From Victim to Client: Preventing the Cycle of Sexual Reactivity

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Cashwell, C. S., Bloss-Snyder, K. K., & McFarland, J. (1995). From victim to client: The cycle of sexual reactivity. *The School Counselor, 42*, 233-238.

Article:

Much has been written concerning the incidence of sexual abuse of children and adolescents, the potential long-term consequences of such abuse, and the need for child sexual abuse prevention efforts (Barker, 1990; Barth & Derezotes, 1990; Krivacska, 1990). Education about sexual abuse and other prevention efforts is becoming increasingly prominent in schools, community-based agencies, and in the home (Krivacska, 1990). Recent literature, however, has emphasized as important sexual reactivity, another potential repercussion for the sexual abuse victim. Sexual reactivity refers to sexualized behavior that appears in direct response to recent sexual abuse (Friedrich, 1990; Sgroi, Bunk, & Wabrek, 1988). This article will focus on the sexually aggressive behavior of children and adolescents who have been sexually abused as children. We will provide an overview of the current literature on sexual reactivity, offer theoretical explanations for the incidence of sexually reactive behavior, and discuss implications for prevention and early intervention of this phenomenon.

Frequently, the cycle of sexual reactivity begins before adulthood. Adolescents perpetrate 20% of all rapes and 30% to 50% of child molestations (Johnson, 1988). Although Finkelhor (cited in Krivacska, 1990) noted that the majority of persons abused as children do not themselves become abusers, empirical studies suggest that between 50% and 80% of male adolescents who commit sexual offenses have a history of having been victimized (Breer, 1987; Burgess, Hartman, & McCormack, 1987; Johnson, 1988). Also, younger children who are sexually abused by another child may not disclose because they do not comprehend that the behavior is inappropriate (Sgroi et al., 1988). Clearly, both a greater understanding of this phenomenon and intervention strategies are needed.

In assessing the appropriateness of sexual behavior, the developmental level of the sexually reactive offender is a vital consideration. Accurate assessment of an individual's developmental level provides a reference point for determining what behaviors, when perpetrated by a child or adolescent, constitute sexual abuse (Sgroi, et al., 1988). Sgroi et al. offered a developmental framework (see Appendix A) for assessing children's sexual behaviors that examined the appropriateness of masturbation, looking at others, and touching others among various aged children and adolescents.

COUNSELING CONSIDERATIONS

Two psychological theories that have been used to explain the incidence of sexual reactivity are behavioral and psychedynamic. From a behavioral perspective, modeling is a determinant in learning and engaging in the sexually reactive behavior. Paired-associate learning, the linking of the victimization experience with a pleasurable affect, may also predispose the victim to engage in sexually reactive behavior (Friedrich, 1990).

According to the psychedynamic perspective, the processes of internalization, identification with the aggressor, and dissociation contribute to the incidence of sexually reactive behavior. Guntrip (cited in Fried rich, 1990) reported that children internalize experiences with people and then act according to these internalizations. Although similar to modeling in that the child is abused and thus abuses, this perspective is distinct due to the intrapersonal rather than interpersonal focus. Breer (1987) described identification with the aggressor as the

psychic operation that reduces the anxiety from the traumatic experiences. The sexually reactive offender reexperiences the victimization in the role of the aggressor to overcome feelings of powerlessness caused by the experience (Breer, 1987; Stevenson, Castillo, & Sefarbi, 1990; Stuart & Greet, 1984). This identification offers relief as the victim relives the molestation experience in a role of power and control. The result is what Rieker and Carmen (1986) depicted as the victim to patient process. The sexually reactive offender may also be able to shape the truth of the incident through dissociation with the act (French, 1988). Various authors have suggested that through dissociation there is a blocking at the sensory, perceptual, and cognitive levels, resulting in the psychological splitting off of the victimization experiences (Burgess et al, 1987; French, 1988).

Because sexual reactivity is a relatively new area to researchers, many counselors are unaware of the psychological dynamics involved in treating reactive offenders. Friedrich (1990) provided several reasons as to why counselors are poorly equipped to deal with this issue. First, counselors are often uncomfortable acknowledging children as sexual beings. Second, male counselors may prompt sexual behaviors in children who have been sexually abused by men. Given that there are more female than male counselors for sexually abused children and adolescents, children who have been sexually abused by men may not "act out" sexually in the presence of a female counselor. Third, defensive parents, motivated by guilt and self-blame for the sexual abuse of their child, may sabotage intervention attempts. Finally, treatment for sexual offenders and sexual abuse victims has historically fallen at opposite ends of the facilitative continuum. Victim therapy is typically grounded in the client-counselor relationship and is supportive. Conversely, offender therapy often considers the client-counselor relationship as less important and relies more heavily on confrontation. Thus, the treatment of sexually reactive behavior must find a delicate balance between each of these seemingly dichotomous approaches. Both victim and offender strategies, however, share the common focus of establishing clear responsibility and positive control (Rencken, 1989).

IMPLICATIONS FOR INTERVENTION

Effective intervention efforts with sexually reactive clients will be community-wide and holistic in scope, involving primary, secondary, and tertiary prevention efforts. Primary prevention refers to school and community-based education aimed at raising childrens' awareness of sexuality and sexual abuse. Secondary prevention, or targeted intervention, refers in this case to treatment of sexually abused children in an effort to defuse the processes that may lead to sexually reactive behaviors in the future. Tertiary prevention refers to the treatment of sexually reactive children, adolescents, and their families in an effort to deter repeat offenses.

Primary prevention efforts should be aimed at preventing susceptible individuals from being victimized. Because those children who are at risk cannot be identified with any reliability, services should be provided to the entire population. A primary benefit of this "blanket" education is that it leads to increased rates of disclosure among sexually abused children. Nevertheless, sex education in the schools is important to children and youths regardless of whether they have experienced sexual problems (Biehr, 1989). Primary prevention efforts are typically conducted through group sessions in schools and must be developmentally appropriate for the group. For example, programs with elementary school age children must be concrete and specific, dealing with such topics as touch, "big people-little people" rules, and keeping secrets. An area of concern for such programs is that although many such prevention efforts focus on "good" and "bad" touching, they neglect to mention that "bad" touches can often feel confusing or even good or that abuse can exist with no touching. Another limitation of most available instructional materials is that they avoid issues such as molestation by parents, relatives, baby-sitters, or family friends, despite the fact that most sexual abuse is committed by these individuals and is unreported (Hollander, 1992).

Secondary prevention efforts should include individual and group counseling with children who have been sexually abused. For those children who show traumatic effects of the abuse, attention in counseling should focus on a wide range of issues. First, it is important to deal with any damage that may have occurred to the student's sexuality or perceptions of sex (Krivacska, 1990). Second, issues of the child's sense of shame, unworthiness, and powerlessness must be addressed (Barker, 1990). Developmentally, younger children will be more inclined to accept blame for the abuse, which is often reinforced by peers and family members. Finally,

development of empathy in the child or early adolescent, fostered by the decrease in egocentrism, will decrease the likelihood of sexually reactive behavior (Friedrich, 1990). This is best accomplished through opportunities for perspective-taking through role-playing in a group setting.

Tertiary prevention, or treatment of the child or adolescent sex offender, has previously been the missing link in this comprehensive prevention process, due largely to reasons previously mentioned. It is worth noting that one study cited that 70% of adolescent sex offenders receive neither counseling services nor incarceration for their offense (French, 1988). This statistic is startling in light of the results of a study by Becker and Abel (1985), which suggested that without treatment, the average male adolescent sex offender will commit 380 sexual offenses in his lifetime. Clearly, increased treatment resources are needed.

Tertiary prevention for children and adolescents is typically a modified version of adult offender treatment programs. The intervention may be community-based or residential and a range of services, including individual, group, and family therapy for the offending child or adolescent, is recommended. In this manner, individual and family issues of denial and suppression can be explored and remediated. Family interventions should deal with the cycles of abuse, appropriate modeling, and communication. Group interventions are useful in developing interpersonal skills, affective expression, self-concept, teaching sex education, and exploring sex-role issues (Rencken, 1989).

THE ROLE OF THE SCHOOL COUNSELOR

A fundamental role of the school counselor is in assessing the appropriateness of sexual behavior and, based on this assessment, determining the need for intervention. Recommended actions for school counselors in working with possible sexually reactive adolescents include the following:

1. Develop appropriate referral sources for cases that require highly specialized interventions.

2. Acknowledge and accept children and adolescents of all ages as sexual beings.

3. Develop the ability to assess the pathology of sexual behavior (see Sgroi et al., 1988).

4. Know the laws within your state for reporting child victimization.

5. Determine the preferred gender of the counselor; inability to match this may require referral.

6. Anticipate defensive reactions from one or both parents; minimize guilt and self-blame of the parents at the outset of the counseling process to increase the potential of gaining their support.

7. Assess damage that may have occurred to the student's sexuality or perceptions of sex.

8. Address the following treatment issues: guilt, fear, depression, low self-esteem and poor social skills, repressed anger and hostility, inability to trust, role confusion, failure to meet developmental tasks, control, and intimacy (Porter, Blick, & Sgroi, 1982).

9. Assess the student for suicidal ideology; the powerlessness and shame felt by the abuse victim increases the risk of both attempting and succeeding at suicide (Rencken, 1989).

10. Assess peer relationships and support structure.

11. Gain trust and respect while maintaining an appropriate role and distance (Rencken, 1989).

12. While acknowledging and discussing the victimization experience in detail, do not accept the victimization as an excuse or justification for an offense (Rencken, 1989).

CONCLUSION

School counselors will be called on increasingly to deal with issues of sexually reactive behavior among children. Clearly, more empirical research is needed surrounding this topic. It is hoped that more research efforts and clinical sensitivity to this issue will enhance the profession's capacity to mediate the incidence of sexually reactive behaviors among children and adolescents.

Note.

From Table 1-2 in Suzanne M. Sgroi, Barbara S. Bunk, & Carolyn J. Wabrek, "Children's Sexual Behaviors and Their Relationship to Sexual Abuse." In Suzanne M. Sgroi (Ed.), Vulnerable Populations, Vol. 1 (pp. 1-24).

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APPENDIX A

Sexual Abuse Behaviors by Children: Assessment Methodology

• Complaint Status

Has a complaint of sexual abuse initiated by a child already been made? By the victim or the injured party himself or herself? By someone else on behalf of the victim? The existence of a complaint implies that someone has already objected to sexual behavior initiated by a child and deemed it questionable, inappropriate, or frankly abusive.

• Behavioral Indicators of Sexual Abuse

Has one or more children exhibited a behavioral indicator of sexual abuse? At least one child will have done so, by definition, in the course of initiating an interactive sexual behavior that was viewed by others as abusive. If the sexual behavior involved two children--an initiator and a recipient, a leader and a follower, or an abuser and a victim--the second child may also have exhibited a behavioral indicator of sexual abuse (e.g., excessive masturbation, promiscuity, or sexual abuse of others).

• Developmental Perspective

Does the sexual behavior initiated by a child fit into anticipated developmental norms with regard to ages of the participants, patterns of activity, and sexual behavior? Specifically, is the pattern of activity and type of sexual behavior age-appropriate for the child who initiates the sexual behavior? If the other participants are children, is their behavior appropriate with a developmental perspective?

• Relative Power Positions of Participants

What are the relative power positions of the participants? Does the child who initiates sexual behavior with another person occupy a subordinate position to the other person? Or are they peers with regard to their age, size, cognitive abilities, life experiences, and the like? Does the child who initiates sexual behavior with another child who is apparently a peer occupy a less obvious power position over the second child? Or is the victim an adult or an older child who is at a disadvantage because she or he was not expecting the abuser to initiate sexual activity and was taken by surprise?

• Force or Intimidation

Did the child who initiated the sexual behavior use force or intimidation to engage the cooperation of the other party? What did the victim believe would be the result of noncompliance with the sexual behavior? Was force used or threatened in carrying out the sexual acts? Did the victim fear physical injury to himself or herself or "just" embarrassment?

• Ritualistic or Sadistic Behaviors

Did the sexual behavior have ritualistic or sadistic elements? Did the child who initiated the behavior do so within the context of performing a religious or occur rite? Did the sexual behavior include elements of bondage, sacrifice, torture, or other sadomasochistic elements?

• Secrecy

Did the child who initiated the sexual behavior do so openly or furtively? With concern about discovery or disregard for being detected? Were other participants bribed or threatened? What did the victim think would happen if she or he told others?