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The Prevention of Sexual Abuse: Psychological and Public Health Perspectives

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Medical, psychological, and environmental factors can contribute to the development of sexually abusive behavior. This article uses the language of both psychology and public health to elaborate on the links between sexual addiction and sexual abuse, and offers public health prevention strategies to recognize, manage, and ultimately diminish sexually abusive behaviors.

PSYCHOLOGY AND PUBLIC HEALTH

The field of psychology has concerned itself with diagnosing mental health problems and offering treatment services. Most of the research on, and training of professionals working with, sexual abuse issues has focused on the diagnosis and healing of those who have been victimized, and more recently toward those who sexually abuse. This work has helped to move the general public from denial of sexual abuse to the recognition of the prevalence of this epidemic in our society.

With a traditional psychological approach to sexual abuse, nearly all of the resources of psychology are applied after exploitation has occurred. Although it may be obvious to the reader, someone has to either sexually abuse another person or be sexually abused before they are offered support. The focus is not placed on preventing sexual abuse. Further, the language of "victim" and "abuser," labels people who have committed this offense or have been victimized by this offense, rather than identifying and labeling the problem and then using the information to prevent the sexual abuse of others.

Much, however, must be done to prevent this type of iatrogenic harm. First, a greater link must be made between the fields of sexual abuse and sexual addiction. With that, professionals will then be able to identify and diagnose sexually abusive behavior. The addiction field offers research and

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resources that can detect warning signs of potential sexual abuse at an early stage. This, too, could lead to the effective treatment of sexually addictive behavior before abuse occurs.

Second, the authors suggest strengthening an alliance between the fields of psychology and public health that could address problems in their early stages. Public health offers a multidisciplinary scientific approach to prevention. It examines not only the etiology of an epidemic, not just the individual impact of sexual abuse, but also how to change societal conditions and social norms that may allow sexual abuse to continue.

By expanding our vision from the treatment of sexual abuse toward early diagnosis based on the detection of warning signs of sexual addiction that indicate heightened risk of sexual abuse, we may be able to stop much abuse before it starts.

THE UNFOLDING OF SEXUAL ADDICTION THEORY

Authors and clinicians, especially those in the field of addictions, began acknowledging the prevalence of sexual addiction in the early 1980s (Carnes, 1983; Hatterer, 1980). Literature in the sex abuser field has repeatedly made reference to this disorder using a diverse and loose nosology that classified the same, or similar, phenomenon under different diagnostic labels. Coleman (1992), Hanson and Harris (1997), Pithers (1990), Prentky (1992), Berlin (1997), Laws (1995), Freeman-Longo and Blanchard (1998), Marshall and Marshall (2001), and others referenced an addictive or addictive-like component to specific forms of sexual behavior that can fuel certain types of sexual assaults. Historically, the professional language used to describe sexually addictive behavior includes diverse labels such as sexual compulsion, hypersexuality, nonparaphilic sexual behavior, sexual craving disorder, sexual impulsivity, egodystonic promiscuity, Don Juanism, satyriasis, and nymphomania.

In 1987, the DSM-III-R recognized sexual addiction as a distinct diagnostic category (American Psychiatric Association [APA] 1987). With the advent of the DSM-IV in 1994 (APA, 1994) reference to the disorder was eliminated. Coleman (2001), who has grappled with the complexities of finding a suitable nosological classification for this disorder, now believes the term "sexual addiction" most appropriately describes much of the out-of-control sexual behavior observed by health care professionals. Recognizing the growing acceptance of this terminology, the American Foundation for Addiction Research (AFAR) is now spearheading an effort to reintroduce sexual addiction in the next DSM revision.

WARNING SIGNS

Carnes (1990), in a publication on sexual abusers, first offered a DSM-like diagnostic criteria for sexual addiction. Among the warning signs Carnes

listed were the following: sexual obsession as a coping strategy, inordinate amount of time spent in sexual activity, sexual behavior exceeding intent, severe mood swings around sexual acting out, persistent pursuit of self-destructive or high-risk sexual behavior, escalating sexual behavior with increased risks, adverse consequences to self and others resulting from failed efforts to stop sexual behavior, out-of-control (compulsive) sexual behavior for two years of more, extreme sexual shame, accompanying depression, unresolved childhood maltreatment (often physical, sexual, and emotional abuse), few or no nonsexual relationships, suicidal ideation or attempts, and presence of a "double life" due to the secrecy of the sexual behavior.

More recently, Goodman (1998) in one of the most comprehensive examinations of sexual addiction, offered an epidemiological perspective on this behavioral pattern. His expanded diagnostic criteria included the following warning signs: tolerance (with a need for increased amounts of intensity of sex as well as a markedly diminished effect from sex over time at the same level of intensity), withdrawal (with psychophysiological changes), and a continuance of sexual behavior despite knowledge of recurrent physical and psychological problems. As the authors of this article, we suggest consideration of a diagnostic criteria that includes recurrent legal problems arising from sexual misconduct.

Goodman's (1998) epidemiological examination of sexual addiction noted many psychiatric disorders that are found in association with sexual addiction, many of which are referenced later in this article. Epidemiology—a branch of medicine—not only notes the comorbidity of epidemic disorders, but also researches the sources, or causes, of disease. From that perspective, the focus of diagnosis can go in many directions. Early detection is accomplished, the disorder is traced back to its origins, and specifically targeted prevention policies are instituted.

Another warning sign is the onset of a sexual crime, which always calls for an assessment for sexual addiction. The addiction may, if untreated, lead to the escalation of sexually abusive behavior at more serious or violent levels. One survey of 109 incarcerated sexual abusers (Blanchard, 1990) screened for the prevalence of sexually addictive behavior. Sexual addiction symptomatology was observed in 55% of a variety of sexual criminals studied, with child molesters meeting the criteria for sexual addiction in 71% of the cases.

IDENTIFYING RISK FACTORS FOR INAPPROPRIATE SEXUAL BEHAVIORS

A focus on intervention after sexual abuse has occurred places inadequate attention on identifying the risk factors that put an individual in jeopardy for initial perpetration. In recent surveys conducted by Market Street Research (1995, 1997, 1999) and by ORC/Marco (2000) in connection with Stop It Now!, residents in Vermont and Philadelphia, PA, were asked to identify the

warning signs of abuse in an adult or older child who may be at risk for perpetrating sexual abuse (Chasan-Tager & Tabachnick, 1999; Tabachnick & Dawson, 2000; Tabachnick, Henry, & Denny, 1995, and unpublished data). In both cases, nearly half of the respondents were unable to articulate at least one warning sign in an adult or older child's sexual behaviors. Perhaps more disturbing were the number of residents who believed that there were no warning signs at all.

Effective child sexual abuse programs also must consider factors that put adults, adolescents, or children at risk to sexual abuse. Through interviews with sex abusers and their families, as well as through a review of available literature, Stop It Now! identified a number of risk factors that could be easily recognized by both sex abusers and their families. Until Stop It Now! developed screening guidelines, there was little specific information in sexual abuse prevention literature that focused on behaviors in adults who may be at risk for abusing, or on sexualized interactions between adults and children. More importantly, virtually no information exists on the role of sexual addiction in putting individuals at risk for abusing. Of the literature reviewed, most warning signs or risk factors only included information about what to look for in a child who had already been sexually abused. In these cases, the opportunity to prevent sexual abuse had been lost.

Similarly, in the medical and helping professions, there is a paucity of information on the prevalence, causes, and warning signs of sexual addiction. Neither recipients or providers of health care services have access to accurate information on the subject. Consequently, we strongly suspect sexual addiction has been greatly under diagnosed.

ETIOLOGY OF SEXUAL ADDICTION

Early literature in the sexual addiction field placed a heavy emphasis on the role of childhood maltreatment and resultant neurotic shame as the cause of most sexually addictive behaviors (Bradshaw, 1998; Carnes, 1983, 1989, 1991). Since the malady has been more widely recognized, observed, and debated, clinical observations in the fields of psychology, sexology, and psychiatry have offered many other possible casual explanations: obsessive-compulsive disorder, attention deficit hyperactivity disorder, bipolar disorder, anxiety disorders, brain injury, hormonal abnormalities, chemical inbalances, endocrine abnormalities, diabetic hyperglycemia, hypoglycemia, and more.

Obsessive-Compulsive Disorder

Sexual disturbances, including sexually compulsive behavior, have been documented as symptomatic signs of Obsessive-Compulsive Disorder (OCD). It has been theorized that an increase in sexual desire may stem from an OCD patient's rigid viewpoints on moral and religious matters, and the ad-

dictive expression of those urges may serve to momentarily reduce serious anxiety (Neziroglu & Yaryura-Tobias, 1997). Compulsive masturbation, exhibitionism, and other expressions of sexually addictive behavior have long been associated with an OCD diagnosis. Forbidden or perverse thoughts and images (involving children, incest, bestiality, etc.) are acted on by some who suffer from OCD when, in fact, they may have few if any traits of a criminal personality. Thus, when untreated (or inappropriately treated), OCD can, in a small minority of instances, cause an individual to drift into exploitive or criminal behavior.

Affective Disorders

Bipolar Disorder (or manic-depressive illness) is characterized by its dramatic swings from depressive, to manic, or hypomanic symptomatology. During the latter phase of elevated mood and great energy, intensive and impulsive sexual behavior may be evidenced (Jamison, 1994). Alcohol consumption also can increase in the manic phase serving as a disinhibitor to previously restrained forms of sexual expression (Goodwin & Jamison, 1987). Studies are quite consistent in revealing elevated rates of addictive behaviors among bipolar patients. When impulsive and addictive sexual behavior occurs, and the disinhibiting role of drugs and alcohol are present, sexually abusive behavior can emerge.

Bipolar Disorder typically emerges, on average, around the age of 18—a time of increasing testosterone levels in males. When left untreated at this vulnerable time, some individuals with this illness may engage in sexually addictive behavior that can harm other individuals, lead to relationship breakups, result in occupational discipline, or even culminate in an arrest.

For years psychologists and psychiatrists documented the loss of sexual desire as one symptom of depressive disorders (Hawton, 1985; Yapko, 1988). But others (Kafka & Prentky, 1992) have more recently noted how dysthymia and major depression may be correlated with unconventional and problematic sexual interests and activities such as sexual addiction. In these syndromes, they explain sexual desires appear to be elevated. They further hypothesized that paraphilias, nonparaphilic sexual addictions, and certain impulse control disorders may share a common agitation of central serotonin pathophysiology that is responsive to serotonin reuptake inhibitor interventions.

Attention Deficit Hyperactivity Disorder

Some individuals with Attention Deficit Hyperactivity Disorder (ADHD), who have difficulty focusing their attention, in some instances, turn to a "hyperfocused hypersexuality" as a way of regaining a sense of focus (Hallowell & Ratey, 1994). For these patients, sex becomes a form of self-medication. For some individuals hyperfocused hypersexuality is expressed

by what some have termed a *romance addition*. Still others regain focus by exhibiting compulsive sexual behavior that can include exhibitionism, voyeurism, and child molestation.

Fago (1999) noted research that was conducted with sexually aggressive children who had been diagnosed with ADHD. He found that as many as 81% of the subjects studied had a prior or current diagnosis of ADHD. The presence of ADHD in sexually aggressive children was even more likely when they were under the age of 13.

It is essential to the prevention of sexual abuse that ADHD and its possible symptomatic sexual hyperactivity be diagnosed and treated before its potential escalation into exploitive activity.

Brain Injury

Aberrant sexuality of various sorts, including hypersexuality, have repeatedly been linked to closed head trauma as well as injury and disease that causes damage to the frontal and temporal lobes of the brain (Pallone, 1990; Wood, 1987). Temporal lobe epilepsy has been theorized to be a causal factor in the development of certain paraphilic and nonparaphilic sexual addictions. Hypersexual behavior also can be a symptom of a brain lesion, particularly a lesion in the medial basal-frontal diencephalic, or septal region (Goodman, 1998).

Attention deficit hyperactivity disorder has been theorized to be caused, at least in part, by a decrease in metabolic activity in the prefrontal region of the brain. Positron emission tomography (PET) scan test results reviewed by Zametkin and colleagues at the National Institute of Mental Health revealed depressed frontal lobe activity among attention deficit disorder (ADD) patients, with similarity between their symptoms and frontal lobe syndromes resulting from injuries or lesions to the frontal areas (Hallowel & Ratey, 1994).

Hypersexual and risk-taking behavior (including perpetration of sexual abuse) by attention deficit hyperactivity disorder (ADHD) patients are thought by some to be an attempt to heighten the level of arousal in the depressed frontal cortex; it becomes a way to return the brain to "normal" functioning.

Brain damage or neuropsychological deficit is significantly associated with criminal sexual activity (Pallone, 1990), and from the authors' observations, often the injury preceded the onset of sexually addictive or abusive behavior. Pedophiles have a high incidence of neuropathology (Hucker, Langevin, Wortzman, & Bain, 1986). Abnormal readings of quantitative electroencephalograms were found in 100% of sexual abusers in one study (Corley, Corley, Walker, & Walker, 1992). Additional research is now being conducted on violent sexually compulsive men using PET scans and quantitative magnetic resonance imaging techniques, finding prefrontal brain injuries among some of the most violent sex offenders (Rain, 2000).

Treatment remedies are available for some forms of brain injury. Anti-

convulsant drugs, such as carbamazepine, have been used to manage sexually compulsive behaviors directed toward inappropriate sex objects (Corley, Corley, Walker, & Walker, 1994). Biofeedback is enjoying a resurgence of popularity in the treatment of sexual problems arising from brain trauma.

Hormonal Abnormalities and Chemical Imbalances

Berlin et al. (1997) and Berlin (2001) described the sexual cravings of sex abusers as a "paraphilic coercive disorder." Many of these individuals, the authors argue, have a hormonal drive or an inborn sexual orientation (i.e., pedophilia) that propels them into compulsive sexual behaviors. Lust murderers and serial killers also can have sexual addictions comorbid with a variety of chemical and hormonal imbalances (Blanchard, 1995).

Valcour (1990) believes chromosomal and hormonal abnormalities are possible causal factors in the development of sexual addiction among pedophile populations. Anti-androgenic drug interventions (referred to as "chemical castration" in lay terminology) lead to a decrease in erotic imagery, a manageability of sexual urges, and subsequent decreased risk of sex offending (Valcour, 1990). Additional success has been reported in medically managing sexually aggressive behaviors that result in part from hormonal abnormalities, with reported recidivism rates below 10% (Berlin et al., 1991).

In addition to the aforementioned adjustment of serotonin levels, it has been theorized how stimulants, blood sugar stabilizers, and lutenising hormone-releasing hormones (LHRH) also can help manage sexually addictive behavior resulting from chemical and hormonal imbalances, thereby reducing the risk of sexual abuse.

A PUBLIC HEALTH RESPONSE TO SEXUAL ABUSE

Since the first awareness of the magnitude of child sexual abuse in the United States, a comprehensive response system was demanded. The primary interventions to the epidemic rate of child sexual abuse have been through the criminal justice system or through the child protection system. The criminal justice system has developed a variety of responses ranging from extensive incarceration, mandatory psychopharmacological interventions, sex abuser registration, community notification programs, alternative sentencing options, and restorative justice interventions. The child protection systems have developed a range of responses that include coordinated investigations, treatment, and advocacy programs for child victims. Both the criminal justice and child protection systems provide intervention oriented responses; the systems begin to respond only after sexual abuse has occurred, after a child has been traumatized, and after a child has developed the ability and requisite social connections to speak to a trusted adult.

The field of public health offers another option that can be added to

policies and programs already in place. Public health as a discipline focuses attention to prevention through a multidisciplinary scientific approach. Henry (1996) proposed applying three levels of public health prevention towards our efforts to stop the sexual abuse of children. She asked professionals who treat sexual abusers to examine the behaviors, thoughts, and feelings of those who are about to abuse and design a way to interrupt the behavior. McMahon (1997) summarized a public health approach to sexual violence that identified three levels of prevention: primary, secondary, and tertiary. At the primary level, the goal is to identify and prevent inappropriate sexual behaviors before they begin. At the secondary level, the goal is to identify individuals at risk of abusing or being abused, and reduce that risk. At the tertiary level, the goal is to identify and develop interventions for individuals who have a history of sexually abusing children. In 1995, the American Medical Association (AMA) named sexual abuse as "silent, violent epidemic" (AMA, 1995). Freeman-Longo and Blanchard (1998), Laws (2000), and Mercy (1999) offer examples of traditional as well as innovative programming at all levels when they described a public health model of addressing sexual violence.

Mercy and Hammond (1999) proposed a four step public health model to look at interpersonal violence. This model can be useful as we examine the role of public health policies to prevent child sexual abuse. The four components include (1) public health surveillance, which measures trends in prevalence and incidence of child sexual abuse. (2) risk factor research, which identifies the warning signs that would put an adult, adolescent, or child at risk for perpetration, (3) program development and evaluation, and (4) developing guidelines for implementing effective programs.

The Centers for Disease Control and Prevention uses a public health model to work in collaboration with individuals and organizations throughout the United States. McMahon and Puett (1999) note that through an amendment to the Public Health Service Act in 1995, the Centers for Disease Control and Prevention began research to develop definitions and a minimum data set for monitoring trends in child sexual abuse. This marks the beginning of a public health surveillance system distinct from our common post-conviction police surveillance of convicted sex criminals.

CALL TO ACTION

In the Surgeon General's Call To Action To Promote Sexual Health and Responsible Sexual Behavior (2001), Dr. David Satcher calls for a mature national dialogue on issues of sexuality, sexual health, and responsible sexual behavior. He calls on individuals, communities, the media, and government, each in their own way, to: (1) increase public awareness of sexual health and responsible sexual behavior, (2) provide the intervention necessary to promote sexual health and responsible sexual behavior, and (3) invest in

research related to sexual health while disseminating the findings widely. The authors of this paper echo Dr. Satcher's call to action and challenge professionals working with sexual behavior issues to join this movement as individuals, members of communities, and as professionals working with professional organizations.

We have four specific recommendations to move this agenda upward:

1. *Early detection, diagnosis, and treatment:* The prevention of sexual abuse must include primary, secondary, and tertiary approaches. The diagnostic screening of sexual addiction symptomatology, the identification of the risk factors and warning signs of sexually addictive and sexually abusive behaviors, as well as the treatment of these disorders allows professionals to intervene early, before harm is done. Although most of society's resources are devoted to management of this problem, resources devoted to primary or secondary prevention approaches can be equally effective. Professionals in a variety of fields have both the knowledge to intervene earlier in the cycle of sexual abuse as well as the information to bring public attention and resources to these prevenient opportunities.
2. *Grassroots education:* Professionals in the fields of sex abuser treatment and sexual addiction treatment know a great deal about how to discuss and identify unhealthy sexual patterns, about how to set clear sexual boundaries and support for inappropriate sexual behaviors, and about the treatment of mental health disorders that can precipitate both sexual addiction and sexual abuse. Such professionals can orchestrate a public dialogue that begins to address these issues in the schools, with parent groups, with health care professionals working with individuals at risk, or with civic organizations in the community.
3. *Consumer involvement:* As professionals, we have extensive knowledge of the literature surrounding the inappropriate sexual behaviors and associated treatment issues. However, through our familiarity with these issues, we are in danger of speaking for others who may have a stronger voice in the community if empowered to speak for themselves. We encourage professionals to create a safe environment that can invite individuals and their families who have been affected by sexual abuse and inappropriate sexual behaviors to speak out publicly. By encouraging consumers who have successfully completed treatment to speak out, they can deliver a more hopeful message on how to manage unhealthy sexual behaviors. They also can address prevention by helping others to recognize these behaviors before the escalate into assaultive acts.
4. *Organizational response:* Professionals in the fields of sexual addiction and sexual abuse treatment are in the unique position to initiate collaboration across various disciplines. By beginning to network with existing educational organizations, we can broaden our perspective of the medical, psychological, and environmental factors that give rise to inappropriate sexual behaviors. Furthermore, professionals are in key positions to

work at the local, state, and national levels to educate the public regarding unhealthy sexual behaviors arising from identifiable medical and mental health disorders.

In all of these capacities, there is the ability to advance the agenda of sexual abuse prevention while promoting both sexual health and responsible sexual behavior. This will happen when extensive collaboration occurs.

CONCLUSION

If the American public believed that one in four children had been injured in their schools, we would likely spare no resources to find the cause and determine what is needed to stop the epidemic. This is the same statistic long accepted as the number of children who will be sexually abused before the age of 18 (Finkelhor, 1994).

If the public also learned that four in ten adults had become violently ill from a tainted food, again we would spare nothing to stop the underlying virus from affecting other persons. This is the same statistic conventionally accepted as the number of women who are likely to be victims of attempted or completed rape at some time in their lives (Russell, (1984). Yet we have devoted relatively limited resources to stop or prevent sexual violence toward women.

To be successful in reducing sexual aggression, we must find the resources to address this violent and under-acknowledged epidemic. Our society has devoted considerable energy to hold abusers accountable for their actions, and the authors concur with the need to hold perpetrators accountable. Just as importantly, though, we believe that society should demonstrate a compassionate commitment to support all who are affected by sexual abuse. This includes those who have been victimized by sexual abuse, those who have struggled with sexual addiction, individuals who have abused adults or children, or those who know and love victims of sexual abuse or the abusers themselves.

American society has directed its attention to managing sexual abusers who have already been caught. However, to truly move toward the reduction of this epidemic of sexual exploitation, society must change the way it thinks about sexual abuse, talk more about sexual abuse and sexual addiction, and expand efforts to address the epidemic. If we expand the field of sexual abuse treatment to include the study of sexual addiction, it will be possible to make earlier diagnoses of problematic sexual behaviors before they progress into sexual assaults. By identifying the individuals at risk for abusive behavior—those who have not committed any crime—we also have an opportunity to prevent sexual abuse from occurring. Finally, by moving toward a public health approach, we can understand how to address societal factors and social norms that discourage us from discussing sexual behavior,

learn how to confront unhealthy sexual behaviors, and disclose sexually abusive behaviors so that they can be treated and managed.

Although these recommendations are for everyone to consider, helping professionals can intervene during contacts between patient and clinician. It is necessary to set aside our judgement and anger if we are to respond compassionately and effectively to sexual abusers and sexual addicts. This requires remarkable professionalism and grace. In doing so, patients can come forward with reduced shame and seek the help they require and deserve. By providing a respectful, caring, and safe place to reveal and examine their secrets, further exploitation can be prevented. It is in this caring alliance that we too, as professionals, are changed. Reaching deep into our souls to provide compassionate care for some of the most disenfranchised individuals can nurture some of the best qualities in ourselves. By supporting this healing process and making these issues more public, we can help model broader changes in society that can support people in dialoguing about sexual issues. In this way, opportunities for prevention are expanded.

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