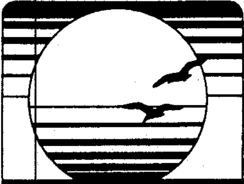

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The Sex Offender

A Compilation

by

Dr. Ray Kim

Director, Forensic Psychology Program

October 11, 2000

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CURRICULUM VITAE

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EDUCATION

1996	***Postdoctorate in Forensic Psychology***, Elgin Mental Health Center, Elgin, Illinois.
1994	***Ph.D. in Clinical Psychology*** (Accredited by the American Psychological Association), Temple University, Philadelphia, Pennsylvania.
1991	***M.A. in Clinical Psychology*** (Accredited by the American Psychological Association), Temple University, Philadelphia, Pennsylvania.
1988	***B.A. in Psychology*** (Departmental Honors), Northwestern University, Evanston, Illinois.

CLINICAL EXPERIENCE

1999-Present

Senior Psychologist, Chicago Metropolitan Forensic Services, Elgin, Illinois.
Activities: Supervision of a team of psychologists and social workers who evaluate and recommend placement for defendants in custody who are adjudicated Unfit to Stand Trial (UST) and those acquitted Not Guilty by Reason of Insanity (NGRI). Coordination of forensic outpatient evaluations (i.e., UST and NGRI). Development of treatment plans with

community mental health agencies for this forensic population.

Evaluation of forensic inpatients and outpatients, which include juveniles and adults who are mentally ill and/or developmentally disabled. Evaluation of sex offenders for sexual dangerousness under the Sexually Violent Persons Commitment Act. Testifying in court as a forensics expert. Consultations at psychiatric hospitals regarding patients who are considered behavior management problems. Consultations at community agencies regarding forensic issues, such as fitness restoration.

1999-Present — ***Licensed Clinical Psychologist***, The Counseling Center, Crystal Lake, Illinois.
Activities: Conduct psychological testing of children, adolescents, and adults. Specialize in forensic evaluations, such as fitness evaluations and sex offender evaluations. Also conduct substance abuse assessments. Counseling services for primarily forensic population (e.g., sex offenders).

1997-Present — ***Licensed Clinical Psychologist***, Horizons Behavioral Health, Hoffman Estates, Illinois.
Activities: Individual, couples, family, and group therapy of outpatient population of children, adolescents, and adults. Psychological assessments and testing. Crisis interventions. Privileges at Alexian Brothers Behavioral Health Hospital and Saint Alexius Medical Center.

1997-Present — ***Licensed Clinical Psychologist***, Patrick J. Kennelly, Ph.D. & Associates, P.C., Schaumburg, Illinois.
Activities: Individual, couples, and family therapy of children, adolescents, and adults. Psychological assessments and testing as well. Privileges at Provena Saint Joseph Hospital and Streamwood Behavioral Health Center.

1995-99 — ***Forensic Psychologist***, Elgin Mental Health Center, Elgin, Illinois.
Activities: Psychological assessment, testing, individual therapy, and case management of forensic inpatient population, specifically patients who have been adjudicated Unfit to Stand Trial and those acquitted Not Guilty by Reason of Insanity. Fitness evaluations and individualized treatment planning in an interdisciplinary team. Evaluations for involuntary admission and second level reviews of privilege proposals for patients who have been acquitted Not Guilty by Reason of Insanity. Facilitation of Fitness Restoration Group and Chemical Dependency Group. Development and monitoring of behavior programs for complex and problematic patients. Evaluation of sex offenders for risk of sexually dangerous behavior, as well as testifying in court. Participation in committees and work groups (e.g., Behavior Program Committee,

Discharge Standards Work Group).

1994-95 ***Clinical Director***, Rogers Park Child and Adolescent Services Program, Chicago, Illinois.
Activities: Development and management of a child and adolescent program. Building relationships with agencies and organizations serving children and adolescents, including the Child and Adolescent Local Area Network. Supervision of case workers and case managers. Comprehensive outpatient assessment and crisis intervention in the clinic and in the home. Individual, family, and group therapy of severely emotionally disturbed children and adolescents.

1993-94 ***Psychology Intern***, Ravenswood Hospital Community Mental Health Center, Chicago, Illinois.
Activities: Individual, couples, family, and group therapy of extremely varied outpatient population of children, adolescents, and adults. Group and milieu experiences on an adult inpatient unit. Crisis intervention and emergency consultation in the Intensive Care Unit and Emergency Room of the hospital, as well as consultation throughout the Medical Center. Psychological testing of children, adolescents, and adults.

1989-93 ***Clinician***, Psychological Services Center, Department of Psychology, Temple University, Philadelphia, Pennsylvania.
Activities: Individual and family therapy of adolescents and adults. Cognitive assessment of children and clinical case conference presentations.

1990-92 ***Practicum Trainee***, Friends Hospital, Philadelphia, Pennsylvania.
Activities: Psychological testing (i.e., personality, cognitive, and neuropsychological) of inpatient population of children, adolescents, and adults. Duties also included group therapy and milieu experiences.

1988-89 ***Therapist***, Child and Adolescent Anxiety Disorders Clinic, Department of Psychology, Temple University, Philadelphia, Pennsylvania.
Activities: Participation in the development of a cognitive-behavioral program in treating anxiety disorders of childhood and adolescence. Assessment of anxiety disorders of youth. Cognitive-behavioral therapy of children and adolescents receiving a diagnosis of an anxiety disorder.

1987-88 ***Co-Founder***, Community Service League, Northwestern University, Evanston, Illinois.
Activities: Unified the major community service organizations at Northwestern University in order to coordinate volunteer efforts. Areas of focus included mental illness, substance abuse, developmental disabilities,

child abuse, poverty, and homelessness.

1987-88 ***Volunteer***, Adult Community Outreach Network, Evanston, Illinois.
Activities: Provision of emotional support for the homeless and mentally ill, who are in the midst of chronic or critical problems which threaten their ability to function or survive. Helping program participants meet their needs for physical survival, security, affiliation, self-esteem, and fulfillment in order to maintain themselves in the community and to reduce the frequency of psychiatric hospitalizations.

1986-88 ***President***, Northwestern University Helpline, Northwestern University, Evanston, Illinois.
Activities: Training and supervision of peer counselors of a crisis hotline. Peer counseling of students with a variety of emotional problems, including eating disorders, sexual issues, relationship problems, family problems, adjustment issues, depression, stress/anxiety, academic pressures, suicidal ideation, and grief. Organization of educational seminars on topics such as stress management and depression.

1986-88 ***Vice President***, Northwestern's Organization of Volunteers in Action, Northwestern University, Evanston, Illinois.
Activities: Organization of community service projects such as taking abused children to the zoo and accompanying retarded adults to Northwestern football games, as well as participation in these events. On-going activities included Big Brother/Big Sister program, coaching for youth groups, tutoring, visiting nursing homes, and volunteering at soup kitchens and drop-in centers. Other volunteer activities included Students Working Against Poverty, Special Olympics, and Hands Across America.

1986 ***Volunteer***, CIT Mental Health Services, Cleveland, Ohio.
Activities: Group therapy and milieu experiences with chronically mentally ill patients. Diagnoses of patients included Schizophrenia, Bipolar Disorder, and Major Depressive Disorder.

1986 ***Counselor***, Ramapo Anchorage Camp, Rhinebeck, New York.
Activities: Supervision and behavior therapy of emotionally disturbed children, including autistic children, mentally retarded children, and children with low self-esteem.

RESEARCH EXPERIENCE

1991-93 ***Dissertation***, Differential activation of clinical disorders by self-focused attention, Department of Psychology, Temple University, Philadelphia, Pennsylvania.
Activities: Investigation of self-focused attention as a vulnerability factor in the etiology of various clinical disorders, including depression and personality disorders.

1990-93 ***Research Assistant***, NIMH Grant Project on Depression, Department of Psychology, Temple University, Philadelphia, Pennsylvania.
Activities: Psychological assessment of Axis I and Axis II disorders, utilizing structured interviews (i.e., Schedule for Affective Disorders and Schizophrenia, Personality Disorders Examination). Interviewing of subjects for information on life stressors and cognitive styles.

1989-90 ***Master's Thesis***, Understanding drug experiences through the semantic differential, Department of Psychology, Temple University, Philadelphia, Pennsylvania.
Activities: Examination of drug experiences of both high risk and low risk substance abusers by means of the semantic differential.

1988-90 ***Research Assistant***, NIAAA Grant Project on Homeless Poly-Drug Addicted Mothers and Their Children, Department of Psychology, Temple University, Philadelphia, Pennsylvania.
Activities: Collection of information through a structured interview (i.e., Addiction Severity Index) on drug/alcohol use history, housing and family situation, employment and support status, and psychiatric status. Cognitive assessment of homeless mothers and their children. Observation of interactions between mothers and their children
through the "strange situation" and "play videos." Play therapy of homeless children.

1987-88 ***Honor's Thesis***, Affect intensity as an individual difference in anxiety and impulsivity, Department of Psychology, Northwestern University, Evanston, Illinois.
Activities: Investigation of the personality construct identified as affect intensity, including collection, scoring, coding, and analysis of the research data.

1986-88 ***Research Assistant***, Projects on Depression, Department of Psychology, Northwestern University, Evanston, Illinois.
Activities: Collection of data in a study investigating the cognitive style of depressives. Collection and scoring of data in a study investigating the nature of self-focused attention in depression. Scoring, coding, and analysis of data in a study investigating the role controllability plays in the etiology, maintenance, and amelioration of depressive disorders.

1985-86 ***Research Assistant***, Project on the Effects of Modeling, Department of Psychology, Northwestern University, Evanston, Illinois.
Activities: Collection and analysis of data in a study investigating modeling effects on young school children, based on the research of Albert Bandura, Ph.D.

PROFESSIONAL AFFILIATIONS

American College of Advanced Practice Psychologists

American College of Forensic Examiners

American Psychological Association

American Psychologist Physicians' Register

American Psychology-Law Society

American Psychotherapy Association

Association for the Treatment of Sexual Abusers

Illinois Alcohol and Other Drug Abuse Professional Certification Association

Illinois Association for the Treatment of Sexual Abusers

Illinois Psychological Association

AWARDS AND HONORS

2000	Board Registered Mental Illness/Substance Abuse II, Illinois Alcohol and Other Drug Abuse Professional Certification Association
1999	Diplomate of the American Psychotherapy Association
1999	Founding Member of the American Psychologist Physicians' Register
1999	Founding Fellow of the American College of Advanced Practice Psychologists
1998	Diplomate of the American Board of Psychological Specialties
1997	National Register of Health Service Providers in Psychology
1997	Licensed Clinical Psychologist, Illinois Department of Professional Regulation
1997	Discharging Award, Elgin Mental Health Center
1988-93	Tuition Scholarship, Temple University
1992	Commendation, Temple University
1988	Psi Chi, Temple University
1988	Departmental Honors in Psychology, Northwestern University
1988	Maycourt Community Involvement Award, Northwestern University
1985-88	Dean's List, Northwestern University
1987	Benton J. Underwood Fellowship, Northwestern University
1987	Outstanding College Students of America, Northwestern University
1987	Mortar Board, Northwestern University
1987	Kappa Alpha Pi, Northwestern University
1987	Alpha Lambda Delta, Northwestern University

REVIEW ACTIVITIES

1994 Reviewer for Anxiety, Stress, and Coping: An International Journal.

1992 Reviewer for Cognitive Therapy and Research.

PUBLICATIONS

Alloy, L. B., Abramson, L. Y., Hogan, M. E., Whitehouse, W. G., Rose, D. T., Robinson, M. S., Kim, R. S., & Lapkin, J. B. (2000). The Temple-Wisconsin Cognitive Vulnerability to Depression Project: Lifetime history of Axis I psychopathology in individuals at high and low cognitive risk for depression. Journal of Abnormal Psychology, 109, 403-418.

Kim, R. S. (1997, September 24). Managing children's misbehavior. The Korea Central Daily, p. 3.

Kim, R. S. (1997, September 17). Are you depressed? The Korea Central Daily, p. 3.

Kim, R. S. (1994). Differential activation of clinical disorders by self-focused attention (Doctoral dissertation, Temple University, 1994). Dissertation Abstracts International, 55, 12B.

Kendall, P. C., Chansky, T. E., Kane, M. T., Kim, R. S., Kortlander, E., Ronan, K. R., Sessa, F. M., & Siqueland, L. (1992). Anxiety disorders in youth: Cognitive-behavioral interventions. Boston: Allyn and Bacon.

Kim, R. S. (1991). Understanding drug experiences through the semantic differential. Master's thesis, Temple University, Philadelphia, PA.

Kim, R. S., Poling, J., & Ascher, L. M. (1991). An introduction to research on the clinical efficacy of paradoxical intention. In G. R. Weeks (Ed.), Promoting change through paradoxical therapy (pp. 216-250). New York: Brunner/Mazel.

Kendall, P. C., Chansky, T. E., Freidman, M., Kim, R., Kortlander, E., Sessa, F. M., & Siqueland, L. (1991). Treating anxiety disorders in children and adolescents. In P. C. Kendall (Ed.), Child and adolescent therapy: Cognitive-behavioral procedures (pp. 131-164). New York: The Guilford Press.

PRESENTATIONS

Kim, R. S. (2000, September). Profiling the Sex Offender. Lecture conducted at Sexual Assault Nurse Examiner Conference, Illinois Criminal Justice Information Authority, Chicago, IL.

Kim, R. S. (2000, February). Standardizing Forensic Placement Evaluations in Illinois. Presentation given at Forensic Network Meeting, Elgin Mental Health Center, Elgin, IL.

E

Kim, R. S. (2000, January). Review of 1999 Forensic Outpatients in the Chicago Metropolitan Area. Presentation given at Metro South Network Strategic Planning Meeting, Tinley Park Mental Health Center, Tinley Park, IL.

Kim, R. S. (2000, January). Assessment and Treatment of Forensic Patients. In-service conducted at Woodlawn Neighborhood Health Center, Chicago, IL.

Kim, R. S. (1999, October). Restoration of Fitness to Stand Trial. In-service conducted at Metropolitan Family Services of South Chicago, Chicago, IL.

Kim, R. S. (1998, December). Assessment and Treatment of Attention-Deficit/Hyperactivity Disorder. Seminar conducted at Horizons Behavioral Health, Elgin, IL.

Kim, R. S. (1998, July). Organizational skills training. In-service presented at psychology meeting, Elgin Mental Health Center, Elgin, IL.

Kim, R. S. (1998, May). Understanding Attention-Deficit/Hyperactivity Disorder. Seminar conducted at Horizons Behavioral Health, Elgin, IL.

Kim, R. S. (1998, March). Parenting adolescents. Seminar conducted at Horizons Behavioral Health, Elgin, IL.

Kim, R. S. (1998, February). Sexually Violent Persons Commitment Act. In-service presented at Forensic Treatment Program administration meeting, Elgin Mental Health Center, Elgin, IL.

Kim, R. S. (1998, January). Managing time effectively. In-service presented at forensic unit staff meeting, Elgin Mental Health Center, Elgin, IL.

Kim, R. S., & Alloy, L. B. (1993, October). Self-focused attention as a vulnerability factor in a variety of clinical disorders. Poster presented at the 8th Annual Meeting of the Society for Research in Psychopathology, Chicago, IL.

Kim, R. S., Alloy, L. B., Whitehouse, W. G., Teraspulsky, L., Abramson, L. Y., Rose, D. T., & Hogan, M. E. (1993, March). Axis II personality dimensions in individuals at cognitively high and low risk for depression. Poster presented at the 83rd Annual Meeting of the American Psychopathological Association, New York, NY.

Kim, R. S., Alloy, L. B., Lipman, A. J., Whitehouse, W. G., Abramson, L. Y., Rose, D. T., & Hogan, M. E. (1992, November). The relationship between cognitive style and personality dimensions: Exploring the personality characteristics of cognitively high and low risk subjects in the Temple-Wisconsin Cognitive Vulnerability to Depression Project. In S. D. Hollon (Chair), The Temple-Wisconsin Cognitive Vulnerability to Depression Project: Initial retrospective findings. Panel conducted at the 26th Annual Convention of the Association for Advancement of Behavior Therapy, Boston, MA.

Kim, R. S. (1988, May). Affect intensity as an individual difference in anxiety and impulsivity. Paper presented at honors seminar, Northwestern University, Evanston, IL.

REFERENCES

Available upon request.

Bureau of Justice Statistics (1997)

- Approximately 1 in 10 males and 1 in 5 females report being sexually assaulted as children.
- Today, 6 million American children are victims of sexual abuse.
- Between 10% and 20% of women report being the victim of sexual assault as adults.
- Among 906,000 offenders confined in State prisons in 1994, 88,000 or 9.7% were violent sex offenders.
- Since 1980, the average annual growth in the number of prisoners has been about 7.6%
- However, the number of prisoners sentenced for violent sexual assault other than rape increased by an annual average of nearly 15%, which is faster than any other category of violent crime and faster than all other categories except drug trafficking.
- Per capita rates of rape/sexual assault were found to be highest among individuals age 16-19 y.o., low-income residents, and urban residents.
- No significant differences in the rate of rape/sexual assault among racial groups.
- Overall, an estimated 91% of the victims of rape and sexual assault were female.
- Nearly 99% of the offenders in single-victim incidents were male.

SEXUAL OFFENDER
LAWS, PSYCHOLOGY OF, RECIDIVISM, EVALUATING, TREATING, ETC,

I. History of Sexual Offender Statutes

- in 1937, Michigan was the first state to initiate a sexual offender statute
- since then, 28 other states have enacted similar laws
- recently, there has been a resurgence of sexual offender laws
- goals of these laws
    1) enhance public safety by removing predatory or dangerous sex offenders from society
    2) facilitate the treatment and rehabilitation of sex offenders

II. Sexually Violent Persons Commitment Act

- on January 1, 1998 a new sex offender law took effect in Illinois, called the Sexually Violent Persons Commitment Act
- it states that an individual charged with a sexual offense cannot be released by the Department of Human Services (DHS) or the Department of Corrections (DOC) until evaluated for sexual dangerousness
- if assessed as likely to re-offend, the individual will attend court for a Probable Cause Hearing, in which a judge decides if there is probable cause that the individual is a sexually violent person
- if probable cause exists, this individual will be transferred to an SVP Program in Joliet for further evaluation
- the sex offender will then attend a Commitment Hearing in which a judge or jury will determine whether to civilly commit this individual for sex offender treatment or to release this individual to the community

III. Psychology of the Sex Offender

A. Definitions

- sexual aggression: any behavior, verbal or nonverbal (physical), that is a sexual transgression or violation of another person's rights
- non-contact offenses: obscene telephone calling, stalking, voyeurism, exhibitionism, verbal sexual harassment, etc.
- contact offenses: physical sexual harassment, pedophilia, date rape, sadistic rape, marital rape, sexual murder, necrophilia, etc.

B. Demographics

- sexual victimization is a common event
- 1 in 10 males and 1 in 5 females report being sexually assaulted as children
- between 10% and 20% of women report being the victim of sexual assault as adults
- such surveys suggest that in addition to the large number of victims, there must also

be a significant number of sexual offenders
- among 906,000 offenders confined in State prisons in 1994, 88,000 or 9.7% were violent sex offenders
- since 1980, the average annual growth in the number of prisoners has been about 7.6%; the number of prisoners sentenced for violent sexual assault other than rape increased by an annual average of nearly 15%, which is faster than any other category of violent crime and faster than all other categories except drug trafficking
- per capita rates of rape/sexual assault were found to be highest among individuals age 16-19 y.o., low-income residents, and urban residents
- no significant differences in the rate of rape/sexual assault among racial groups
- overall, an estimated 91% of the victims of rape and sexual assault were female
- nearly 99% of the offenders in single-victim incidents were male
* based on Bureau of Justice Statistics (1997)

C. **Dynamics of Sexual Aggression**

1. Motivations of sexual aggression
   - e.g., anger, lack of power, deviant arousal, distorted attitudes
2. Contributors to sexual aggression
   - e.g., stress, substance abuse, mental retardation, psychosis, brain damage, cognitive distortion, lack of empathy, pornography, environmental opportunities

D. **Types of Sex Offenders**

1. Regressed Offender
   - low risk to re-offend
   - short offending history
   - few victims
   - primarily incest offender
2. Situational Offender
   - low to moderate risk to re-offend
   - moderate offending history
   - sporadic victims
   - no serious psychological problems
   - takes advantage of situation to offend
   - preference toward opposite sex victims
3. Chronic Offender
   - high risk to re-offend
   - strong deviant arousal patterns
   - personality disorder
   - preference toward same sex victims
4. Extreme Hard Core Offender
   - extreme high risk to re-offend
   - long history of offending
   - large number of victims

- high psychopathy index
- low motivation for change
- diverse victim pattern

5. Mentally Disturbed Offender
   - serious psychological problems
   - organic brain damage
   - mentally retarded or developmentally disabled

IV. Sex Offender Recidivism

A. Predicting Recidivism

- the assessment of dangerousness of sexual offenders requires information concerning the overall recidivism rate of sexual offenders and information about those factors that increase or decrease a particular sexual offender's recidivism risk

B. "Predictors of Sexual Offender Recidivism: A Meta-Analysis" by Hanson and Bushier (1996)

- currently considered the best study regarding the prediction of sex offender recidivism
- 87 articles reported on 61 different data sets from 6 different countries (30 USA, 16 Canada, 10 United Kingdom, 2 Australia, 2 Denmark, 1 Norway)
- half of the studies were produced after 1989 (i.e., recent studies)
- median follow-up period was 4 years
- report examined 28,972 sexual offenders
- review examined 69 potential predictors of sexual recidivism, 38 predictors of nonsexual violent recidivism, and 58 predictors of general recidivism
- given the average 4-5 year follow-up period, the overall recidivism rate was 13.4% for sexual offenses, 12.2% for nonsexual violent offenses, and 36.3% for any recidivism
- the strongest predictors of sexual recidivism were characteristics related to sexual deviance (e.g., sexual preference for children, history of diverse sexual crimes), and to a lesser extent, general criminological variables (e.g., age, marital status, total prior offenses)

V. Evaluating Sex Offenders

A. General Guidelines

1. Caveats for Risk Assessment
   - use more than one source of information (e.g., do not rely entirely on self-report)
   - professional discretion should be used in combination with structured systematic risk assessment
   - converging information is more reliable
   - ultimate goal should be to assign higher risk offenders to more intensive types and levels of treatment
2. Assessment Data Sources

- collateral information
- clinical records
- police reports/statements
- past arrest records
- clinical interview
- psychological assessments (e.g., Sexual Violence Risk - 20)
- physiological evaluation (e.g., Plethysmograph)

B. Evaluation Procedure

1. Criteria for Evaluation
   - charged with sexual offense:
     Criminal Sexual Assault
     Aggravated Criminal Sexual Assault
     Aggravated Criminal Sexual Abuse
     Predatory Criminal Sexual Assault of a Child
     Sexual Exploitation of a Child
2. Evaluation Procedure
   - gather materials and review them
   - clinical interview with sex offender
   - administer sex offender assessments
   - determine risk for sexual dangerousness
3. Sexual Offender Profile
   - past history of sexually violent offenses
   - currently sexually inappropriate
   - deviant sexual preferences
   - predictors of sexual recidivism (Hanson and Bushier, 1996)
     - sexual preference for children ® = .32)
     - prior sexual offense ® = .19)
     - early onset of sexual offending ® = .12)
     - never married ® = .11)
     - young ® = .13)
     - any prior offenses ® = .13)
     - antisocial personality disorder ® = .14)
     - lack of motivation for treatment ® = .16)

VI. Treating Sex Offenders

A. Challenges in Treating Sex Offenders

1. Denial/Minimization
   - common defense mechanism
   - present in all offenders to some degree
2. Resistance to Treatment
   - resistance to being labeled as "mentally disordered" or as a "sexually violent person"
3. No Confidentiality
   - difficult to develop trust and rapport

B. **Treatment Methods and Models**

1. Integrative Model of Treatment
2. Psychoeducational Component (e.g., social skills training, empathy training)
3. Cognitive Methods (e.g., cognitive restructuring)
4. Behavioral Methods (e.g., positive reinforcement, token economies)
5. Relapse Prevention (e.g., identify deviant cycle)
6. Psychopharmacological Approaches (e.g., Depo, Provera, Prozac, Luprin)

VII. <u>Reasons for Sex Offender Evaluations</u>

A. **First Offense**

- if no history of sex offending, likely to be low risk for sexually offending

B. **Sentencing Phase of Trial**

- if low risk for re-offending, evaluation may reduce the severity of the sentence

C. **Treatment Recommendations**

- when treatment is a condition of the sentence, evaluation to determine intensity level of treatment

Significant Risk Factors for Sexual Dangerousness

- Sexual interest in children (particularly boys).
- Any deviant sexual preference.
- Prior sexual offenses.
- Any prior offenses.
- Antisocial personality.
- Any stranger/unrelated victims.
- Early onset, young, single.
- Diverse sexual crimes.
- Treatment drop-out.

Myths About Sex Offenders and Their Victims

- **Myth:** Rapists are healthy, lusty young men "sowing wild oats." Rape is a crime of passion.

  Truth: Rape is always a sign of weakness, indicating a need to exert power and control over someone else. Rape is not an expression of sexual desire, but is an act of sexual violence. It's about the desire for power and domination. Rapists purposely use forced sex to humiliate and degrade victims. Rapists can be of any age.

- **Myth:** Women really want to be raped. After the initial shock, they enjoy being sexual with a "powerful" man. Some women act seductive and alluring to provoke rapists.

  Truth: Being raped is universally traumatic, and one of the worst events that a person can experience. No one wants to be raped. Rapists are usually desperate, angry, and insecure men. Most rapists select their victims because they are available or vulnerable (not because of the way they dress).

- **Myth:** Rapists rape attractive women who are drunk in bars.

  Truth: Rapists rape anyone anywhere. Most rapes occur in the victim's home.

- **Myth:** Infants, young boys and men are never sexually assaulted.

  Truth: Victims of sexual abuse range from newborn to the elderly, including both males and females of all ages, and all levels of society and lifestyles.

- **Myth:** Rapes occur in the summer when people are wearing fewer clothes.

Truth: Rapes occur every time of day and night, summer, fall, winter, and spring.

- **Myth:** Rapists are mostly accused falsely by women or girls who went along and regretted it later.

Truth: Rapists blame the victim to avoid taking responsibility for their crimes. Some victims may comply with the rapist's demands because they are in fear for their lives. Compliance is not consent.

- **Myth:** If a person was really abused, then he/she would report is right away.

Truth: Many victims of sexual abuse are too frightened or embarrassed to tell someone.

- **Myth:** Rapists are just men who were being sexual with a woman. But after the woman turned him on, she wanted to stop. She deserved what she got.

Truth: Appropriate sex stops if and when either partner becomes uncomfortable with what is happening. Everyone has the right to stop sex at any point. No one deserves to have his or her body violated. No one deserves to be raped.

- **Myth:** A woman can stop a rape if she really wants to.

Truth: Some women do stop rapes by resisting, running, using self-defense skills, or figuring out how to get help or get away. Most victims are afraid of being killed or maimed during a rape. Rapists use weapons, violence, and threats to control their victims. Rapists are also usually larger and stronger. Rapists are always responsible for their actions. Rape will stop when rapists stop raping. Victims cannot stop rape.

- **Myth:** You cannot rape your wife.

Truth: Every person has a right to say no to sex and to have their statement respected without fear of harm. Marrying someone does

not give you rights to her body. Having sex with someone when she does not want it is not love or lust. It is violence.

"Predictors of Sexual Offender Recidivism: A Meta-Analysis" by Hanson and Bussiere (1998)

- Currently considered the best study regarding the prediction of sex offender recidivism.
- 87 articles reported on 61 different data sets from 6 different countries (30 USA, 16 Canada, 10 United Kingdom, 2 Australia, 2 Denmark, 1 Norway).
- Half of the studies were produced after 1989 (i.e., recent studies).
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- Given the average 4-5 year follow-up period, the overall recidivism rate was 13.4% for sexual offenses, 12.2% for nonsexual violent offenses, and 36.3% for any recidivism.

****

- The strongest predictors of sexual recidivism were characteristics related to sexual deviance (e.g., sexual preference for children, history of diverse sexual crimes), and to a lesser extent, general criminological variables (e.g., age, marital status, total prior offenses)

Goals According to Gene Abel (1998)

1. Stop the development of the problem.

2. Control the existing problem carriers.

3. Isolate, study, and treat the person who carries the problem.

Integrative Model of Treatment

- Psychoeducational component.
- Cognitive methods.
- Behavioral methods.
- Relapse prevention.
- Psychopharmacological Approaches.

Paraphilias

1. **Fetishism** - arousal to non-living objects.
2. **Transvestic Fetishism** - urges and fantasies involving cross dressing.
3. **Pedophilia** - urges and fantasies involving prepubescent children.
4. **Sexual Sadism** - urges and fantasies of acts in which psychological and/or physical suffering of the victim is sexually exciting.
5. **Sexual Masochism** - person derives sexual excitement from being humiliated, beaten, bound, or otherwise made to suffer.
6. **Exhibitionism** - exposure of genitals to unsuspecting stranger.
7. **Voyeurism** - observing an unsuspecting person, naked, disrobing, or engaged in sex.
8. **Frottage** - touching and rubbing a non-consenting person.
9. **Necrophilia** - contact with corpses.
10. **Zoophilia** - contact with animals.