised of a twenty-five item scale by which, responses are indicated on a five-point Likert scale ranging from 1 (rarely or none of time) to 5 (most or all of the time). The clinically significant cutting point for low self esteem is 31 and above. The scale measures the degree or magnitude of a problem the client has with his self esteem.

This scale was chosen because of its ease of administration and ease of collation. As well, it has been shown to be an accurate and reliable measure and is also

acknowledged to be sensitive to observable change. It has been shown, through repeated use, to have high stated internal and test-retest reliability correlations of 0.90 (Hudson, 1982). The scale also has high face, concurrent, and construct validity (Hudson, 1982).

The only limitation seen, as with other scales used, is its possible reactivity due to the nature of the identified problem. Again, this problem is controlled by telling the client that honesty is in his best interests.

6.9 Sexual Knowledge Scale

This scale was developed by Abel and associates to measure sexual knowledge. It is a self anchored scale which, by design, has high face validity because it is specifically designed to measure knowledge before and after intervention. As with other scales developed by Abel and Becker, no reliability or validity data are reported. This scale was used to ensure that the individual's misinformation about sexuality could be identified and correct information provided during the course of the intervention.

6.10 Client Satisfaction Questionnaire

A client satisfaction questionnaire (Appendix 6) was administered at the completion of the intervention program. This allowed the client to give feedback about the impact of the package, and presentation by the therapist to identify the benefits of the package to himself. Because these questionnaires can be subject to biases, such as a desire to please therapists, the client was instructed at length about the value of being honest and precise in his responses.

In summary, three measures were used in the measurement process. The Attitude Index and Hudson S.E.I. were administered on a regular basis during both assessment and intervention phases. The sexual knowledge scale was administered on a pre-post basis, to measure for any change in sexual knowledge following completion of that portion of treatment.

6.11 Evaluation Design

This program utilized the A-B basis single system design (Bloom and Fischer, 1982).

6.12 A-B Basic Single System Design

This design, consisting of two distinct phases, was used to evaluate two variables, the perpetrators attitude to offence and impact on victim, and his own feelings of self worth. This design was used to evaluate any alterations in client's attitudes to the offence and in client's self esteem. First it was used to give the perpetrator a picture of his own beliefs and history. From that information the therapist was able to identify areas of behavior which required modification. As well, the A phase was used to establish a base line which represented the client's level of functioning and knowledge before intervention. The B phase refers to the intervention, the behavioral techniques which were used to confront and modify inaccurate knowledge and inappropriate beliefs. The modification of attitudes and beliefs gives the perpetrator some tools to help him control the likelihood of reoffence.

6.13 Advantages

Bloom and Fischer (1982) identify a number of advantages of using the A-B design. First, it is a time series design which enables the practitioner to obtain repeated measures of participant's progress throughout assessment, intervention, and follow-up phases. This allows the therapist to

give the perpetrator feedback as to progress. The design allows for an examination of the problem, for providing knowledge and control of behavior during intervention, and for comparing this to the client's starting point during assessment. And finally, because accountability is a key issue, the measures used can be shown to therapist, the perpetrator, the referring agency and society to give a picture of the client's progress.

6.14 Limitations

The primary limitation of the A-B design is the fact that it does not control for threats to internal validity; subsequently, there may be other factors which could be explanations for changes in behavior (Bloom & Fischer, 1982). Pressures that a perpetrator experiences from family, courts, and external agencies, is an example of the potential for external factors that can effect treatment outcome. The perpetrator's change may have already begun due to the above pressures prior to beginning treatment. However what we can observe by examining the base line is that change which occurs as the client begins and continues in treatment.

This study attempted to avoid threats to internal validity by noting changes in clients during the

intervention. Each session began with a review of the week and discussion of any stresses the perpetrator may be experiencing. It should be noted that on two occasions stress was so high that a session was spent dealing with those issues instead of new treatment issues. As well, by examining the data across subjects, one is able to look at lessening the threats. Repetition of these observations would add strength to any statements made regarding its impact.

6.15 Data Collection

To establish a base line The Attitude Inventory (A.I.) and the Hudson Scale (SEI) were completed by the clients on at least three occasions on a weekly basis during the A phase. This ratio is suggested as being necessary to give us a picture of the client's level of knowledge, etc., prior to B phase (Bloom & Fischer, 1982). On a regular interval during the B phase, before and after each module of the treatment regime, the two scales were completed by the client. Also the sexual knowledge questionnaire was administered before and after that portion of treatment module to observe effects on the perpetrator's personal sexuality knowledge. All measures, were readministered at a

six week follow up session Finally, the client satisfaction questionnaire was distributed at the termination session of the program.

7 Intervention Procedures

For the purpose of this study treatment was done individually with three convicted incest perpetrators. While these men certainly require much more in the way of intervention, not only for themselves, but for their victims and their spouses, the focus of the intervention, provided by this study, was a behaviorist approach, administered on an individual basis, specifically to deal with the perpetrator's sexually inappropriate behavior.

It should be noted that comments are made about other perceived approaches and the treatment needs of these men, in the discussion portion of the paper.

The treatment protocol was offered in three distinct stages. Each stage dealt with information gathered during the assessment phase as well as with other issues identified by the therapist. Linking the individual's needs and problems with those described in Finkelhor's Four Factor Model was the framework used. The descriptions used to describe the three stages of treatment were drawn from Ellis, Hartry, et al, (1987)

7.1 Cognitive Restructuring

A perpetrator holds a number of beliefs which limit his ability to control his offending behavior. This module

focused on these beliefs using Finkelhor's Four Factor model as a guide. The perpetrator is often an individual who has suffered abuse as a child. As a result he may develop beliefs about himself and his experiences, which may show themselves through his acting in a sexually offensive manner. Such experiences fit well into Finkelhor's Precondition I: Emotional Congruence. The perpetrator may also have beliefs about parenting, formed through observations of his own parents which influence the role he feels he should play as parent. Such beliefs are encompassed by Finkelhor's model as he describes the effects parenting can have in Pre-conditions I, II and III. Each factor has a great deal to say in helping to explain how these men change from being a parent to the child to taking the child as a sexual partner. The final key point was to help the perpetrator identify his rationalizations which allowed the behavior to occur. The man must be confronted with these rationalizations to help him avoid similar difficulties in the future.

Cognitive distortions relevant to offending are identified through the client's individual history, police reports, and statements to other professionals. These beliefs are exposed for what they are to the perpetrator. This process was also achieved through role playing the

beliefs other perpetrators hold about offending behavior.

The major objective and focus was to confront each rationalization, and attempt to show the perpetrator how his belief in them has allowed him to breach a well established cultural taboo in our society. The perpetrator was then taught that he must be careful for the rest of his life not to make similar rationalizations a part of his belief system. The therapist utilized two videos during this module, to help break down the perpetrator's defensive wall. The videos were "Men Who Molest" (Appendix 7), a descriptive overview of a similar program in Washington State - and "Incest, The Untold Secret", (Appendix 8) - a video which dramatically shows the effects incest has on the victims of this offense.

7.2 Covert Sensitization

The second module consisted of teaching the perpetrator the behavioral technique of covert sensitization. As described by Abel et al (1984), covert sensitization is a guided imagery technique whereby the patient interrupts a fantasy approximating the cycle of his sexual offence with a image of an aversive consequence for involving himself in the behavior. The individual was instructed to pick his own aversive image - one which has a great personal meaning and

impact. The perpetrator was instructed to use the technique, and expected to practise it with the therapist. As well, he was expected to complete at least two taped sessions each week as a homework assignment. The tapes were spot checked by the therapist.

Each covert sensitization cycle begins with a neutral scene. Then the perpetrator describes his offence cycle out loud, and then interrupts this cycle prior to assault with an aversive image. The final stage is an escape scene, where the offender is encouraged to channel his arousal to an age appropriate consenting partner. The perpetrator was shown how he can use this technique to assist himself if he felt inappropriate arousals, which could indicate a increased chance for reoffence.

7.3 Sex Education

This treatment module dealt with another identified area of concern in most men who are sexually assaultive. Most of these men have been found to be lacking in knowledge about sexual functioning, anatomy and behavior. The curriculum developed was designed to ensure correct information for each perpetrator in order to avoid any misinformation which in the past may have contributed to offenses.

As discussed, each individual perpetrator referred for this study had the benefit of each of these modules on an individual basis. The final two weeks were spent helping the perpetrator develop a personal control plan to prevent reabuse, which was incorporated in its contents all the material offered to him.

7.4 Didactical and Printed Materials

The program consisted of several mini-lectures, which were designed to expand the perpetrators knowledge about sexuality and its impact on himself and others. The sources of printed materials used are identified and discussed in the section of the report which examines the content of sessions.

7.5 Role modeling

The therapist also used himself as a model for comparison. This was especially useful when discussion centered on many of the myths we as men carry with us.

7.6 Feedback and Reinforcement

Although the feedback to the perpetrators was not always totally positive - strong efforts were made to support the men whenever possible. The therapist gave special

recognition to any intimate sharing - as the men found this so uncharacteristic from their normal experience of interactions with another man. The most obvious example of this was the difficulty the men had discussing their sexual histories. In the cases of two of the men - this involved sexual victimization as a child, a point they had a great difficulty discussing.

8 Content of Sessions

8.1 Mr. K.

Mr. K. is a 31 year old separated male. The separation resulted from his conviction for sexual assault of his 7 year old step daughter. The assaults occurred on numerous occasions, and came to the attention of the legal authorities only after his second detection by his spouse.

On the first occasion his wife went to the pastor of their church and the situation was not brought to the attention of authorities. Mr. K. comes from a fundamentalist religious background as did his wife. Because the church was such a major part of their lives, his wife felt the matter would be brought under control. However, the behavior did not stop for long, and when his wife was told of the new assault by her daughter, the police were called. The abuse

involved fondling of the child's vagina during dressing and bathing, and mutual fondling in the bedroom. As a result of the police investigation, charges were laid and a conviction secured. The disposition of the court was three years probation, no contact with the victim, and attendance at an appropriate therapy.

After the conviction Mr. K. left the town where his wife and the victim resided and moved to Winnipeg to enter studies at the University of Manitoba. At the time of the study, he was in the second year of his studies, taking numerous language arts (e.g. French, German etc.). Also, as a result of his conviction he was excommunicated from his church, an organization he was heavily involved with and dependent upon.

Mr. K.'s early history is quite consistent with other abusive men. He was raised in a very authoritarian home, with his father being very firm and not especially supportive to his children. The only time he remembers contact with his father was when he was bad. He remembers his mother as being very submissive and often the recipient of verbal and physical abuse from his father. This abuse also took the form of her knowledge of her husband's infidelity.

Mr. K. received no formal sexual education from his parents. His own interest and peer discussions were all he remembered. Mr. K. also remembers sexual experimentation with his sibling as a youngster. This took the form of mutual masturbation with three of his four brothers. One of his most significant memories is the death of one of his brothers - one of the three he was closest to. Mr. K's oldest brother, whom he describes as being his father's favorite, really wasn't someone he saw as being really close to.

8.1.1 Session 1 Cognitive Restructuring (C.R.)

The first session was spent preparing Mr. K. for the subject matter we would be discussing. As we moved into cognitive restructuring it was important for the subject to fully understand the concept. As well, it was important for him to see how, in the past, he has perhaps minimized his behavior and its impact on the victim through his beliefs.

To begin the treatment program, the subject was shown two videos, to firstly focus him on the nature of the model and secondly to impress upon him his responsibility to own the problem and examine fully its impact on himself and others.

"Men who Molest" - Appendix 7, Public Broadcasting - Frontline -1986

This is a tape showing a program currently used in Washington State. It gives the subject a chance to observe the techniques to be used, and observe other men who have offended as well as a bit of the impact the behavior has had on the victim.

"Incest, The Untold Secret" Appendix 8, 1984.

This tape presents the stories of a number of victims of incest. It shares their pain, guilt, and trauma. The tape is shown to again focus the responsibility where it belongs - on his shoulders as the perpetrator.

As one might imagine this session is extremely painful for the perpetrator. The therapist acknowledged this to Mr. K., however he also added that is a necessary step he must take on the road to better controlling his inappropriate behaviors. The discussion following the tapes is meant to acknowledge the subjects desire to gain control of his behavior. Mr. K., although depressed, acknowledged that he now sees he used many of the same rationalizations prior to

his assaults. He sees many of the items he must work on during therapy. As well he admitted, for the first time, a real sense of the pain he caused his daughter.

8.1.1.1 Wrap up

The therapist closed the session with a review of the intended purpose and key points in the tapes, as well as acknowledging Mr. K.'s efforts and honesty, shown when he discussed and examined his own scenario in the context of the material presented to him.

8.1.1.2 Homework

Mr. K. was told to develop his own list of distortions. The therapist explained his list would be discussed and added to if necessary, with items gathered either from the assessment or from a review of the referral documentation.

8.1.2 Session 2 - C.R.

The first few minutes were spent reviewing the previous session, and Mr. K.'s feeling both about the material and his current state of mind. Again it is seen as very important that the discussion of any difficulties which may limit his attention to the material presented be dealt with prior to the actual session beginning.

8.1.2.1 Mini Lecture

The next portion of the session was devoted to a mini-lecture explaining the term Cognitive Restructuring and how this module will be presented to him. The importance of developing his list of the distortions he used prior to his assaults is expressed at length. The therapist then explains that to aid that process we will be using role plays of other perpetrators' rationalizations shared by, Abel and associates (1984), in their treatment manual. To help him really examine these, the therapist will reverse roles with the perpetrator, having him take the role of a interviewing authority figure. The goal of this process is to get the perpetrator to see the weakness and incongruous nature of the beliefs. (Appendix 9). Mr. K. has some difficulty completing role plays. He attempts at times to be too intellectual. Mr. K. was confronted and told to follow instructions to the letter. He discussed his own distortions, and acknowledged the fact that he felt his behavior was better than cheating on his wife. He also admitted that he needed comfort he wasn't getting from his wife.

8.1.2.2 Wrap Up

Again a review of material presented and acknowledgment of Mr. K.'s efforts during the session. Discussion of any perceived difficulties and his understanding of content completed with therapist.

8.1.2.3 Homework

Discuss situation with ex-wife by phone to see if she can help with his distortions.

8.1.3 Session 3 - C.R.

8.1.3.1 Review of Week

The subject is encouraged to share any information about the previous week. Again importance was placed on having the subject free of any baggage which might limit his abilities to participate. As well Mr. K. was asked to give the therapist a quick review of the material discussed last week as well as sharing his list of distortions.

8.1.3.2 Session

Again role reversal was used with the therapist acting out distortions from the Abel list. As well, the therapist

used examples drawn from Mr. K.'s list. The subject was instructed that his position must really show the perpetrator why the distortions are distortions and why they are inappropriate. Remainder of session spent going over two examples: The first being his distortion that a 7 year old can take the place of an adult contact, both sexually and to provide him with emotional needs, and his rationalization that his abuse really wasn't that serious, "only" fondling.

8.1.3.3 Wrap Up

The material presented was reviewed, and subject given feedback as to his strengths or weaknesses at his role. He was asked to share any feelings about the distortions used by the therapist if they represented his position at the time.

8.1.3.4 Homework

The subject was instructed to be prepared to present his list to therapist next week to allow therapist to role play his own rationalizations. Again the therapist explained the importance of honesty as the purpose of this whole exercise is to increase his ability to control himself and save all parties involved from further pain and anxiety.

8.1.4 Session 4 C.R.

8.1.4.1 Discussion of Homework and Review of Week

Mr. K. again explained in a spontaneous manner how for the first time he saw he in fact did use distortions of reality to allow his behavior. He realized that in the past his minimization and blaming caused him to see himself as the victim. The two major points presented were that he saw his assault as very minimal - as he described it "only touching". Another point was that he felt his daughter would grow out of it. He usually saw how he blamed his spouse for not keeping him happy sexually. Each of these were acknowledged as key points he had to work at controlling. The therapist added his efforts were well appreciated and acknowledged.

8.1.4.2 Session

The role plays used this week were those given by Mr. K as ones he used. Again, Mr. K. was pushed to really show the therapist how weak and inaccurate they were. Excellent role playing session with Mr. K using real effort to show the inaccurate nature of these beliefs.

8.1.4.3 Wrap Up

Review of week, and again supportive comments to Mr. K on his efforts at self evaluation.

8.1.4.4 Homework

The only request was to have Mr. K do a final examination of his own situation to see if any stones have been left unturned.

8.1.5 Session 5 - C.R.

8.1.5.1 Introductory Material

The session began with the completion by Mr. K. of the Attitude Inventory and the Hudson Index of Self Esteem. As well the weeks review of Mr. K's life events occurred.

8.1.5.2 Discussion of Homework

Mr. K. again acknowledged further soul searching and review of material. The one point he saw as most important was how, at the time of the assaults, he saw himself as a victim. He described his inability to have any female friends outside his marriage and the lack of this friendship within his marriage.

He also felt his very conservative, fundamentalist background prevented him seeking this outside the marriage. He in turn saw how he began to see his young daughter as a mini adult, with whom he attempted to gain things he did not have in his marriage. He could now see that he is the only person responsible for the assault. As he said, he is the one who knew better, his daughter was just doing what kids are taught to do, listen to their parents.

8.1.5.3 Session Wrap Up

Final session was used to tie together the material presented and show Mr. K. how he must work to avoid similar difficulties in the future. The subject was told, that he is the one who must work at changing his behavior, not anyone else. As well, he must take extreme care that he doesn't allow himself to ever again use rationalizations. This demands that he watch all situations involving kids, and avoid any unnecessary testing of his ability to control himself.

8.1.6 Mr. "K" Covert Sensitization (C.S.) Session 1

8.1.6.1 Review of the Week

The first item of business was to have the client complete all necessary questionnaires.

8.1.6.2 Mini Lecture & Session

The instructions on the techniques and its use were given as described in previous section, Intervention Procedures - 5.2. Covert Sensitization page 48.

In Mr. "K's" situation specifically he developed a personal list of aversive scenes and identified his chain of arousal.

Mr. "K's" chain of arousal always began the same way - his being alone at home when his daughter came home from school. She arrived home before her sibling because she attended school in close proximity to the family home. When she came in, he would ask her to go upstairs to play their secret game. He always saw her willingness to do so as an indication that she liked the game. The game involved mutual fondling, his to the point of orgasm with his clothes on.

The next agenda item was to get Mr. "K" to describe his discovery scene. All of his examples involved discovery by his wife and information coming out in the community. Mr. "K" did not use any scene he himself had not experienced,

many were very powerful for him.

In his neutral scene Mr. "K" used numerous variations of a scene involving him going for a walk on a summer evening around a small lake in the country.

Mr. "K" chose sexual involvement with his current girlfriend as his escape scene. He also used a non-sexual scene involving a woman he would like to get to know.

8.1.6.3 Homework

The perpetrator was instructed to complete a tape of at least two complete sequences of the technique. The therapist advised him that the tapes would be spot checked to ensure compliance and understanding

8.1.7 C.S. #2

8.1.7.1 Review of the Week

The session began with a review of the week, and verification of compliance in completing the homework assignment. Again Mr. "K" was told the importance of using this technique, if he finds himself being aroused by a child. The technique was again completed by the client as

the therapist monitored to guarantee completion. If monitoring identified areas that needed work the client was advised and coached to increase the impact.

Mr. "K" reported that it was difficult to complete the exercise with the therapist in the room. The therapist took a firm stand, indicating the importance of ensuring compliance, but also acknowledged that he appreciated the difficult nature of the exercise. The client was reminded that he had to complete the technique, if he really wanted to gain more control over his behavior. The therapist gave Mr. "K" support for the effort he showed in working through this week's session.

8.1.7.2 Homework

Mr. "K" is again instructed to complete another tape and also that feedback will be given on tape handed in from the previous weeks homework assignment.

8.1.8 C.S. #3

8.1.8.1 Review of the Week

Mr. "K" was given feedback on his first homework tape. The client was told that he had a good understanding of process, however both steps were too brief. He was

admonished that on one occasion, he mentioned actually touching the victim. Mr. "K" stated he had realized that he had, and that he was going to advise the therapist but forgot. Mr. "K" also advised that when developing an aversive scene, he wanted to add a new one. The scenario involved being discovered by his wife, who stated that as a victim of abuse herself, she could not believe the man she married could do this to her children. This truth is something Mr. "K" experienced in his own situation, and is also one that really hurt him.

The session moved on to the client completing two sequences of the technique. Mr. "K" showed good understanding and compliance.

8.1.8.2 Homework

Mr. "K" was to complete a homework tape on at least two occasions during the week.

8.1.9 C.S. #4 Last Session

8.1.9.1 Review of the Week & Homework Tape

The client reviewed the week's activities, commenting that the pressure of school had been increasing and making time to do the tape, harder o find. Therapist restated the

need and importance of completing all homework assignments during treatment. Mr. "K" also advised, that he was using a new aversive image. He advised, he now recalls that his wife had been a victim of sexual abuse at the hands of her father, and that the pain he saw in her face, when she discovered his abuse, had much more meaning to him.

8.1.9.2 Session

Mr. "K's" understanding of the concept was very solid, however he still tended to shorten the length of the scenario. During this week's exercise, the therapist watched the time closely and pushed the client to complete every section completely.

Mr. "K" shared personal information, and stated he finds it difficult to do the exercise because he now sees the pain he has caused. The therapist explained that keeping this clear in his mind is very important so that he can control the behavior he dislikes so much.

The session ended with completion of the self esteem index and attitude inventory.

8.1.9.3 Homework

The client was asked to complete a final homework tape. Again, he was advised that it would be checked and discussed at the next session.

8.1.10 Sex Education (SE) Session # 1

The session began with completion of forms, Hudson (S.E.I.), Attitude Inventory and Sexual Knowledge Inventory (Abel et al, 1984). This last measure was used as a pre - post test, of improved understanding of sexuality information.

8.1.10.1 Mini Lecture

The session then moved on to a mini lecture on the need and value of the information. Mr. "K" was advised that incomplete or inaccurate sexual knowledge, is common to this client population. He was advised that the therapist feels that a program was necessary to insure accurate knowledge, as it is difficult for anyone to admit a lack of personal knowledge about human sexuality.

The next portion of the session was spent watching a short film on adolescent male sexuality entitled "AM I NORMAL; 1979 (Appendix 13). This short film depicts a young

man searching for answers about his own body and human sexuality. The therapist used the film to lower tension and address some basic issues about male sexuality, e.g., masturbation, wet dreams, erections, etc.

8.1.10.2 Homework

Mr. "K" was given some reading assignments this week - a short article on male myths. (Appendix 11).

8.1.11 S.E. Session #2

8.1.11.1 Mini Lecture and Check on Knowledge

This session was spent on a discussion of male and female anatomy. Prior to the mini lecture Mr. "K" was asked to name various parts of male and female genital areas. This was achieved by having the client fill in appropriate names besides a diagram which was provided (Appendix 14, 15). In the client's copy of these diagrams, all parts are left unlabelled. The client was instructed to use the correct name if possible, otherwise, whatever name by which he knew the body part.

The therapist then moved into a mini lecture on male and female anatomy, checking the client's understanding, as we got to it in notes, again using the client's diagrams. Mr.

"K's" knowledge in this area was fairly sound, however there was some difficulties especially with female anatomy. the session was highlighted by excellent discussion and effort by Mr. "K".

8.1.11.2 Homework

Mr. "K" was given a general article to read in the area of venereal disease (Appendix 10) and a general article on sexual dysfunctions (Appendix 16). These were given to hopefully stimulate discussion, if either area needs more discussion during our meeting.

8.1.12 S.E. Session #3

8.1.12.1 Discussion of Homework

Mr. "K" came with a number of questions about venereal disease. The therapist asked the client to make a note of them, and was also encouraged to seek out answers himself prior to us covering material in our next session.

8.1.12.2 Mini Lecture

This portion of the treatment was very much in lecture format. However, this met the identified goal of dispelling misinformation and lack of knowledge. This session covered

areas of conception and contraception. Mr. "K" felt that all responsibility for contraception should be with women. This view was discussed stating the responsibility should be taken by both and must be mutually agreed upon. There was extra time spent discussing vasectomy and the need and proper use of condoms. Mr. "K" lacked a great deal of information in this area. As mentioned he felt that the major responsibility for contraception should be the woman's as he went on to describe a situation using biblical references to argue his point. Mr. "K" was confronted on his beliefs, telling him without any opportunity for rebuttal that his response must be seen for what it is, a belief in the need for men to be dominant in their sexual relationships. The therapist stated clearly this is another rationalization he must work on to prevent himself from perhaps using it in the future to make his involvement in an unplanned pregnancy totally the woman's responsibility. The client was told clearly that he and his partner must mutually agree upon what methods of birth control are necessary, and that it cannot be a subject that is left undiscussed. The therapist and client discussed this issue at length, and the client linked his views to his very fundamentalist background. At the end of the session, the

therapist, although confident that the information was understood, was not convinced that the client fully accepted the presented position.

8.1.12.3 Homework

Mr. "K" was asked to do some research into the area of venereal diseases to facilitate discussion in the next session which would be spent covering that material.

8.1.13 S.E. Session #4

The last session was spent discussing various venereal diseases and reviewing all the various types of birth control. During this session Mr. "K" also shared information he had gathered concerning A.I.D.S. and Herpes II. The session began with another lengthy discussion on birth control. This was aided greatly by the therapist's ability to show various techniques and devices, included in the birth control kit on loan from Planned Parenthood Winnipeg. The discussion was very positive and Mr. "K" seemed to be amazed by the facts around effectiveness and the difficulties the user sometimes has with some of the methods. The two areas which generated the most discussion were the I.U.D. (Inter Uterine Device) and the cervical cap.

The discussion in the area of venereal diseases was also very positive. Mr. "K" had a sound knowledge in this area which he linked to a science course he had taken at university. The session ended with the completion by the client of all the necessary questionnaires.

8.1.13.1 Homework

The client was given a homework assignment - to begin to pull together all data discussed and see how it could be used to prevent reabuse.

8.1.14 Session #1 Control Plan (C.P.)

8.1.14.1 Review of Week & Homework

Again the session began with a review of the client's week. He advised that his week had been quite productive, and that he had done a great deal of thinking about the content of the program. He felt it has given him insight into himself, as well as skills to control his behavior.

8.1.14.2 Mini Lecture

The focus of this lecture was to explain the concept of a control plan. The therapist explained to Mr. "K" that he

is the one who must monitor his behavior for the rest of his life. The therapist added that if he is serious about doing so, he must develop a personal control plan.

The importance of having these things written down and available for review was also explained so that they would always be in his thoughts.

The next discussion centered on Finkelhor's Four Factor Model (Appendix 17) which was used with the client, to identify areas, which are problematic for him, and need to be addressed in his control plan. These are hopefully identified by the client, however, if they are not, the therapist would confront the client with other possibilities.

The next task, was to begin to identify issues to be included in the control plan. Using the Four Factor Model as a guide the client identified the following.

1) To use the technique of covert sensitization if aroused by a child.

2) To make and seek out adult social contacts.

3) Avoid situations which place him alone with children, if in relationship, partner needs to be aware of his history and take on majority of child caring responsibility.

4) Begin working on own self-confidence, by being more

outgoing and work on my stuttering.

5) Maintain interest outside of academics - work towards locating enjoyable employment, not low level stress causing jobs.

6) Remember pain and sorrow caused to victim and spouse.

7) Remember outcome of court process, public response.

8) Think about consequences of reoffence, pain to others and self, realize it would result in incarceration.

9) Never put blame anywhere, but where it belongs.

8.1.14.3 Homework

The therapist asked client to review items already on list and think of others.

8.1.15 C.P. Session #2

8.1.15.1 Review of Week

The therapist conducted a short review of the week and the effort put into homework. The client had come to the session with a number of other things to add to his list.

8.1.15.2 Session

10) Avoid situations where he is totally alone with kids.

11) "I realize I am at risk, as long as I am alive."

12) Never let things in my life boil over in the future, more communications with spouse and friends, more sharing of frustrations."

13) "Always keep in mind that children cannot give informed consent to sexual contact."

14) Be assertive. Say no to situations that put me at risk."

8.1.15.3 Wrap Up

The remainder of the session was spent completing closure. The therapist acknowledged the effort Mr. "K" put into the program and was encouraged to make use of his new skills. The therapist asked client to complete final battery of questionnaires, as well as the Client Satisfaction Questionnaire (Appendix 6). Also advised therapist would be contacting him in future for further follow-up.

9 Content of Sessions

9.1 Mr. B

Mr. "B" is a 36 year old married male with three children. The two youngest are the product of this current union. The eldest daughter, the victim, was a child of Mrs. "B's" previous union. The children range in age from 6 to 16, the victim being 13 at the time of the assault.

The assaults took place over a number of years and involved fondling of the victim's vagina through and under clothing. It also involved the victim being encouraged by the perpetrator to rub her body against client's penis through clothing. The majority of the assaults took place during wrestling episodes while watching television in the basement and during times when both were doing the laundry.

When the matters were reported by the victim to her mother, the client readily admitted them and turned himself over to police. The result of the court proceeding was the placement of the subject on three years probation with a major condition being involvement in treatment deemed appropriate by Probation Services and the Child Protection Center.

The therapist worked closely with the Child Protection Center due to the victim's continued residence in the family home with the client. There were also extensive involvement with Child and Family Services.

Mr. "B's" early history is again consistent with those of men charged with alike offences. Mr. "B" was raised in a home where his mother and father fought continually. The client's father was a very abusive man, and a heavy drinker. The end result was that he left the home to escape when the children were in early teens.

Mr. "B" remembers that he and his sibling took on the major part of their own upbringing. Mr. "B" remembers many beatings at the hands of his father and these only ended when he was old enough to fight back.

Mr. "B's" adolescence was marked with numerous difficulties. He had a great deal of trouble with school and left fairly early. Mr. "B" was involved extensively with delinquencies a large portion of which came to the attention of authorities.

Mr. "B's" own sexual history began fairly early. It involved sexual contact including intercourse at a very early age. Mr. "B" also remembers sexual games with an older sister. This involved mutual masturbation and fondling.

Mr. "B's" marriage has also been very strained. Mrs. "B" is herself a victim of sexual abuse by her father at a young age as well as numerous rapes as she was growing up. Mr. "B's" stepdaughter, the victim, is a product of one of the countless relationships Mrs. "B" was involved in prior to their marriage. Mrs. "B" has never resolved her own victimization, although a number of professionals involved with the family continue to work in that direction.

As expected, the trust factor between client and spouse was extremely strained at times. The therapist continuously pushed and encouraged the family to seek couples therapy. To this point in time, this has met with little success. The major stumbling block being Mrs. "B's" feeling that this shows she was somehow responsible for her daughter's assault. This is a problem the professionals involved with the family continue to struggle with. The message was very clear, that the therapist's only concern is that her decision to remain with the client, required her to take certain steps to protect her children.

The ones identified were to increase effective communication as a couple, and especially help her husband avoid situations where he is in high risk of reoffence (e.g. baby-sitting children).

The victim, now 16 years of age, has had numerous problems herself. She is a young lady who has totally rebelled against her parents. At the time of the study she was out of the home and involved with a man in his mid-twenties. Child and Family Services continued to work with both victim and the total family. Mr. "B" saw himself as the one who must take responsibility for his daughter's problem.

9.1.1 C.R. Session #1

9.1.1.1 Mini Lecture

As with the previous client, sessions began with completion of all necessary forms and questionnaires followed by a step by step description of cognitive restructuring as described in section 5(1) of the intervention procedures.

The therapist also screened the two videos as previously discussed in both the intervention procedures and in Mr.

"K's" content section. The session ended with a discussion of the impact of materials on Mr. "B". The client advised that both videos were extremely powerful. He can now see his behavior in a way he has never looked at it before. The impact on the victim is especially haunting as he sees his daughter's current difficulties mirrored in the young ladies on the tape.

9.1.1.2 Homework

The therapist asked the client to examine his own reality and begin to identify some rationalizations he may have used.

9.1.2 C.R. #2

9.1.2.1 Review of the Week

Mr. "B" began with a number of statements regarding the content of videos. He was disturbed by the content and stated it really hit him extremely hard. He and his partner discussed the content at length and he requested the use of the videos to view at home. The therapist advised that this was possible, if they were prepared to do it with someone in a therapeutic role because of the tension that this might generate in the relationship.

Mr. "B" agreed and felt he and his wife could discuss the matter more. The client then offered two rationalizations he had identified over the week. They will be noted now and addressed later.

1) Mr. "B" stated that he often felt that he was showing his victim special attention, not hurting her.

2) Mr. "B" also rationalized that the victim's returning to him was a sign that she was enjoying the abuse, not seeing her as a young child who had no other choice.

9.1.2.2 Session

The remaining time was spent with the therapist reversing roles with Mr. "B" and role playing rationalizations listed in Abel and Associates. (Appendix 12) This exercise successfully showed Mr. "B" how real these beliefs become to men like himself, and how he must learn to recognize when he is slipping into that pattern of thought. The therapist discussed each after the role plays, and pressed Mr. "B" to see if he might have used any of the examples discussed. In the discussions he saw some of the issues as possible, advising the therapist he will do more thinking during the week.

9.1.2.3 Homework

The therapist instructed the client to examine his own situation and identify any rationalizations that had not been discussed.

9.1.3 C.R. #3 "week 3"

9.1.3.1 Review of Week

Mr. "B" reported that stress within his family was again at a crisis point. Mr. "B" indicated that his victim was once again at home, however she was continuing to act out. Mr. "B" advised that as a result of the two tapes shown to him in therapy, he had written the victim a letter accepting total responsibility for the abuse. As well, he reported that he had asked her to work with the family and Child and Family Services to resolve the current problems. He told the victim that he felt that because of his involvement in the abuse, the family would need external help to deal with these issues. Mr. "B" was given positive strokes for how he handled the situation. The therapist offered to be part of any team meeting that might be called. Mr. "B" added more rationalizations to his list.

(3) "I didn't have intercourse with my daughter, therefore I didn't molest her".

(4) "The victim will grow out of it."

(5) "Because I told her I was molesting her, and she didn't run away, she must enjoy it."

9.1.3.2 Session

We continued the use of role play on this occasion, using examples previously identified by the perpetrator, from his own situation. After working through two examples, we had a general discussion about the exercises and process. Mr. "B" acknowledged the value he felt this process has in helping to cure him of his problem. The therapist confronted Mr. "B" because of this statement, stating very clearly the goal of intervention is to give Mr. "B" insight into his problem and some ability to control his behavior. He was reminded that there is no magical cure available, but that it is a lifelong direction, he must take to prevent reabuse.

9.1.4 C.R. #4 "Week 4"

9.1.4.1 Review of Week

Mr. "B" reported that the previous week went quite well. He reported that his family meeting was held and his stress was quite low.

9.1.4.2 Session

We moved into more role plays of his own rationalizations. Mr. "B" stated, that he found this a very valuable exercise as it let him observe his behavior as seen by the victim. It made him realize how he really misused his position, physical size, and his daughter's trust when he was abusing her.

9.1.4.3 Wrap Up

Session ended with the therapist expressing some real support for the effort shown by Mr. "B". Necessary forms and questionnaires completed.

9.1.5 Covert Sensitization (C.S.) Week 1

9.1.5.1 Review of Week

Mr. "B" again stated that the program was a positive experience so far because of the opportunity it gave him to gain insight into his own behavior.

9.1.5.2 Mini Lecture

Prior to moving into new material all forms and questionnaires were completed by the client. The step by

step explanation of this procedure was gone over with the client. The therapist advised Mr. "B" that C. S. is a behavioral technique, which can be used by the client to control inappropriate arousal, and is a direct step he can take to control his own behavior. The total sequence of stages was explained as stated in intervention procedures.

The first step was then to get Mr. "B" to develop his unique offense cycle. That is to be able to identify, both the activities and the feelings he had prior to the offence against the child.

Once he can verbalize his own unique cycle he is instructed to make a list of the most aversive consequences for being discovered involved in the activity.

Mr. "B" then began to describe his unique offence cycle. As mentioned briefly in his background section Mr. "B" had two different scenarios. The first involved him and his daughter lying side by side watching television. He would then begin to wrestle with his daughter which he made sure involved her being pressed and rubbed against his penis. He would also grab her during these episodes in the area of the vagina and breasts.

The second scene involved him being in the laundry room doing some wash. His daughter would enter the room, they would again begin to wrestle and the assaults would occur.

In looking specifically at his aversive scenes he had no difficulty coming up with a number. The first involved being discovered by his wife in the scene. Mr. "B" advised he can still remember the look of pain on her face when she found out. Also very real to him is that this made her own abusive history come screaming back at her. Another scene Mr. "B" used was to remember the time he spent locked up at the Public Safety Building during the investigation. He verbally described the smell, the sounds of the doors clanging shut and of other inmates whimpering in the darkness.

Mr. "B's" neutral scene always was the same. It involved sitting in a boat in the middle of a lake on a summer day fishing - not really caring if he caught anything, just listening to the waves lap against the sides of the boat.

The final stage was identification of his escape scene. Mr. "B" again used the same escape scene, for the most part that being sexual involvement with his wife. On a couple of occasions the activity did not always result in intercourse, but certainly involved mutual pleasuring - not always sexual in context.

9.1.5.3 Homework

Mr. "B" was first acknowledged for effort he extended during the week's session. Mr. "B" was given a blank tape and instructed to complete at least two full twenty minute sessions of the technique. He was advised that the tapes will be spot checked to ensure compliance and understanding.

9.1.6 C. S. #2

9.1.6.1 Review of week

The session began with a review of client's week. Mr. "B" was requested to produce homework tape and advised it would be checked and commented on next week. Mr. "B" advised that at present things at home are going okay.

9.1.6.2 Session

Mr. "B" completed the cycle and put good effort into the exercise. The therapist questioned why only one aversion scene was used, that being the detention in the jail. Mr. "B" advised that the discovery by his wife was very hard to talk about and describe - he admitted to avoiding its use. The therapist advised the client that it must be used and instructed the client to do another complete cycle. Mr. "B"

put in a good effort and personal pain was evident. Mr. "B" was given positive comments regarding his efforts exerted during the last example.

9.1.6.3 Homework

The therapist asked Mr. "B" to complete two complete rehearsals during the week.

9.1.7 C.S. #3

9.1.7.1 Review of Week

There was actually two weeks to review due to client's holidays. A number of events had occurred in the client's life during that time. Mr. "B" reported that he was involved in assault of his daughter's (victim's), boyfriend. He reported that his daughter is fifteen years old and her boyfriend is twenty-four years of age. The therapist identified a number of issues and contracted with client to set up a team meeting with all parties during he coming week. Mr. "B" reported feeling more at ease and agreed to attend.

Mr. "B" then indicated that he had no difficulty completing the assignment. The therapist noted that Mr. "B" used one aversive consequence. Mr. "B" advised that after

last week's discussion, he used all images, and he felt that this weeks homework tape would indicate that to the therapist.

9.1.7.2 Session

Mr. "B" began with a statement as to the value of technique. He saw how if he was aroused again, he could use this technique to lower arousal feeling.

Mr. "B" then moved into the exercise, and completed it without any difficulties or encouragement. Mr. "B" has a very good understanding of technique and did seem to put honest effort into completing it.

9.1.7.3 Homework

The therapist assigned Mr. "B" to complete the homework tape, and advised him that repeating the exercise will make it a part of his repertoire, which he would come to use automatically. That was why we were repeating it over and over. Again, the goal was to give him control over inappropriate behavior.

9.1.8 C.S. #4

9.1.8.1 Review of Week

Mr. "B" advised that the situation at home was much better and that charges against him had been dropped. He reported that his family was now involved in ongoing contact with a family therapist. Mr. "B" advised that his homework tape was completed as prescribed and that he had also done extra repetitions. The therapist advised that review of the previous tape showed good understanding and effort in completion.

9.1.8.2 Session

Mr. "B" went through two excellent examples of technique. His understanding and use of methods was very positive. The therapist acknowledged Mr. "B's" effort and instructed him that this is a technique he must practise to ensure its freshness in mind. The therapist also advised him that, this technique should be included in his control plan. The session ended with the client completing all necessary forms and questionnaires.

9.1.9 Sex Education (S.E.) Session 1

This session began with completion of forms, i.e., the Hudson (S.E.I.) Attitude inventory and Sexual Knowledge inventory (Abel et al, 1984). This last measure will be used as pre - post test, of improved knowledge about sexuality information.

9.1.9.1 Mini Lecture

The therapist explained the need and value of this type of information. The therapist advised, that incomplete or inaccurate sexual knowledge is common to this client group. The therapist began from the position that the client knew little, therefore the content had to cover all the main areas.

The next agenda item as discussed in the intervention procedures section 5(3) was to screen and discuss the short film "Am I Normal." Mr. "B" advised that the nature of the film and its content made him a little more at ease moving into this section of treatment. He felt a little more comfortable in perhaps talking about sexual matters.

9.1.9.2 Homework

Mr. "B" was given a short reading assignment on male myths (Appendix 11).

9.1.10 S. E. #2

9.1.10.1 Review of Week

Mr. "B" advised that things at home were fairly stable, and in general he himself was more at ease. Completed reading assignment and had no major questions.

9.1.10.2 Session

The therapist then moved into the session on male and female anatomy. Mr. "B" had a great deal of trouble completing diagrams. As well his lack of knowledge of proper names made it necessary to check into various slang terms he used. The therapist was careful not to insult his understanding, however the therapist did show him all the proper parts with correct names, and when appropriate, linked the clients term or slang with the correct name.

9.1.10.3 Homework

The therapist gave Mr. "B" general reading material on venereal diseases (Appendix 10) and a general article on sexual dysfunctions (Appendix 16). This was given to stimulate discussion.

9.1.11 S. E. #3

9.1.11.1 Review of Week

Mr. "B" stated he had a number of questions about venereal diseases and also about birth control. The therapist encouraged him to locate answers prior to us covering this in session, and if still unsure, to raise the issue again as the material was covered in class.

9.1.11.2 Mini Lecture

The purpose of this weeks lecture was to cover information on contraception. A majority of the time was spent explaining the process of egg fertilization and changes that both the male and female body undergoes as impregnation occurs.

9.1.11.3 Homework

The therapist instructed Mr. "B" to attempt to answer his own questions by doing some research, and encouraged him to share his findings or lack of findings as the material was covered.

9.1.12 S.E. #4

This session was spent covering venereal diseases, with extra time spent on AIDS and Herpes Simplex II, as Mr. "B" acknowledged that these were two items about which he had questions. Mr. "B" revealed that he knew very little about other sexually transmitted diseases (STD's). This was surprising based on the fact that he had twice been infected with STD's.

We then moved into a discussion of all types of birth control, making use of the birth control kit loaned from Planned Parenthood Winnipeg.

The session ended with an open discussion and completion by Mr. "B" of all required forms and questionnaires.

9.1.13 Control Plan (C.P.) Session 1

9.1.13.1 Review of Week

Mr. "B" advised that his week was without major problems. He also stated that he has reviewed the last few months of work and feels more aware of his own situation.

9.1.13.2 Session

The therapist began by commenting on his shared information making a basic statement that evaluation of content and its potential value for him as a perpetrator will be one of our primary tasks over the next two weeks.

The next item to be addressed was a general definition and explanation of the idea of a personal control plan. The therapist informed Mr. "B" that the control plan is the personal list of things he can't, should and must do to prevent him from reabusing another child. The therapist impressed upon the client the importance of identifying these items and in turn writing them down.

The therapist again used Finkelhor's Four Factor Model (Appendix 17) to identify potentially problematic areas of behavior and beliefs, which require constant monitoring by the perpetrator.

Mr. "B" using the four factor model as a guide began to identify areas needing personal attention.

1) "Realizing the danger of trying to relive times as a youngster when I was involved in very pleasurable sexual activity."

2) "When marriage is under stress, talk things out with partner, don't look to my children for comfort."

3) "Avoid baby-sitting, continue to work with spouse, to help me avoid such situations".

4) "Remember to use covert if I become aroused by a child."

9.1.13.3 Homework

The therapist instructed Mr. "B" to examine his own history to look at other points to add to his control plan. The therapist encouraged him to discuss his idea with his wife for her input.

9.1.14 C.P. #2

9.1.14.1 Review of Week

Mr. "B" advised he had a productive week. Has returned with a list of added conditions for his control plan.

9.1.14.2 Session

The added conditions were:

4) "Avoid use of pornography in relationship - films etc."

5) "Continue to be involved with partner in working on improving our communication".

6) "Use masturbation, if no other outlet available to relieve arousal. (Use appropriate fantasy)

7) "No play fighting or wrestling with kids."

8) "If under stress, marriage, job family etc. - talk to someone, don't hold it inside."

9) "Be more assertive - learn to say no to kids and difficult situations that I may find myself in."

10) "Remember children cannot give informed consent to involvement in sexual activities."

11) "Never forget what happened to me and my family because of what I did."

12) "Because of my attitude towards women. Realize I at times want to hurt them. Because I still view my mother leaving me as a child as her fault and a personal put down. Remember, she had to leave for her own safety because of my father's behavior."

Therapist acknowledged clients efforts, and restated the necessity for him to use this plan for the rest of his life.

9.1.14.3 Wrap Up

The therapist acknowledged Mr. "B's" efforts over the last few months and encouraged him to continue his efforts. The therapist asked the client to complete the last set of necessary questionnaires as well as the client satisfaction questionnaire (Appendix 6). The client was also advised that he would be requested to complete the same at a six and nine month follow-up.

10 Content of Sessions

10.1 Mr. "H"

Mr. "H" is a 26 year old separated male. The separation resulted from his sexual assault of his seven year old step daughter. His step daughter reported the assault to her mother who in turn confronted the subject and then contacted police.

At first the subject denied the charge and obtained a lawyer to fight the case. However, once he realized the pain the court proceedings would cause his family, especially his daughter, he pleaded guilty to the charge. Mr. "H" admits his involvement and said at first he was only thinking of his own discomfort, not that of his victim.

The mother went to court and Mr. "H" was placed on three years probation with conditions that he have only supervised contact with his children and that he become involved in therapy deemed appropriate by the Child Protection Center. Mr. "H" was originally involved in therapy with Ms. Brenda Gravenor, a therapist at the center. After consultation with the supervising probation officer and therapist he was referred to this program.

Mr. "H's" assault was, according to the subject, and the police report, a one time occurrence. Mr. "H" however admits

to thinking about his daughter sexually on previous occasions, but not acting on the feeling. The assault itself occurred while Mr. "H" was watching television and baby-sitting. The subject was lying back drinking beer and smoking pot. His daughter and young son were in the room playing. He looked at his daughter and began to see her as a little mini-adult. He then began masturbating, pulling his pants down. As his daughter approached the couch he pulled her down and tried to get her to put her mouth on his penis. She struggled and screamed and he let her go. She told her mother when she returned home.

In examining Mr. "H's" own history, the similarity to the other clients emerges. The subject describes his father as being very stern and unemotional with his children. He can remember no real nurturing behavior from his father. As well, his father in his early years drank quite a bit and had numerous affairs. His father was also charged and convicted of sexually assaulting one of his students, while he was a teacher, the result of which was the loss of his job, incarceration and increased stress at home.

The subject's own sexual history started very early. His first recollection was mutual masturbation and fellatio with male siblings, and also some cousins around the same age. He also recalls doing a lot of exposing to passing motorists on

a highway near his home. Heterosexual activity also started quite early and he cannot remember, as he put it, not "getting laid" when he dated. In looking at his history he sees these short, one night stands as a regular part of his life even during marriage.

Mr. "H" does not know why he got married, saying he doesn't ever think he loved his wife. However he does state that her willingness to be involved in all types of sex did turn him on. After she became pregnant with his child, he however did move in and eventually married her.

10.1.1 Cognitive Restructuring (C. R.) #1

Mr. "H" reported experiencing great stress, due to fighting between himself and his ex wife. The end result was that the client was allowed only limited contacts with his children. The visits occurred at the parents home with supervision at all times. Mr. "H" felt these conditions were too heavy and his wife was being unfair. The therapist confronted Mr. "H" stating very clearly that these conditions are not unusual nor excessive, because he sexually abused one of his children. He reported that it was his fear of loosing contact with his kids which would affect him greatly.

10.1.1.1 Session - Mini Lecture

As with previous clients, sessions began with the completion of necessary questionnaires. The therapist advised the client of the content of the next five weeks of treatment. The instructions given were as described in the intervention procedures section 5(1).

The session then moved on to the screening of the two video resources. Mr. "H" was visibly shaken by the content of the two videos. After watching them Mr. "H" discussed his feelings around the victim tape. He had some real questions about whether his daughter would suffer some pain. He added that it made him even more aware of his responsibility to work on his problem.

10.1.1.2 Homework

The therapist instructed the client to examine his own situation and try to identify any rationalizations and distortions he may have used.

10.1.2 C.R. #2

10.1.2.1 Review of week

The client began the session by discussing the impact

the videos had on him over the week. He stated that they had really caused him to examine his behavior. He reported that he now realized that his abuse may have long term impact on his daughter, and he must work hard on his own problems.

10.1.2.2 Session

Therapist and client discussed how this section of treatment was to take place. The therapist and Mr. "H" would role play rationalizations listed in Abel et al (1984). The actual format is listed in the intervention procedures section of the practicum report. Mr. "H" acknowledged that he did use rationalizations and distortions of reality. The subject realized that he really felt his daughter was unaffected and would forget the incident. After he watched the tapes he realized this was not reality. He also identified that he had a problem which required that he really examine his behavior and work to gain control of it.

10.1.2.3 Homework

The therapist asked the client to examine his own history and return next week with at least one rationalization he used.

10.1.3 C.R. #3

The client stated that he had some difficulties during the past week around access to his children. Mr. "H" indicated that police were called and came to visit him. It was unclear, after their visit, why they had come to see him as no charges were laid. The therapist advised that he would check with the probation officer during the week as to the reasons for the visit.

10.1.3.1 Session

The session began with a review of the homework assignment. Mr. "H" acknowledged two particular things he viewed as rationalizations and one he was not sure about. The first was that his abuse wasn't really that serious, not involving intercourse. Secondly, he viewed his seven year old daughter as a miniature model of his wife and saw her as a young adult. The last point was that he needed sexual stimulation and was not concerned where he got it. The last example was the one he had some question about, however the therapist clearly stated it certainly was a distortion of reality as having sex at will is not a right of manhood.

The next portion of the session was spent role playing the two scenarios described by the client, again letting him

hear the therapist attempting with great effort to rationalize the beliefs. As Mr. "H" confronted the issues, he quickly acknowledged how weak and inaccurate they were. The therapist ended with acknowledgment of the effort expended by the client.

10.1.3.2 Homework

The therapist asked the client to examine his own situation and try even harder to identify any other rationalizations he may have used.

10.1.4 C.R. #4

10.1.4.1 Review of Week

Mr. "H" discussed a number of issues he has examined over the week. He realized he must always be aware of things he says and thinks about his contact with children. He reported that he sees how he became involved with his daughter through a gradual process, thinking prior to the assault how his behavior wouldn't really affect her. Mr. "H" also stated that he also felt, because his daughter still talks to him, that the effect of the assault is probably very minimal. He reported that he now realizes that he is being very self-serving, when he thinks these things. After

viewing the films he now sees these beliefs as a way of rationalizing to himself, that his behavior wasn't really that bad.

The therapist again acknowledged Mr. "H's" efforts with respect to self examination as well as the effort invested in role playing.

10.1.4.2 Session

The remainder of the session was again spent doing role plays of various rationalizations. Mr. "H" came up with concrete and factual reality to each rationalization presented by the therapist. During the session Mr. "H" showed good effort and understanding of technique.

10.1.4.3 homework

The therapist asked the client to do final evaluation of his own situation. Again the therapist acknowledged the effort put out by the client.

10.1.5 C. R. #5

10.1.5.1 Review of Week

Mr. "H" discussed his picture of himself at the time of

the abuse. He realized that he was very self centered, and totally unaware of the impact of his behavior on the victim. He reported that he sees how he used various internal statements to allow this to occur and that this is a situation he must consistently guard against.

10.1.5.2 Session

The therapist and client role played three different situations, this time using three rationalizations given by the perpetrator. After completing the exercise Mr. "H" commented how weak and shallow they were. Again, he also identified the self centered image of himself at that time, thinking only about what he wanted, not taking into account anything his daughter was doing or saying to protest his abusive behavior.

10.1.5.3 Wrap Up

The session ended with therapist acknowledging the effort Mr. "H" put into the process. The therapist acknowledged Mr. "H's" realization that he alone is the one who must monitor and control these feelings in the future. Mr. "H" felt he realized the importance of critically examining every statement and behavior he does with his child. He reported being fully aware of how rationalizations

made about the impact of his actions on his victim, or the effects of his behavior, cannot be fully appreciated without taking into account the total situation. The last comment he made was extremely relevant, "I now realize children cannot give consent, either by their actions or verbal statements. They as children cannot comprehend the full impact of their behavior."

The session ended with the therapist advising that this skill he has learned and practiced, must be included in his final control plan. The last item of business was completion of all necessary questionnaires.

10.1.6 Covert Sensitization (C. S.) #1

10.1.6.1 Review of Week

The gathering of data and completion of required questionnaires was the first item on the agenda. Mr. "H" reported that the week was extremely positive and he is looking forward to the next section of treatment.

10.1.6.2 Mini Lecture

The therapist again used the appropriate section of Abel's manual, as a guide to introduce this section. A quick overview of procedure was given to the client, then a more

step by step process began.

The therapist then helped the client reconstruct the stages leading up to the assault of his step daughter. Mr. "H" remembers lying on the couch and watching television, having consumed both marijuana and alcohol. As he was sitting there he began to look at his daughter and feel sexually aroused. Mr. "H" describes himself as picturing her as a mini adult, a young version of his wife. It was more than looking at her as an adult - she became another woman from whom he could perhaps get sexual pleasure. He then grabbed her and pulled her towards him.

At that point the therapist advised him that the aversive scene should then be verbalized.

Mr. "H" then made a list of three aversive scenes. The first and most personally uncomfortable was losing all contact with his children. In his scene, his wife packs all her belongings and moves to the East Coast with the children. The second is to be discovered by his wife and the matter entering the legal system. The whole matter becomes public knowledge, causing great pain and discomfort to his parents, his family and himself. The final scene involved discovery and conviction with the end result being incarceration. Inside the institution he is able to observe

and experience all sorts of cruel vicious behavior. The therapist asked him to describe how he felt during each step of the cycle.

Mr. "H's" neutral scene was always the same, it involved getting on his motorcycle and driving off with no real destination in mind. He talked about feeling the wind in his hair, and being unaware of anything around him.

The escape scene involved both a sexual and non sexual example. The sexual one involved sexual activity with his current girl friend and the other riding off into the sunset on his motorcycle.

The client was instructed that he would be required to complete homework tapes, as well as in-session repetitions. The therapist also advised him of the importance of doing the exercise, making him aware it would be a technique that he could make second nature.

10.1.6.3 Homework

The client was provided with a blank tape and requested to complete two twenty minute examples during the week.

10.1.7 C. S. #2

10.1.7.1 Review of Week

The session began with a review of the previous week and questions about his homework assignment. Mr. "H" indicated that he completed only one short session on the tape. Mr. "H" reported that he finds completing exercises very depressing and difficult. The therapist instructed the client that completion of the tape is extremely important and made him understand that failure to follow through may result in him gaining less from this portion of treatment. The therapist acknowledged that it was difficult, but necessary so that the therapist can be sure he understands the technique.

10.1.7.2 Session

Mr. "H" is monitored as he completes sequences in the presence of the therapist. The only feedback the therapist gave involved length and content of the arousal scene in the first example. The therapist instructed the client to talk at greater length about his feeling at that time. The other comment had to do with the discovery scene. The client

talked a lot about pain to himself. The therapist instructed him to discuss the impact on significant others and the victim in addition to his own pain.

The next example was done extremely well. Mr. "H" appeared to understand the technique.

10.1.7.3 Homework

The therapist instructed the client to complete the homework tape and bring it to the next meeting.

10.1.8 C. S. #3

10.1.8.1 Review of Week

The therapist began with a review of the previous homework tape. He advised the client that although it was short, it did appear to demonstrate understanding. The therapist strongly emphasized the need for more effort. Mr. "H" advised that his new tape was longer and certainly caused him great discomfort while completing it. He also added that he can see this technique as being very valuable, if he ever steps back into his old pattern. He reported that he also sees that repeating it is necessary to make it part of his automatic response.

10.1.8.2 Session

Mr. "H" put excellent effort into both examples completed today. The client really appears to fully understand and appreciate its value. The one thing he required after finishing the exercise, was time during which process was discussed as well as the pain he was feeling. The therapist and client spent the time that was required to debrief the exercise.

10.1.8.3 Homework

The therapist instructed Mr. "H" to complete the homework tape for the therapist during the week.

10.1.9 C. S. #4

10.1.9.1 Review of Week

The therapist advised that a spot check of the previous tape showed excellent effort and understanding. The client advised the therapist that his week went extremely well, and that although he found it difficult, the tape was again completed.

10.1.9.2 Session

The session was again comprised of two complete repetitions of the exercise. The therapist instructed the client to use another of his discovery scenes each time. Mr. "H" showed very positive effort and understanding.

10.1.9.3 Wrap Up

The therapist again acknowledged the client's efforts, and stated that this is now something else he can use to prevent reabuse. The therapist encouraged the client to continue completing the exercises and include this technique in his personal control plan. The session ended with completion by the client of all necessary questionnaires.

10.1.10 Sex Education (S. E.) #1

The therapist began this session by having the client complete all necessary questionnaires. These included the addition of the Sexual Knowledge Inventory (Abel et al, 1984). The use of this inventory is discussed in the intervention procedures.

10.1.10.1 Mini Lecture

The therapist began with a discussion of the need and value of this portion of the treatment. The rational for this is clearly stated in the intervention procedures section of this report.

Mr. "H" advised that he had not received any formal sex education himself. He also advised the therapist that he felt very uneasy discussing issues like this with anyone. The client advised the therapist that after watching the film "Am I Normal" he felt more at ease and comfortable. He also acknowledged after completing the questionnaire that he felt concerned that he was not able to answer all of the questions, knowing his answer was correct. The therapist acknowledged the clients efforts and encouraged him to ask questions at any time during the presentations.

10.1.10.2 Homework

The client was given a short article on Male Myths (Appendix 11).

10.1.11 S. E. #2

10.1.11.1 Review of the Week

The session began with a short check-in, and verification of the reading article. Mr. "H" did not read the article, and therefore was given a few minutes to complete the task. The therapist restated the importance of doing all homework assignments. In this section they were used to provide additional information and stimulate discussion.

10.1.11.2 Session

The therapist then followed previously discussed instructions and moved into a discussion on anatomy. Mr. "H" completed assignment of naming body parts, however he was observed to be having difficulty completing the task. He advised the therapist of problems and questioned the therapist about a few items. Mr. "H" was encouraged to do as good a job as he was able, and was advised that the correct answer would be given during the lecture.

Mr. "H" had particular difficulty with female anatomy so the therapist discussed both sexes, using diagrams to facilitate discussion.

10.1.11.3 Homework

The therapist gave Mr. "H" a general article on sexually transmitted diseases (Appendix 10) and a general article on sexual dysfunctions (Appendix 16).

10.1.12 S. E. #3

10.1.12.1 Review of Week

Mr. "H" stated that he found the reading assignment easy and interesting. He also advised that his life was going quite well at this time.

10.1.12.2 Session

As discussed in the intervention procedures, this session covered contraception and conception. The birth control kit provided by Planned Parenthood of Winnipeg made a large impact. Mr. "H" asked a number of questions around the area of birth control and also around the process by which the egg is fertilized and where it occurs.

10.1.12.3 Homework

The therapist asked Mr. "H" to bring with him as much information as he could gather on AIDS. If he was unable to

complete the task, the therapist asked the client to come to the next session with questions on AIDS and other sexually transmitted diseases.

10.1.13 S. E. #4

10.1.13.1 Review of Week

The client reported that he was very unsuccessful in gathering any information about AIDS. He stated that he felt frustrated by this as it is a subject he felt he should know more about.

10.1.13.2 Session

This session was spent covering sexually transmitted diseases. The therapist covered more familiar examples as well as providing information on AIDS and Herpes II. The therapist also advised the client that any unusual symptoms must be checked by a doctor. Mr. "H" advised that although his current partner is on birth control pills, they continue to use a condom, because they both have had multiple partners. The therapist advised that further information can be located through a number of resources in the city, and a list of these were provided to the client.

10.1.13.3 Wrap Up

The session concluded with the necessary questionnaires being completed. The therapist advised the client that the next two weeks would be spent pulling together all information gathered so far.

10.1.14 Control Plan (C.P. #1)

10.1.14.1 Review of Week

Mr. "H" reported that he felt quite positive today. He reported mixed feelings about the fast approaching end of contact. He reported that he would be happy to have another free evening, but also would be upset, that contact geared to deal with his problem would end. The therapist encouraged Mr. "H" to keep contact with the therapist should problems arise.

10.1.14.2 Session

The session then moved into a discussion of what the therapist means by control plan. The example given in Abel's Manual was used to give a visual example of the idea (Appendix 1). The importance of developing a plan unique to himself was impressed upon the client.

The therapist explained that to facilitate its development, we would examine his history and involvement thus far, using Finkelhor's Four Factor Model as a tool to do so. This model examines contributing factors in a number of varied areas. By using the model as a guide, he can identify areas in his life which would require intensive monitoring and continual work.

The session then moved into a number of these issues which the client felt he had to include in his control plan.

1) "Realize that my involvement with my daughter was sexual, and I feel it was me trying to reexperience the arousing situation I had as a child."

2) "When I am having trouble in my relationship, I must work it out with my partner, not turn to my children for comfort."

3) "Remember to practise, and if aroused, use the covert cycle."

4) "Always be aware of what I am saying regarding my activities, especially with children. Be aware of when I think I know what others are feeling and thinking, and watch for my own distortions.

5) "Children cannot consent to something, they don't fully understand."

6) "For me anyone under 18 is a child."

7) "Use masturbation to appropriate stimulus, if no other adult outlet is available.

8) "Remember the impact this assault had on my partner, my children and me. For me remembering police arriving at my job and taking me downtown is very strong. Also the look of my children's faces in the window, after my wife made me leave the house."

10.1.14.3 Homework

The therapist acknowledged Mr. "H" for effort shown so far and asked him to go over his whole situation at home and look at other possible items for his control plan.

10.1.15 C. P. #2

10.1.15.1 Review of Week

Mr. "H" described having a very positive week. He advised that he had a number of other points to add to the list.

10.1.15.2 Session

The session began with another lecture about the importance of a control plan. The client was again reminded that he was at continual risk of reoffense if he does not

remain aware of his actions. He alone can monitor and work at controlling his behavior

9) "When I am under stress, I must deal with it. If it involves my partner, we must work it out together."

10) "Avoid baby-sitting kids; if at all possible my partner must be aware of why."

11) "Learn to say no to kids, and other difficult situations I find myself in."

The therapist acknowledged the clients efforts in this exercise and agreed that he was the one who has to constantly monitor his behavior. The therapist ended with support for the effort extended over the last few months. The therapist also agreed with the client that he must continually work on these issues, using his personal control plan as a guide.

10.1.15.3 Wrap Up

The client was asked to complete necessary questionnaires.

10.1.15.4 Follow Up

The subjects in this study were all followed up at the end of a six month period following completion of treatment.

As well two of the men had Additional follow-ups of 9 months. One participant had moved and there was no new address available.

Of the three participants only one is still under probation supervision. None of the participants have had further contact with the court system either during or subsequent to completion of the program. It should be noted that Mr. "B" will be a participant in a group program to be run by probation services and this therapist which began in November 1987. This program will provide the content of their program plus much added information and structure. While Mr. "B" is officially off of probation supervision, he is seeking additional help and is feeling he has a lot to offer the other perpetrators.

Follow up included completion of all required questionnaires, a check of court records, and an opportunity for the client to give personal feedback.

11 Results

11.1 Analysis of Data

11.1.1 Cognition Scale

The data obtained by using the Cognition Scale were analyzed by means of visual graphs, which were used to compare any changes which occurred between the A and B phases of the design. As well, this scale was administered at a 6 and 9 month follow up, when possible, to check for additional changes.

The therapist suggested that the beliefs identified in the A phase would continue throughout the process, unless an intervention to promote change was implemented (Bloom & Fischer, 1982). The second point is that the use of the behavioral package, as described earlier, would have an observable impact on restructuring beliefs. A comparison of responses to the cognition scale allowed the therapist to make some inference as to the value of the total package.

The visual inspection of the graphs provided a variety of information. One can draw information on a number of attributes of the graphs. As described in Bloom & Fischer, (1982), we can examine (1) level, (2) trend, and (3) stability. The level refers to the direction of the data within each stage as one might imagine this might be

increasing, decreasing or flat. The final component is stability. This relates to the extent the direction of the data can be predicted from a prior to a later period.

Within this analysis, the following interpretation of the cognition scale was followed. The therapist contacted the New York Psychiatry Institute, Sexual Behavioral Clinic, by telephone on October 21st., 1987. In talking to one of the clinical researchers, the following interpretation of data was agreed upon. The cognition scale is a five point Likert Scale composed of 29 items. In their research, the desired score is 5 or strongly disagree. The last two items on the scale are not tabulated in the results, because they also can be addressed in the other direction by a sexually "normal" (non offending) population. Therefore they will be left out of the analysis.

The analysis will reverse score all the answers, to facilitate ease in showing data on graphs. Therefore, the desired answer of 5 will become 1, with all other responses switching accordingly. Therefore the largest response total becomes 27, with anything above 27 indicating inappropriate beliefs. The optimum goal would be to have stability of the responses on the graph at this level of 27.

Clinically significant change was determined if scores went down close to 27 and remained there through follow up.

11.1.2 Hudson Index of Self Esteem

Again, the data gathered from this scale was evaluated by means of visual graphs. Similarly to the Cognition Scale, greater magnitudes are undesirable and, therefore, a decrease in the level of the scores was expected. As well the package offered is designed to provide participants with help in identifying and altering inappropriate beliefs and improving knowledge. For this reason, an increase in self esteem was predicted between the pre-intervention and follow tests.

The clinically significant level to indicate low self esteem is 31 and above.

11.1.3 Sexual Knowledge Scale

Again, this particular scale was given pre-post test and at follow up to check for changes in sexual knowledge. As explained earlier, significant change would be identified by a simple comparison of scores.

11.2 Mr. K

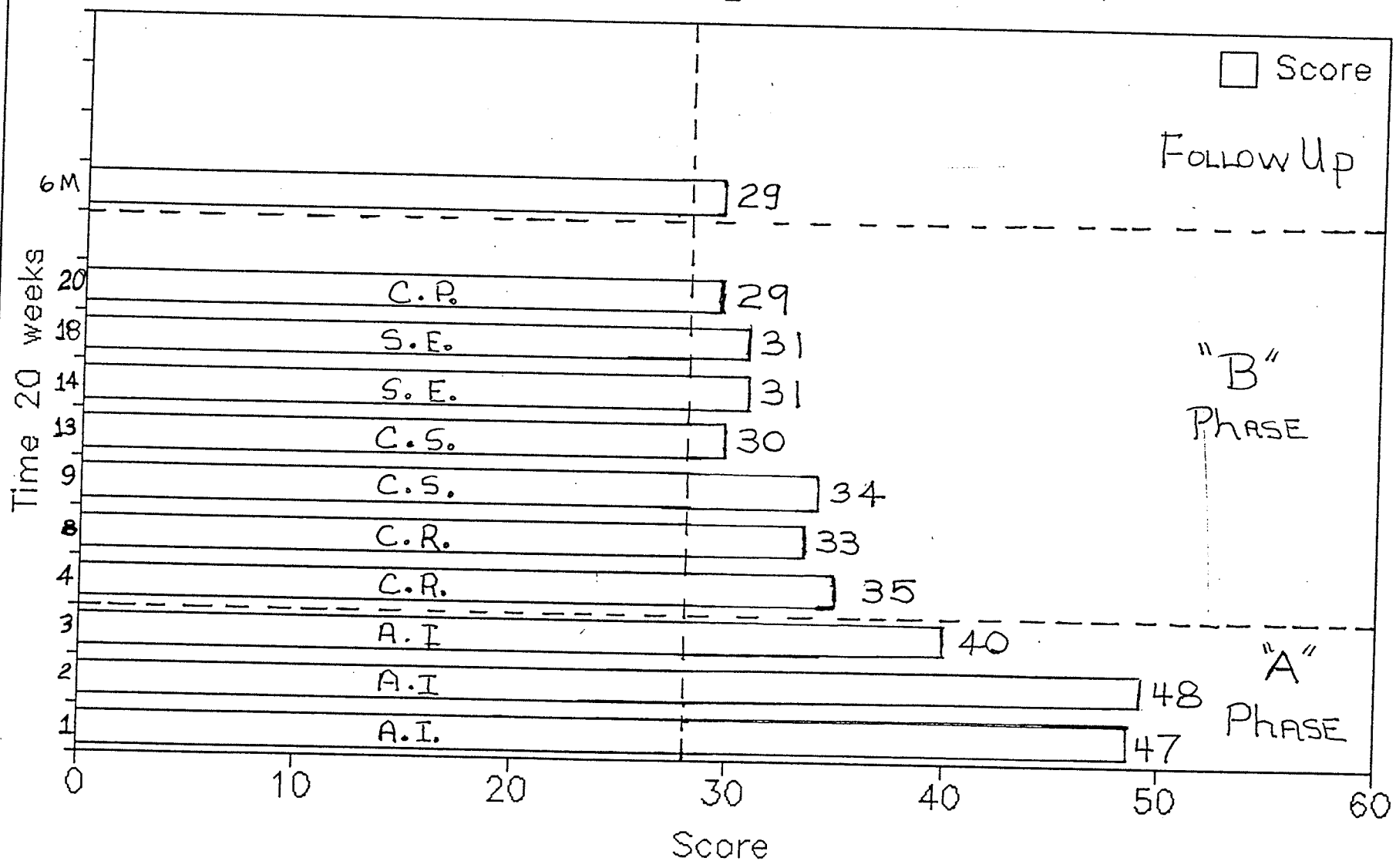
11.2.1 Cognitions

During the assessment portion of treatment the client completed the cognition scale on three occasions. As noted, the results, as well as similar results gathered during intervention and follow up are provided in Figure 1.

In visual inspection, clinically significant change is indicated in Mr. "K's" belief system. In examining the data as explained earlier, the target score is 27. In this graph we see a gradual decline in the numbers towards the stated non significant number of 27.

It is important to remember that cognitive restructuring, covert sensitization and sex education were all expected to improve the clients functioning. In examining the responses to the cognition scale, an improvement in appropriate responses was very observable. Mr. "K" identified a number of distortions he had used, and modified them to fit into appropriate behavior as well as gaining an appreciation of the impact his behavior and beliefs had on himself and others especially in his case the victim.

Fig. 1
Mr. "K" Cognition Scale



Target Beliefs 27 score for normals

However, one concern remained at the termination of cognitive restructuring that merited attention throughout the total time in therapy. During completion of the scale Mr. "K" changed the wording in some of the questions. An example is question #5.

> "If a 13 year old (or younger) child flirts with an adult, it means he (she) wants to have sex with an adult."

At times he would make changes in the stated age or wording. Mr. "K" rationalized, that it very much depended on the particular child as well as the actual age of the child. On a number of occasions he stated, that at 13 or 14 this statement could be true with some children. Again the therapist confronted him stating clearly a number of points. First, that according to the law he lives under, sexual activity with a child under 18 would be considered an assault. Secondly, that the only way a thirteen year old would respond that way would be if she had been trained to do so. Thirdly, a child cannot give consent to something she doesn't fully understand.

Although the results obtained indicated a stronger belief in appropriate behavior, they were not always born out by his behavior. In discussions with the client, he felt even at termination, that his likelihood of reoffense was

minimal. His rationalization at that time involved a belief that, reoffense could not happen if he was the natural father of the children.

Mr. "K" also rationalized that in his chosen career path he wouldn't affect his employment by becoming involved with his clients. Mr. "K" was hoping to become a speech therapist. Mr. "K" was reminded, that he admitted arousal to young children, and that the therapist has clients who have offended against natural children and others. Mr. "K" was advised that he is at risk for as long as he lives, and must constantly monitor his behavior. He was advised that he has responsibilities, which exceed those of other adults to limit and control the situations which involve contact with children.

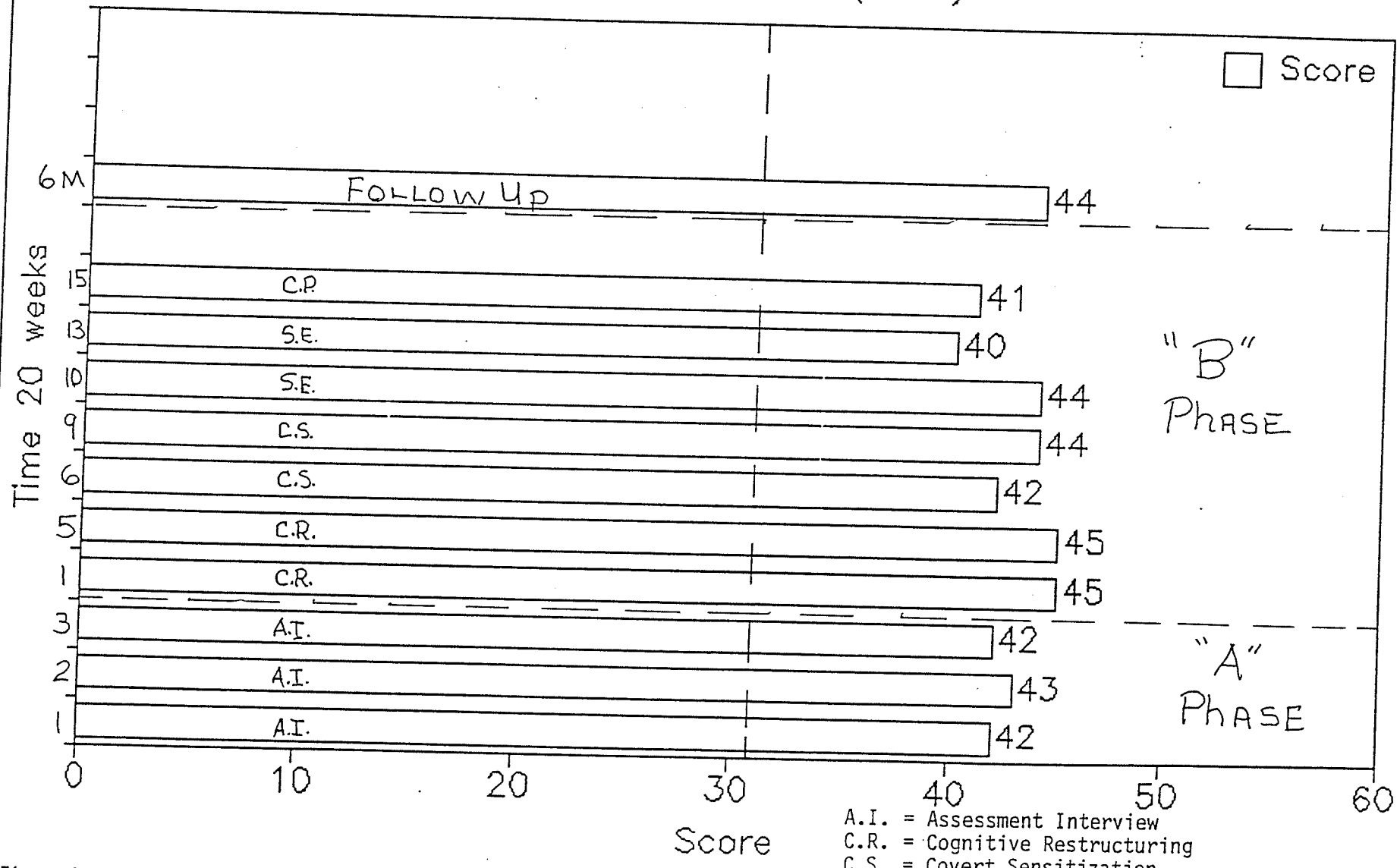
11.2.2 Hudson (I.S.E.)

In examining Mr. "K's" self esteem index, a different picture of this client is projected. It is significant to notice that the (ISE) score remained consistently high throughout the time spent with the therapist (Figure #2)

The therapist links this occurrence to a number of factors. Firstly, Mr. "K" comes from a fundamentalist religious background. One of the consequences of his abusive

Figure 2

Mr. "K" Hudson (I.S.E.)



31 or above = low self esteem

A.I. = Assessment Interview
C.R. = Cognitive Restructuring
C.S. = Covert Sensitization
S.E. = Sex Education
C.P. = Control Pain

behavior was excommunication from his church, an organization he was extensively involved with, including going on service missions to the United States. Secondly, during therapy, he was involved in a relationship with a client seeking therapy to deal with her victimization, by her father. The client believed the responsibility for that relationship's failure was partially caused by the therapist in both projects. This distortion again was challenged for what it was. Mr. "K", again had not been totally open with his partner about his offence, and his arousal to the young child he assaulted. The therapist explained that, this must occur if he is going to get the kind of help, his eventual partner must provide him and that the partner has a role to play, in lessening the risk of reoffense. The last was that Mr. "K" was very conscious and aware of his stammering problem. His ability to converse fluently was extremely important, and he was usual upset when his speech problem caused him difficulty. In taking all of the above factors into account, some potential reasons for the low self esteem scores are apparent.

11.2.3 Sex Knowledge Scale

The use of this scale by Abel et al (1984) is extremely basic. It is offered pre-post intervention to check for improvement of knowledge. As noted in Figure 3, Mr. "K"

Figure 3
Mr. "K"
Sexual Knowledge Questionnaire

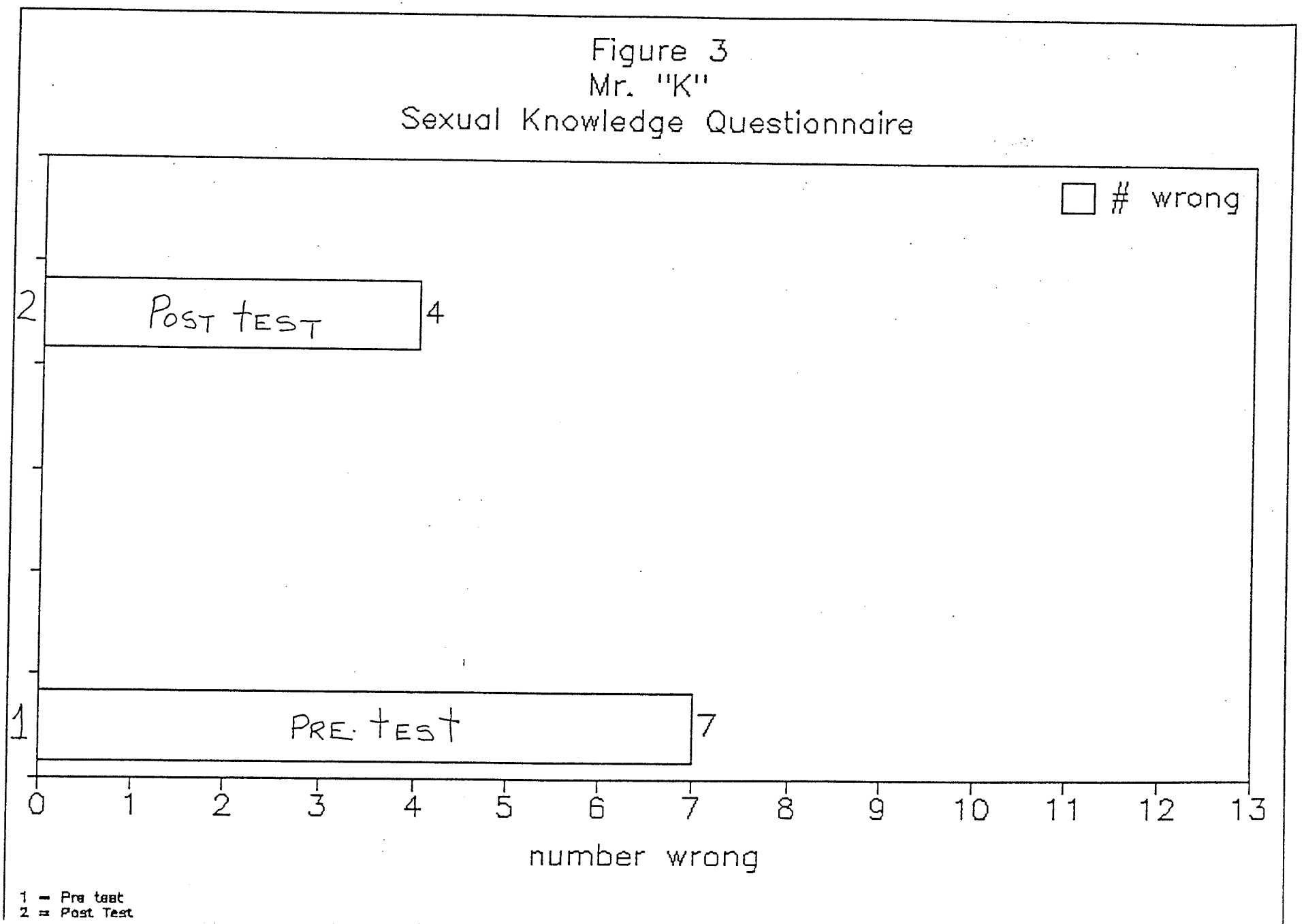


TABLE # 1

The Client Satisfaction Questionnaire (CSQ)

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much, we appreciate your help.

CIRCLE YOUR ANSWER

	MR. "K"	MR. "B"	MR. "H"
1. How would you rate the quality of service you received?	3 Good	4 Excellent	Excellent
2. Did you get the kind of service you wanted?	Yes, definitely	Yes, definitely	Yes, definitely
3. To what extent has our program met your needs?	Most of my needs have been met	Almost all of my needs have been met	Most of my needs have been met
4. If a friend were in need of similar help, would you recommend our program to him/her?	Yes, I think so	Yes, definitely	Yes, definitely
5. How satisfied are you with the amount of help you received?	Mostly satisfied	Mostly satisfied	Mostly satisified
6. Have the services you received helped you to deal more effectively with your problems?	Yes, they have helped somewhat	Yes, they have helped a great deal	Yes, they have helped a great deal

	MR. "K"	MR. "B"	MR. "H"
7. In an overall, general sense, how satisfied are you with the service you received?	Mostly satisfied	Very satisfied	Mostly satisfied
8. If you were to seek help again, would you come back to our program?	Yes, I think so	Yes, definitely	Yes, definitely

ADDITIONAL COMMENTS:

PLEASE ATTACH ADDITIONAL SHEETS IF YOU WISH

exhibited a significant change in a positive direction. It should be noted that the material questioned in the scales was covered by the content of the sex education module.

11.2.4 Client Satisfaction Questionnaire

The results of the Client Satisfaction Questionnaire are shown in Table 1. It should be noted Mr. "K" made minimal use of the opportunity to offer feedback. Additionally, contact with him was lost prior to the last follow up session.

11.2.5 Summary

In summary, in looking at Mr. "K" the gains he made in identifying some of his rationalizations appear significant. As well, the client seems to have gained sound knowledge in gaining more control of his behavior. Mr. "K" understands how to use covert sensitization and watch out for situations where he minimized his involvement with children in the past. Mr. "K" sees clearly that he offendered, however there is concern about his minimization of the possibility of future offenses. The therapist also expressed concern around his view that some young children may be ready for sex at a

younger age. The therapist feels his effort and gains in general were significant, however he also believes Mr. "K" to be more at risk of reoffense than he would admit.

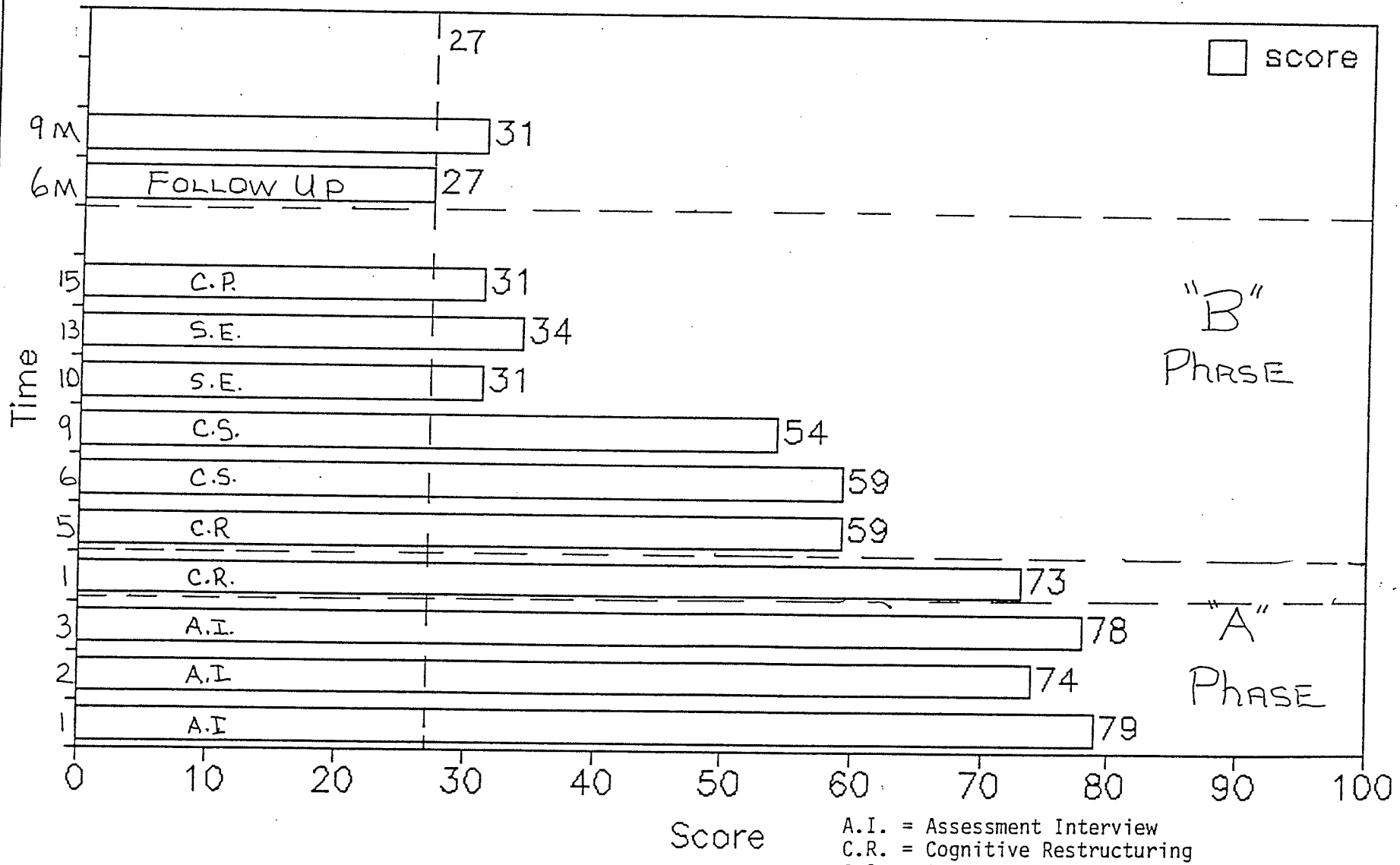
11.3 Mr. "B"

11.3.1 Cognition Scale

During the assessment portion of treatment Mr. "B" completed the cognition scale on three occasions, and also at regular intervals throughout the intervention phase. The results can be noted by examining data shown in figure 4.

In a visual inspection clinically significant change appears to be indicated. As discussed earlier, the target score for this scale is 27. In examining the data, a slow drop up to the end of the covert sensitization portion of treatment is observable. In discussing this with Mr. "B" he acknowledged that the first two sessions of treatment - cognitive restructuring and covert sensitization - gave him a real feeling of control over his behavior. Also he acknowledged, that having relive his experience through the

Figure 4
Mr. "B" Cognition Scale



Sexual Normals score = 27

A.I. = Assessment Interview
C.R. = Cognitive Restructuring
C.S. = Covert Sensitization
S.E. = Sex Education
C.P. = Control Pain

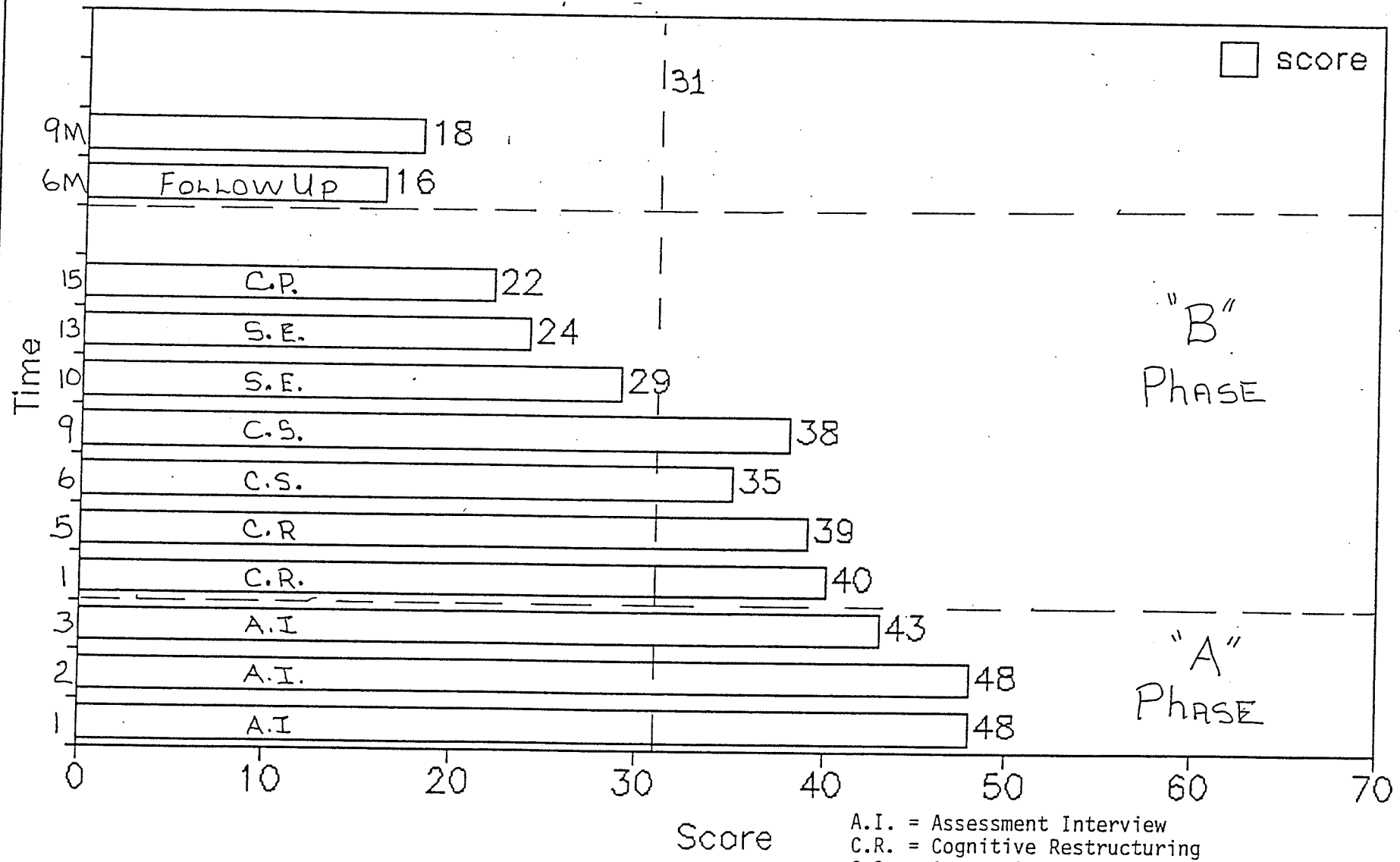
covert exercise gave him a real appreciation for how responsible he was, and still is, for the impact this had on his daughter. Mr. "B" did a great deal of work examining his inappropriate beliefs and restructuring them. As well, his involvement in all parts of treatment showed strong commitment to work at controlling and modifying his inappropriate behaviors.

11.3.2 Hudson (ISE)

In examining Mr. "B's" self esteem index a similar decreasing pattern is observable. Mr. "B" acknowledged, as discussed earlier, that he felt much more in control of himself and his behavior. As well, Mr. "B's" spouse was very supportive of him during therapy, and this helped him through some difficult times. As Mr. "B" stated, "I feel more able to control my thinking and my behavior. I can say no to my kids and tell them why Daddy can't do things with them. I still feel upset about that, but I also feel good, that I can tell them it's because I really love them."

Figure 5

Mr. "B" Hudson (ISE)



Scores above 31 = low self esteem

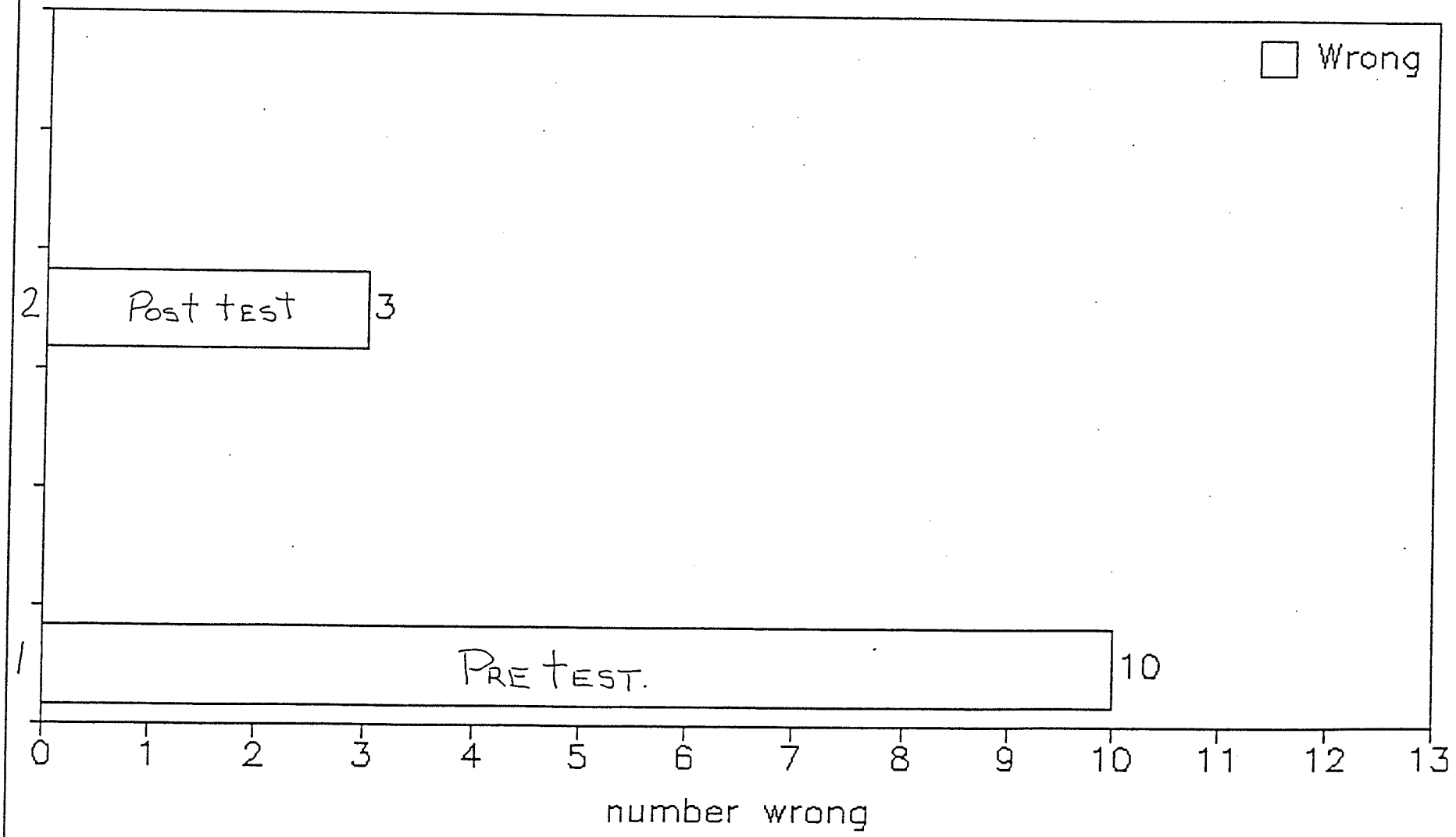
A.I. = Assessment Interview
C.R. = Cognitive Restructuring
C.S. = Covert Sensitization
S.E. = Sex Education
C.P. = Control Pain

This was a positive move for Mr. "B" because for a long time he was terrified to be even near his kids. He reports that he and his spouse now both share some of the parenting functions. He reports that they both realize that there are certain activities, Mr. "B" cannot do with the kids, so his wife takes these tasks on herself.

11.3.3 Sex Education (Sex Knowledge Scale)

In examining Mr. "B's" sexual knowledge Questionnaire we again see a significant lowering in the scores. In the pre-test, he had six wrong and in the post test his score was three. Mr. "B" admitted to the therapist after pre-test that he guessed at a number of the answers. Upon reexamination of the questionnaire, we agreed between us that in fact there were ten questions in which he was not totally positive of the the correct answer. The sex education module included information and material, which would answer all of the questions. Again, in examining Mr. "B" we see a man who never had any formal sexual education. He admitted that the majority of his knowledge came from soft core porn, films and books, and from information from his peers as a youngster. He gained some knowledge about sexually transmitted diseases because he once required

Figure 6
Sexual Knowledge Questionnaire
Mr. "B"



1 = Pre test
2 = Post test

treatment for same. He received no sexual information from his parents, and has learned a fair amount from his wife since their marriage.

11.3.4 Client Satisfaction Questionnaire (CSQ)

The results of the CSQ are shown in Table #1. Mr. "B" made good use of the questionnaire. He made a suggestion that more video material would benefit future participants. He especially felt showing more victim material would be helpful. Mr. "B" expressed overall satisfaction with the program.

11.4 Mr. "H"

11.4.1 Cognition Scale

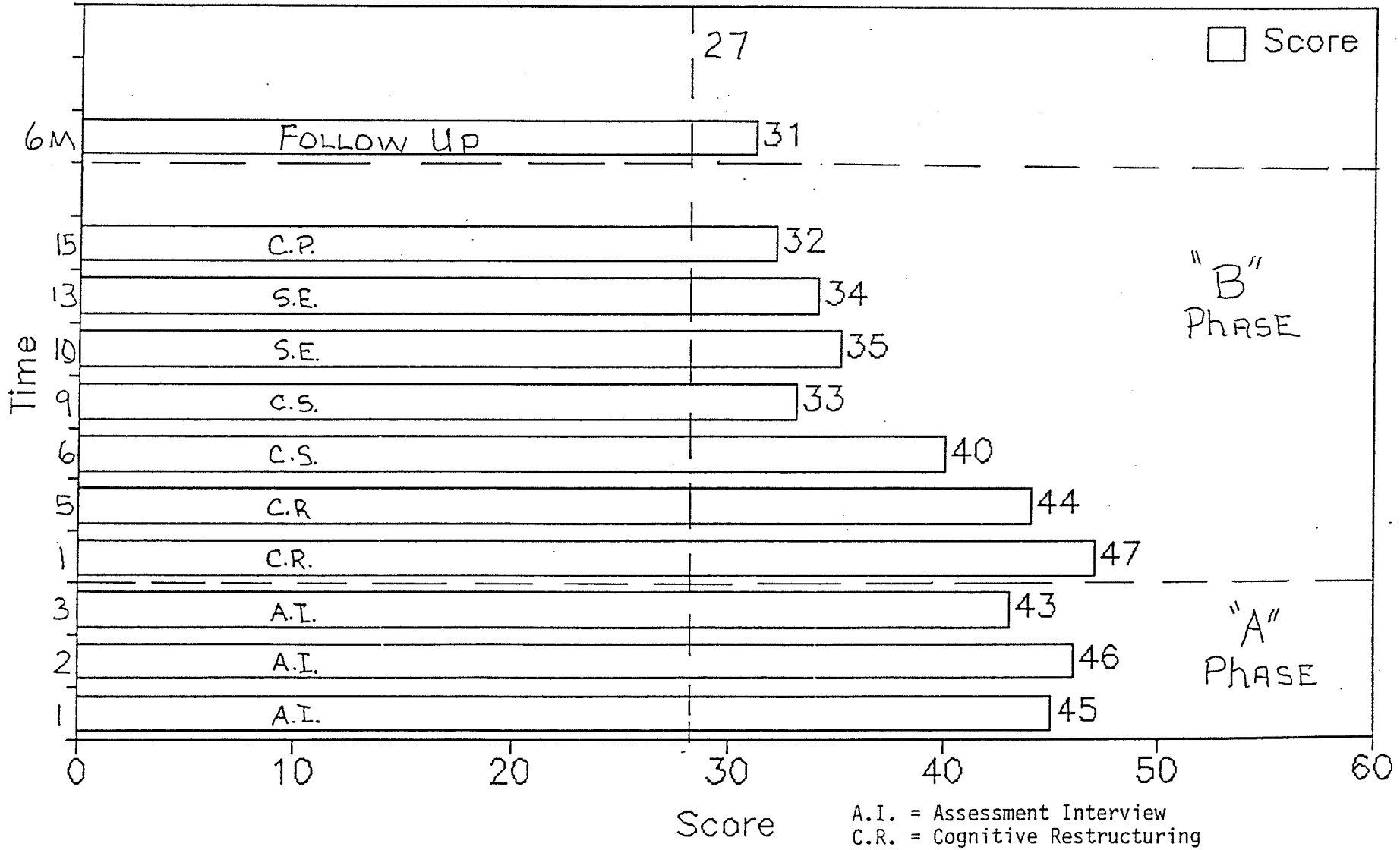
Again, the scale was completed on some occasions as with the two previous clients. In examination of Figure 7, a gradual improvement in sexually appropriate beliefs can be noted. In examining Mr. "H" more closely, a number of points become clear. One question in particular caused Mr. "H" a great deal of trouble. The question states: "My daughter/son or other young child knows I will still love her/him if she/he refuses to have sex with me." This question consistently fell at the wrong end of the continuum. In

examining this with the client, he still felt strongly in his answers. The therapist confronted him on this issue on many occasions, advising him that he must be aware that he cannot know how someone feels without checking it out. He acknowledged that he has never talked to his daughter about the offence or told her it was all his responsibility. We continued to work on this issue to the end of treatment

A visual examination of data indicates a significant clinical change. In examining Mr. "H" more closely he admitted he felt more in control and more understanding of himself as a man. He also acknowledged a need to be more open with his new partner. He acknowledged that if children become a part of their relationship, they must take responsible steps to avoid placing them at risk of abuse. He realizes he is at risk, and feels the skills he has learned will help him to control his feelings.

Figure 7

Mr. "H" Cognition Scale



A.I. = Assessment Interview
C.R. = Cognitive Restructuring
C.S. = Covert Sensitization
S.E. = Sex Education
C.P. = Covert Pain

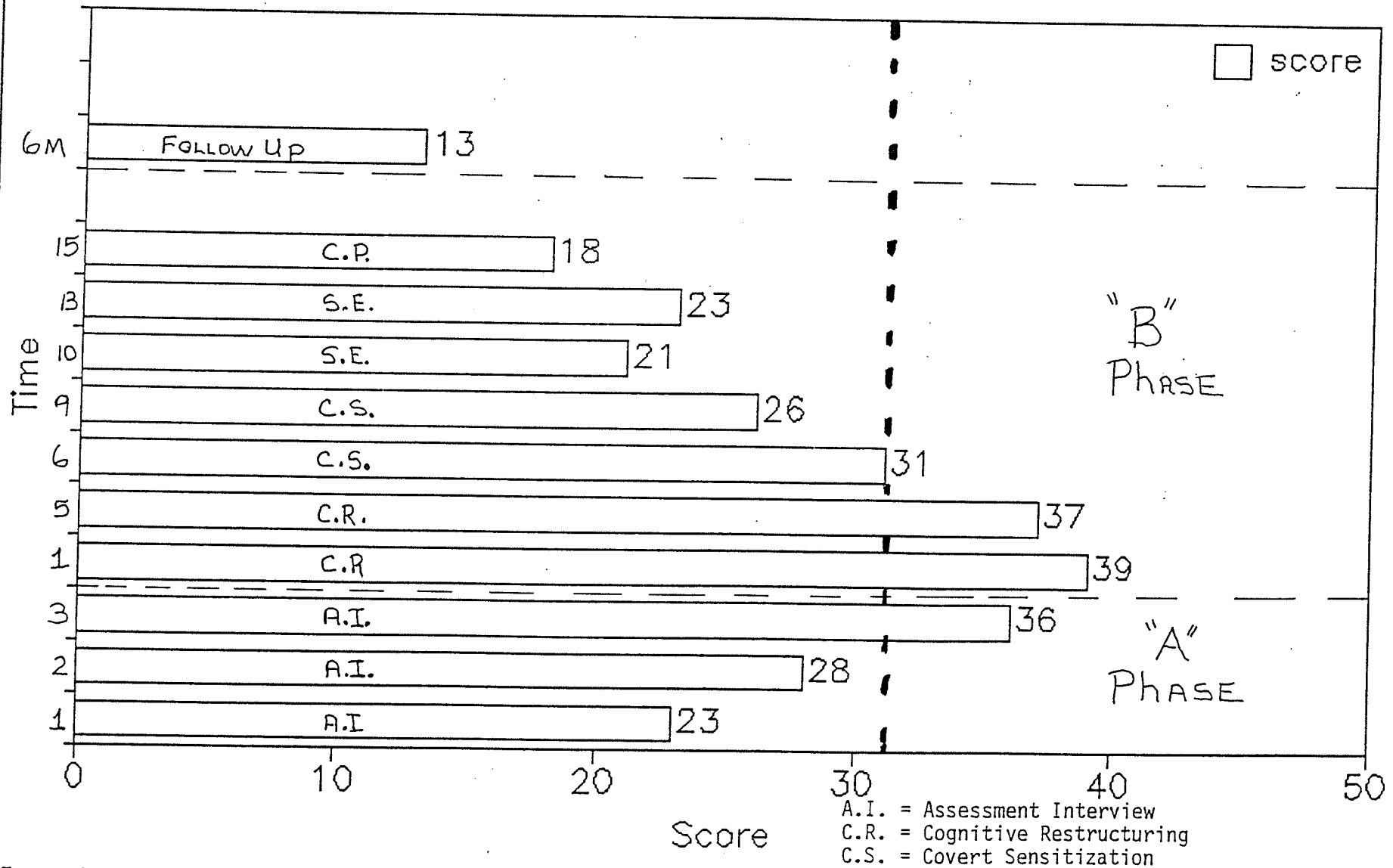
SEXUAL NORMALS SCORE = 27

11.4.2 Hudson (ISE)

In examining Mr. "H's" ISE, a number of unique points need to be addressed. When he began treatment, his ISE was quite low, (Figure 8). The therapist believes this to be the result of prior therapy from another offender specialist in Winnipeg. Mr. "H" had already begun to deal with a number of the problem issues. The gradual rise during treatment is attributed to a very stressful time he was having with his ex wife. During treatment on more than one occasion, she had talked about returning to his original home in the Maritimes. This possibility affected Mr. "H" greatly as he realized this would mean he would not be able to see his kids anymore.

However, as his home situation improved, and he himself felt more in control of his feelings his scores began to fall again. Mr. "H" also near the end of therapy, acknowledged total responsibility for the offence to the victim. Mr. "H" was well moved into a new relationship and advised his new partner of his difficulty. Her response and support during treatment made him feel much more positive about himself as a person. He also acknowledged that the package itself made him feel more aware and in control of his feelings.

Figure 8
Mr. "H" Hudson (ISE)



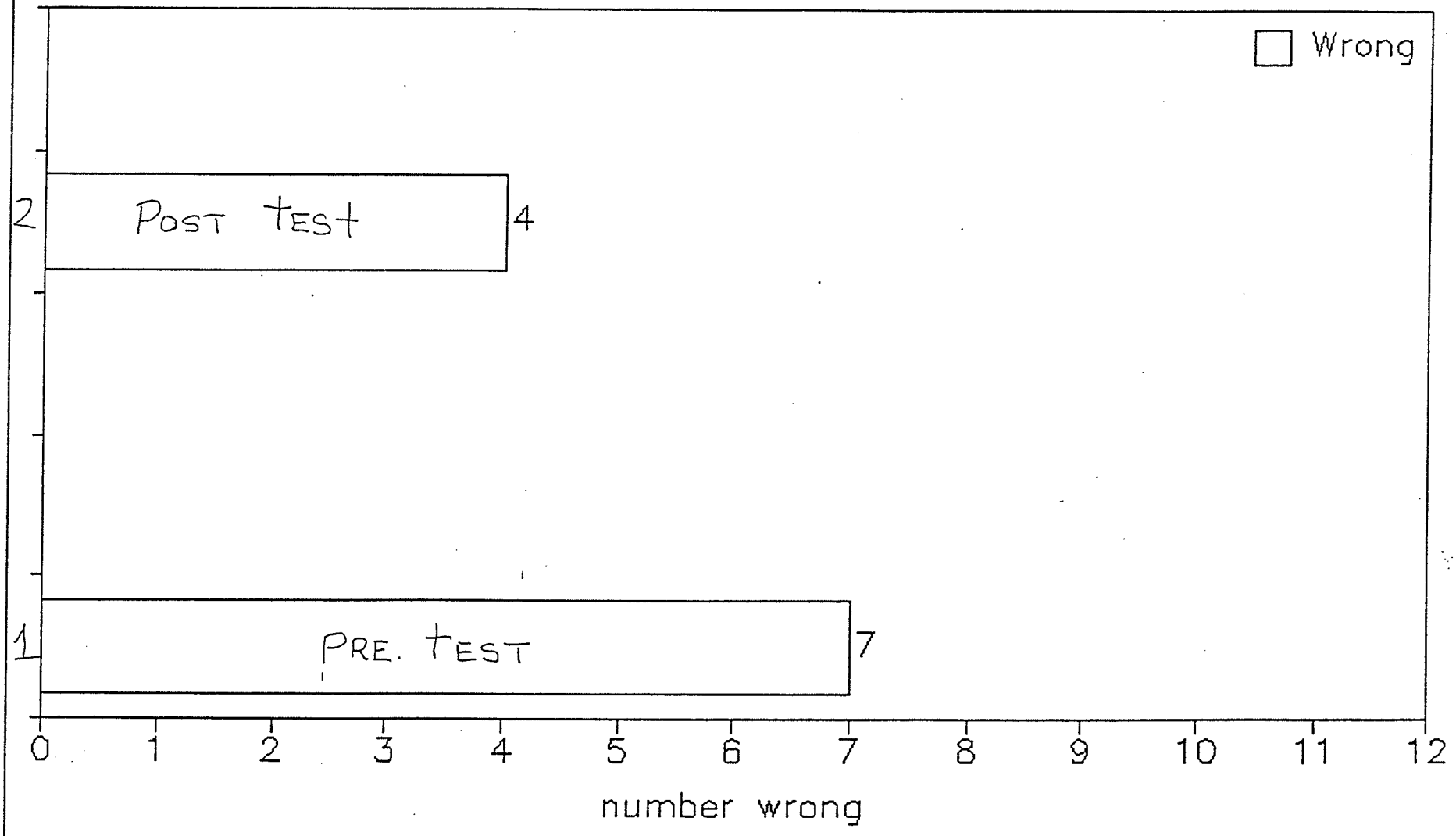
Scores above 31 + low self esteem

A.I. = Assessment Interview
C.R. = Cognitive Restructuring
C.S. = Covert Sensitization
S.E. = Sex Education
C.P. = Control Pain

11.4.3 Sex Education Questionnaire

Mr. "H" exhibited a significant change change in the (SEQ), Figure #9 In the pre test he had eight wrong while in the post test he had three. In discussions with Mr. "H" he acknowledged the usefulness of this section of treatment, stating very clearly that he never had any formal sexual education. He indicated that the program dispelled a few of the myths he was still carrying around. All dealt with some issues causing him and his new partner concern.

Figure 9
Sexual Knowledge Questionnaire
Mr. "H"



11.4.4 Client Satisfaction Questionnaire (CSQ)

The results of the CSQ are shown in Table #1. Mr. "H" made use of the questionnaire and felt fairly positive about the program. He felt fairly strongly that there are other issues to work on, and that perhaps they should be part of the program. He identified a need for improvement in his ability to relate to others and being more confident in doing so.

11.5 Follow scores

The follow scores on each participant are noted in the appropriate figures. As mentioned earlier, Mr. "K's" follow up scores are only available for the six month follow up. As one observed, the scores appear to be consistent with the scores at completion of treatment. It is impossible to make any long term statements about effectiveness of treatment without long term follow-up. As noted in the literature review, reoffence, if it was to occur, normally occurred years after the first detection.

12 Discussion

The present study sought to replicate parts of an existing treatment regimen (Abel et al, 1984) and evaluate its effectiveness. The specific goals of the intervention were to: 1) get the perpetrator to identify and correct any cognitions he may have had which allowed the abuse to occur; 2) To have the client identify his arousal cycle and utilize covert sensitization to control it; 3) to increase his knowledge in the area of human sexuality, which is believed to be a major weakness in the make up of men who molest children; and 4) finally to realize they must develop and follow a lifetime plan to prevent their involvement in similar assaults. As well, the therapist believed that participation in this behavioral package would enhance the client's self esteem. As he gains control of his inappropriate urges and beliefs, he would gain more self confidence and control of his life in total.

12.1 The effectiveness of the Behavioral Package

The effectiveness of this study was evaluated by four measures. The Cognition Scale (Abel et al, 1984) Appendix 3 was used to identify inappropriate beliefs and monitor the effect of treatment in dispelling them. The Hudson Index of Self Esteem (Hudson, 1982) (Appendix 4) was used to evaluate the impact of the package on the clients level of self esteem. The Sex Knowledge Questionnaire (Appendix 5) was

used to evaluate the effect of the sex education curriculum on the clients understanding of human sexuality. Finally, a client satisfaction questionnaire (Appendix 6) was used to enable the participants to rate the effectiveness of the various parts of the program.

The result of the study indicate that the behavioral interventions chosen were successful in helping the participants, to various degrees, achieve the stated goals. The specific goals will now be discussed.

12.2 Distorted Beliefs - Identification and Correction

The results indicated that the program was successful in helping each of the participants identify a number of distorted beliefs. In all three cases significant change occurred, which assisted the clients in identifying and in turn accepting the restructured reality of their beliefs. They appreciated how their behaviors were often self-serving and very seldom had any actual basis. This process helped them appreciate the impact their behavior had on the victim, their family and themselves. It demonstrated that clinically significant changes were observable in 100% of the subjects, all of whom had been shown to have distorted views of their behavior and its impact on those around them.

The use of video material was identified by all participants as a key factor in getting them to see the seriousness of their behavior. The "Men Who Molest" (Appendix 7) was identified as a strong motivator to identify and deal with their inappropriate beliefs. Similar comments were made about the other audio presentation "The Untold Secret" (Appendix 8). This video had special impact with one perpetrator, Mr. "B", who saw the victims very much as a representation of his daughter.

12.3 Covert Cycle

The covert sensitization portion of the module had a very marked impact on all three men. For all it was the first time they could really identify the arousal they felt at the time of the abuse. As well, the discovery scene was extremely powerful in helping them become less self centered in their view of the outcome of the abuse. They all now realize the impact certainly has effects on themselves, as well as the victim and other significant actors in his life. All the participants felt that they would be able to make use of the technique in the future.

12.4 Sex Knowledge Curriculum

In examining the sexual knowledge questionnaire it would appear that the knowledge curriculum met the stated objectives of the program. The reduction in all of the scores from pre-test to post test would appear to indicate a clinically significant improvement in factual knowledge. It is believed that some of the answers to the pre-test questionnaire were guesses by the various participants. When the questionnaire was examined in detail with one participant, significant details were noted in that the number of incorrect answers went up in the pretest

A possible explanation for this observation is contained in the male tendency to maintain a guarded stance towards admitting any weakness in the area of his understanding of issues related to sexuality, especially to other males. Another possible explanation is the format of the questionnaire itself. With a true false response set it is sometimes easier to at least attempt a response, when you have a 50% chance of picking the right answer. In retrospect, the use of a multiple choice questionnaire would seem more appropriate as it would perhaps allow a closer evaluation of the participants actual understanding.

12.5 Self Esteem and Sense of Control

In two thirds of the subjects there was clinically significant change and significant improvement in the participants level of self esteem. In one case, Mr. "K", the level of self esteem remained at a clinically problematic level. The therapist suggests a number of possible reasons for the one group of high scores: (1) Mr. "K" is a gentleman who suffers from a problem (client's view) with stuttering. He is extremely conscious of his difficulty and works hard to control it; (2) Mr. "K" comes from a very fundamentalist religious background and he lost support from this group because of the assault; and (3) finally, he saw his involvement with the therapist as a cause of the end of a relationship he was having with a woman being seen in therapy as part of the adult survivors program run out of the P.S.C. All of these factors, either together or in isolation, could help to explain the higher scores.

In the other two cases, significant improvement occurred. It was less significant with Mr. "H" who had a great deal of individual treatment, with another offender specialist in Winnipeg prior to referral to the therapist's project.

In both the general evaluation of data and evaluation of the Client Satisfaction Questionnaire, improvement in self esteem and the client's feeling of control seems to have been clinically significant. Each of the participants extended themselves to great lengths in producing strong individual control plans. As well, each felt that to varying degrees, the program as a whole, met their needs and dealt with the identified problem.

The therapist felt that for the most part the client statements were sincere. The therapist acknowledged that the nature of the problematic behavior would make discussion of ongoing difficulties next to impossible. To do so would require the perpetrator to admit the high likelihood of reoffence, which for these men would probably mean incarceration. The literature strongly suggests that perpetrators can distort the truth to avoid detection. In a positive sense each participant responded extremely well during therapy, and one participant continues to remain in contact and in therapy even after the mandatory expectation to do so has terminated.

12.6 Summary

On the basis of these results, it can be concluded that the behavioral techniques utilized were effective in meeting

the majority of the original objectives. The changes achieved are not necessarily attributed to the package alone, however, other factors to be considered are the societal pressures around abusive behavior and the potential reinvolvement of the court system for the failure to comply.

12.7 Implications for Future Programming

The present study has strengthened the validity of statements regarding the value and effectiveness of behavioral interventions for use with this client population. The increase in positive and appropriate beliefs and the sense of improved control of their behavior gives these men a sense of control over their day to day lives. In the course of assessment and intervention, the therapist identified a numerous other problem areas common to this client group. These included lack of strong social skills, assertiveness and problems in marital functioning. As described in the literature review, this group is multiproblematic; therefore, replication of this study should perhaps involve dealing with these other variables.

The author would like to suggest that use could be made of stronger, more specific scales and questionnaires. The significance of the data could perhaps be enhanced if different instruments were used. The Sexual Knowledge

Questionnaire was especially weak in its design and the author felt limited success was met using it to evaluate actual increase in sexual knowledge.

The very nature of the offenses and its impact on the victim demands close and effectual monitoring of this client group. The author would suggest that consideration be given to the use of instruments like the lie detector test and the plethysmograph. Although the literature suggests they are not infallible, they would perhaps aid the investigators ability to control for some of the types of behavior previously discussed.

The author would also recommend some discussion with court officials who have control over the client. Disclosure of past undetected offenses may occur during treatment. While current protocols require reporting such disclosures, a new protocol governing the consequences to the perpetrator for such disclosures needs to be developed that reflects the fact that the perpetrator is disclosing during treatment.

13 Appendix 1 - Control Plan (Abeletal - Example)

_ Example included in (Abel et al)

- (p.p. 99)

14 Appendix 2 - Assessment Protocol

PROTOCOL FOR INITIAL ASSESSMENT INTERVIEWS

November, 1987

ADAPTED FROM (JEHU, GAZAN KLASSEN & DREIHBLATT, RBEL ET AL)

DEMOGRAPHIC DATA

A. Client

1. Surname
2. Given names
3. Age
4. Occupation
5. Marital status and history
6. Children (names, sexes, ages)
7. Education
8. Ethnic background
9. Religion

B. Partner

1. Surname
2. Given names
3. Age
4. Occupation
5. Marital status and history
6. Children (names, sexes, ages)
7. Education
8. Ethnic background
9. Religion

CLIENT'S FAMILY OF ORIGIN

C. Father Figure(s)

1. Relationship with client (e.g. natural/adoptive/step/foster)
2. Dead/alive
3. Age now
4. Occupation
5. Ethnic background
6. Religion
7. Client's description of father figure
8. Client's relationship with father figure
9. Problems exhibited by father figure (note 1).
   e.g. Limited social skills
   Oppressed by others
   Interpersonal isolation and alienation
   Anger/hostility/violence
   Physically abusive towards spouse
   Sexual dysfunction/dissatisfaction
   Promiscuity
   Prostitution
   "Psychological absence" from family
   Physical absence from family
   Ineffective/non-nurturing parent
   Excessively religious/moralistic
   Physically abusive to children
   Alcohol abuse
   Drug abuse

Depression
Other psychiatric disorder
Low intelligence/poorly educated
Poor physical health
Poor employment history
Criminal history
Other problems (specify)

D. Mother Figure(s)

1. Relationship with client (e.g. natural/adoptive/step/foster
2. Dead/alive
3. Age now
4. Occupation
5. Ethnic background
6. Religion
7. Client's description of mother figure
8. Client's relationship with mother figure
9. Problems exhibited by other figure (note 1)
   e.g. Limited social skills
   Over-dependence on others
   Oppressed by other
   Interpersonal isolation and alienation
   Anger/hostility/violence
   Physically abusive towards spouse
   Sexual dysfunction/dissatisfaction
   Promiscuity
   Prostitution
   "Psychological absence" from family
   Physical absence from family
   Ineffective/non-nurturing parent
   Excessively religious/moralistic
   Physically abusive to children
   Alcohol abuse
   Drug abuse
   Depression
   Other psychiatric disorder
   Low intelligence/poorly educated
   Poor physical health
   Poor employment history
   Criminal history
   Other problems (specify)

E. Siblings

1. Relationship with client (e.g. natural/adoptive/step/foster)
2. Name
3. Sex
4. Age now
5. Client's relationship with sibling
6. Was sibling sexually victimized?
7. Did sibling sexually victimize others or self?

F. Family Functioning

1. Features characterizing family functioning during client's upbringing (note 2).
   e.g. Social isolation
   Role confusion
   Milieu of abandonment
   Marital conflict/disruption
   Oversexualization
   Poor supervision
   Male supremacy
   Intergenerational sexual victimization
   Others (specify)

G. Other Domiciles

1. Settings other than family of origin in which client lived prior to age 17 years (e.g. foster home, group home, with grandparents).

ABUSIVE BEHAVIOUR

1. Duration of Abuse.

2. Sexual activities that occurred. Sexual activities that occured between victim and any offender.
   e.g. Exhibitionistic display of offender's genitals to victim.
   Voyeuristic observation of victim by offender.
   Erotic kissing
   Erotic fondling of victim's body by offender
   Erotic fondling of offender's body by victim
   Victim observes offender masturbating
   Offender observes victim masturbating
   Manual stimulation of victim's genitals by offender
   Manual stimulation of the offender's genitals by the victim
   Oral stimulation of the victim's genitals by the offender
   Oral stimulation of the offender's genitals by the victim
   Digital penetration of the victim's anus by the offender
   Penile penetration of the victim's anus by the offender
   Simulated/"dry" intercourse
   Penile penetration of the victim's vagina by the offender

3. Methods used by offender(s) to induce victim to engage in sexual activities (note 3).
   e.g.: Misrepresenting activities as a game, fun, "something special", or "fooling around"
   Misrepresenting activities as sex education
   Opportunity for attention and affection
   Proclamation of romantic love
   Bribery
   Promise of sexual gratification
   Exercise of adult authority
   Threats

Physical force
Duty to replace mother
Other methods (specify).

4. Perceived reaction of victim to abuse.
   e.g. Fear
   Guilt/shame/disgust
   Shock/surprise
   Anger/resentment/hostility
   Feelings of helplessness
   Loving, protective, compassionate feelings towards offender
   Emotional pleasure
   Physical pleasure

5. Disclosure

   1. How did it occur?
   2. Your reaction to detection?
   3. How did matter get resolved?
   4. Did you admit or deny?

6. Access to Victim

   1. Do conditions of Order limit contact?
   2. Do you have any contact with children?

7. Sexual History

   1. Were you a victim of abuse?
   2. How and when did your sexual education begin?
   3. Type of sexual activity?
   4. With who? - peers, relative, sibling
   5. Do you have a current sexual partner? Is relationship a positive one?
   6. Do you have fantacies about sex?
      - With who?
      - Does it involve children?
   7. Do you masturbate?
      - To what fantasy?

8. Prior Treatment

   1. Form(s) of treatment that client has experienced prior to current therapy, and which of these included specific attention to the offending behaviour.
      e.g. Individual treatment
      Professionally led group treatment
      Self-help group
      Family therapy
      Marital therapy
      Sex therapy
      Psychotropic medication
      In-patient psychiatric treatment
      Others (specify).

15 Appendix 3 - Cognition Scale (Belief Inventory)

COGNITION SCALE

- LIST OF A NUMBER

OF COMMON AREAS OF DISFUNCTIONAL BELIEFS - CLIENT RESPONSE ON A 5 POINT LIKERT SCALE.

- P.P. 101
- TREATMENT MANUAL
- (ABLE ET AL 1984)

16 Appendix 4 - Hudson Index of Self Esteem

HUDSON INDEX OF SELF ESTEEM

- 25 QUESTION SCALE USED TO MEASURE SELF ESTEEM - 5 POINT LIKEAT SCALE - SCORING AND SCALE MAKE-UP EXPLAINED IN THE CLINICAL MEASUREMENT PACKAGE - A FIELD MANUAL - WALTER HUDSON - DORSEY PRESS 1982.

17 Appendix 5 - Sexual Knowledge Scale

SEXUAL KNOWLEDGE SCALE

- TRUE FALSE QUESTIONNAIRE
- TREATMENT MANUAL (ABEL ET AL)
  p.p. 98-99

18 Appendix 6 - Client Satisfaction

-THE CLIENT SATISFACTION QUESTIONNAIRE (CSQ)

- EVALUATION AND PROGRAM PLANNING
- LARSEN ET AL 1979
- P.P. 179-207

19 Appendix 7 - Men Who Molest

APPENDIX #7

MEN WHO MOLEST (V.H.S. Tape)

- Public Broadcasting System (P.B.S.) Production Frontline - February 1986

- The program is a description of Sexual Offender Program run in Seattle, Washington - Wolfe and Associates Northwest Treatment Association. The program shows viewer types of treatment used and participant's responsibilities. Vignette's also show viewer, various offenders and how their offence has effected themselves and their victims.

20 Appendix 8 - "Child Sexual Abuse: The Untold Secret"

APPENDIX #8

"INCEST, THE UNTOLD SECRET" (Film)

- 1982
- National Film Board
- (30 minutes)

- Documentary of 5 teenage girls describing their years of sexual abuse by their fathers and step-fathers. They offer encouragement to other young people, to seek available help for similar problems.

21 Appendix 9 - Birth Control (Handout)

ARTICLE

RATING THE LATEST METHODS OF BIRTH CONTROL

- JUDITH GREENWALD
- HARPERS BAZAAR MAGAZINE (1975)

22 Appendix 10 - V.D. (Handout)

APPENDIX #10

"U.D.: IF YOU'RE OLD ENOUGH TO GET IT,
YOU'RE OLD ENOUGH TO READ ABOUT IT"

Sol Gordon

Adapted from "Facts About
U.D. for Today's Youth"

Ms. Magazine

June 1974

23 Appendix 11 - Myths and Fallacies (Handout)

APPENDIX #11

"MYTHS AND FALLACIES (Handout)

James L. McCary

reproduced from

Human Sexuality, (1967)

James L. McCary

Van Nostrand Reinhold

- The chapter provides to reader a number of pervasive sexual misconceptions. The therapist used it to encourage the client to examine his own history, for similar misconceptions.

24 Appendix 12 - Rationalizations (Abel's Text)

APPENDIX #12

LIST OF RATIONALIZATIONS

- List of rationalizations used by some sexual perpetrators - used as starting point in developing clients own list of rationalizations.

pp. 39 - 42

Treatment Manual

(Abeletal 1984)

25 Appendix 13 - "Am I Normal"

APPENDIX #13

"AM I NORMAL" (Film)

- 1980
- Planned Parenthood
- Winnipeg (24 minutes)

- Using fictional characters and a humorous story line, the film presents the facts about male secual development, while raising important issues about masculinity, identity and peer pressure.

26 Appendix 14 - Male Anatomy Diagram

-MALE ANATOMY DIAGRAM

- PROVIDED BY PLANNED PARENTHOOD WINNIPEG-
- TEACHING TOOL DEVELOPED BY THAT AGENCY.

27 Appendix 15 - Female Anatomy Diagram

FEMALE ANATOMY DIAGRAM

- PROVIDED BY PLANNED PARENTHOOD MANITOBA
- TEACHING TOOL DEVELOPED BY THAT AGENCY.

28 Appendix 16 - Sexual Dysfunctions (handout)

ARTICLE

NO NONSENSE THERAPY FOR SIX SEXUAL MALFUNCTIONS

- HELEN SINGER KAPLAN
- PSYCHOLOGY TODAY 1974

LEAVES 215 to 218 OMITTED IN PAGE NUMBERING.

FEUILLETS 215 A 218 NON INCLUS DANS LA PAGINATION.

29 Appendix 17 - Four Factor Model (Finkelhor)

FINKELHOR'S FOUR FACTOR MODEL

- MULTIFACTORIAL EXPLANATION FOR SEXUALLY ABUSIVE BEHAVIOUR IN OFFENDERS
- CHILD SEXUAL ABUSE
  :NEW THEORY AND RESEARCH.
- FINKELHOR, D. (1984)

Addendum

-Please omit pages 221-222-
pages numbered in error- Finkelhor
Model not to be included in its
entirety

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