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Editor's Note

Robin J. Wilson, Ph.D., ABPP

Happy Spring to all of you!
I’d like to deal with administrative matters up front. As we noted in the last edition (and as posted on the ATSA.com website) there are two Board of Directors positions open for nomination (Midwest and Southwest). At the time of writing, neither position had garnered a nomination. Please take this matter under advisement, as it is critically important that all regions have appropriate representation. Nominations close at 4:00 PM PDT on April 14. Additionally, on the administrative front, Kurt Bumby and Bob McGrath—co-chairs of the Professional Issues Committee—ask that members provide comments regarding ongoing revisions of the Practice Standards and Guidelines for the Evaluation, Treatment, and Management of Adult Male Sexual Abusers. Comments may be directed to Kurt and Bob at bumbyk@yahoo.com.

Now, on to the meat and potatoes of this edition of your Forum:

I am pleased to report that this quarter’s Forum is packed with interesting information and perspective. However, there is also a something of a bittersweet quality to the issue. As I previously noted on the list-serve, we lost ATSA member Susan Tough in February after a long battle with systemic cancer. Dave Hingsburger and I share our thoughts on Susan’s life and death in a short piece.

Otherwise, this edition raises issues regarding faith and hope for offenders, whether they are in institutional settings, have been recently released, or are anticipating release. Linda Rathjen—a Circles of Support & Accountability (CoSA) volunteer from Abbotsford, British Columbia—shares her experience of volunteering to support a high risk offender in the community. For those who attended last fall’s conference, this is the transcript of her portion of the plenary I organized on CoSA. Also in this issue, the Rev. Rick Sloan—Chaplain at the Florida Civil Commitment Center—shares his thoughts on promoting humanity and understanding in working with civilly committed residents.

The other major theme in this edition regards paraphilia. As we all know, this continues to be a particularly hot topic in many domains, professional and colloquial. During last fall’s conference, Dr. Kieran McCartan of the University of West England in Bristol boldly challenged workshop participants to consider use of the term “paedophilia” (in keeping with the international appeal of ATSA, I have maintained his spellings); particularly, with respect to whether the term retains any collective meaning. Kieran has kindly agreed to share his perspective in the Forum, as presented herein. In addition, we have the pleasure of publishing a number of scales composed by the late Dr. Kurt Freund, as recently compiled/collated by Dr. Ray Blanchard of Toronto’s Centre for Addiction and Mental Health. As a former student of Dr. Freund’s—and having administered and scored literally hundreds of these scales—I am particularly pleased that Ray chose both to undertake this project and to let us publish it here. This material is also available at:

http://individual.utoronto.ca/ray_blanchard/index_files/EPES.html

Last, I am pleased to report that we have continued our run of presenting student contributions in the Forum. Sandeep Mishra (along with supervisor and ATSA Board Member Dr. Martin Lalumière) of the
University of Lethbridge in Alberta, Canada writes about the “big drop” in sex (and other) crime rates in North America. Sandeep and Martin discuss varying hypotheses as to the cause of these reductions, including one particularly fascinating theory that suggests that crime rates have decreased possibly because people in Canada and the USA have generally been more hopeful about their futures. However, as Sandeep and Martin note, it will be interesting to see if the trends noted start to turn in the opposite direction now that the world is facing a significant financial and social crisis.

Enjoy!

Robin J. Wilson, Ph.D., ABPP
President’s Message

David S. Prescott

Dear ATSA colleagues:

The ATSA Executive Board of Directors met by teleconference on January 24, 2009. I thought I would provide an overview of this and other recent activities of interest to ATSA members. Although the results of the board’s activities are important, ATSA members should know that board and committee members work very hard on our collective behalf. This update cannot do justice to all the contributors who make ATSA the efficient organization that it is. Observing a number of the committees (as well as a recent meeting of our chapter presidents) in action has once again shown that ATSA’s greatest strength is its members.

We all know from the headlines that the current global economy has provided more questions than answers in the past year. ATSA Executive Director Maia Christopher managed to turn what could easily have been a loss into a profitable conference in Atlanta. At our teleconference, Finance Committee Chair Art Gordon announced that -- in the final analysis -- conference profits were actually higher than we had expected. This comes as a profound relief. Those who attended the Membership Luncheon at the Atlanta conference might recall my report of the board’s decision to suspend expenditures in some areas, including the awards process. At this teleconference, the board voted to reinstate many of these allocations while assigning the rest to a financial safety net. My personal preference is to be extremely conservative in these areas. Art has managed to accomplish this marvelously. If this were not enough, Membership Committee chair Bob Shilling reports that our dues renewal process is already ahead of where it was last year.

Also important to our organization, our strategic planning process continues. Our hats go off to Joan Tabachnick and Lawrence Ellerby for their diligence in this important task. They have built a very competent committee consisting of Keith Kaufman, Elizabeth Letourneau, David D’Amora, Maia Christopher, Beth Schatzel-Murphy, Robin Goldman, Steve Sawyer, Chris Newlin, myself, and our consultant, Jude Kaye. Our survey of the membership yielded more responses in its first days alone than our last attempts did several years ago. ATSA Executive Director and President-Elect Lawrence Ellerby are working extremely hard to organize and collate the data we have gathered, and you can expect further discussion on this in the coming months.

In case it interests, the board discussed ideas for clarifying and improving processes relating to committee membership, including ways that committees can best help one another. For example, committee input to our conference process has been the source of much discussion, as has ensuring a productive mix of members on our standing committees. More in these areas will follow in future updates.

In other areas, Maia continues to develop opportunities for member benefits. She has also worked with the Membership Committee to make allowances for members who are on active duty in the military. Maia further reports that a number of organizations have sought ATSA’s ideas for collaborating on various conferences, and is exploring these options further.

Craig Latham is establishing new methods for providing continuing education credit to conference attendees. In the past, Carol Ball and her team at New England Forensic Associates have handled this difficult service. ATSA remains grateful for their efforts. Anyone who has waited in line to get CEU’s at the end of the conference has seen just how hard the NEFA folks have worked at this task. What participants will not have seen is all the behind-the-scenes work related to ensuring that the standards of all disciplines are met. The board encouraged
Craig and Maia to continue developing an electronic method that will benefit ATSA and conference participants alike.

Elsewhere in our organization, our Professional Issues Committee, chaired by Kurt Bumby and Robert McGrath, is off to an excellent and thoughtful start to revising our Standards and Guidelines. Our Fundraising Committee, chaired by Grace Davis, is exploring every possible option for developing potential revenue sources. Gerry Blasingame is also working at developing ideas for how ATSA can best align with like-minded organizations.

I hope this is a helpful overview of ATSA’s activities. Don’t forget that conference time is sooner than we think. The Dallas conference (with David Walenta as Conference Committee Chair) is shaping up to be an excellent experience, and the venue itself (the Hilton Anatole) is wonderful.

Please remember that ATSA’s best asset is its members, and that we are a membership-driven organization. Should you have ideas for the board to consider, please feel free to contact your regional representative or the office. The regional representatives are:

Canadian Provincial Coordinator: Martin Lalumière, Ph.D.
E-mail: martin.lalumiere@uleth.ca

Eastern Regional Coordinator: Craig A. Latham, Ph.D.
E-mail: clatham@forensicdoc.com

Midwestern Regional Coordinator: Harry M. Hoberman, Ph.D., LP
E-mail: psychforensic@aol.com

Mountain Regional Coordinator: Christopher Lobanov-Rostovsky, M.S.W.
E-mail: chris.lobanov-rostown@cdps.state.co.us

Pacific Regional Coordinator: Gerry D. Blasingame, M.A.
E-mail: gerryblasingame@aol.com

Southern Regional Coordinator: Candice A. Osborn, M.A., L.P.C.
E-mail: cando001@msn.com

Southwestern Regional Coordinator: Grace L. Davis
E-mail: gavis11@austin.rr.com

All the very best,

David Prescott
ATSA President
Celebrating Susan Tough

Dave Hingsburger and Robin J. Wilson

On February 23, 2008, the Association for the Treatment of Sexual Abusers lost one of its greatest advocates for the ethical and best practice risk management and treatment of persons with co-morbid intellectual disability and inappropriate sexual behavior. Susan Tough was a long-time participant in the ATSA fold, having routinely attended our annual conference—often, as a presenter in either pre-conference workshops or other symposia and paper presentations. Many ATSA members, especially the Canadians, were very fond of Susan and the bright disposition she brought to most situations. For those of you who were not as familiar with her and her role in the field, we hope to share a bit of Susan with you.

Dave Hingsburger:

Over a cup of tea, during a quiet chat, Susan talked about how she wanted to be remembered. After having fought a long and difficult battle with cancer, Susan had reluctantly left her position as the Director of York Simcoe Behaviour Management Services (just north of Toronto, in Canada) to focus on personal needs. It was a heart-wrenching decision for Susan because, as all who knew her understood, Susan loved what she did. Her accomplishments were both significant and plentiful. But, Susan felt that being remembered because of the growth of the agency under her stewardship was like being remembered with an annual report. Too, her publications and research interests, though they were important to her—would be like being remembered with a resume. Susan's passion for what she did began and ended with the effect that her work had on the individuals with disabilities who were under her care, or the care of her agency.

Susan always believed that one had to have an understanding of how disability was not only experienced intellectually, but also socially and politically. To understand and to craft service, one needed to understand the daily experience of prejudice and exclusion that people with intellectual disabilities face. The denial of full adulthood and full adult rights was at the base, she believed, of many injustices in both service and society. Susan's strong 'pro-sex' stance, and her belief that individuals with disabilities needed healthy environments which welcomed (not feared) sexuality, relationships and responsibility, set her apart as both a therapist and an advocate.

Susan ran a large agency that had multiple 'faces' that she as a Director had to ensure maintained ethical clinical focus. Nonetheless, she never fully left her position as a sexuality therapist and consultant. Susan maintained a strong presence in the sexuality team, closely following clinical interventions and contributing to team meetings as a clinician. The sexuality clinic benefited from her years of experience as a clinician, and Susan’s research and publications flowed from this work.

But, in the end, Susan was most gratified by the progress made by individual people with disabilities. She believed that 'the proof was in the pudding' and that treatment only mattered if it made a difference. And because of this ... Susan herself, made a difference.
Robin J. Wilson:

I first met Susan at the ATSA conference in Washington in 1997. She had asked to be introduced to me because, as a Master’s student at the University of Toronto (where I was an internship site supervisor affiliated with the Correctional Service of Canada), she needed a place to complete her internship. I was only too pleased to provide her that opportunity. However, it wasn’t very long before I started to question “who was learning from whom?” You see, Susan was one of those people who developed extensive practical experience in the field before going back to establish the academic credentials. She didn’t need to do that, as she was already well-regarded by her peers—she felt she owed it to herself and her clients. The benefit for me was that I got to “supervise” someone who had a wealth of knowledge and expertise.

One of Susan’s greatest gifts to her clients was ensuring a breadth of knowledge and expertise to solidify a program steeped in evidence-based practice. Susan solicited and received clinical consultation from such notable professionals as Dr. Donald Meichenbaum (a founder of cognitive-behavioral modification), Dr. Vern Quinsey (a recipient of the ATSA Significant Achievement Award), Drs. Marnie Rice and Grant Harris (affiliated with the Mental Health Centre at Penetanguishene), and Dave Hingsburger (well-known for his pioneering work and advocacy for persons with disabilities). It was not long after Susan came to my office as an intern that she broached the topic of my becoming the supervising psychologist for York Simcoe Behaviour Management Services, a role I continue to play. That I have any skill in working with persons with intellectual disabilities is entirely attributable to Susan, and I am in her debt for that reason.

Dave already said this, but I think it bears reiteration: Susan cared. She cared deeply for her clients and their right to live as “normal” people, free of risk to themselves and others. She worked tirelessly to make sure that every client, no matter how challenging, got whatever treatment and guidance he or she needed to maximize access to all of what we now understand constitutes a “good life”. In that way, Susan was well ahead of the curve. Her influence on disability services in Canada and abroad is clearly evident, if somewhat under-attributed. I think I can speak for Dave in saying that we will dearly miss the social, collegial, and professional times we had with her. I know many of you will feel the same. Goodbye, Susan.
Call for ATSA Board of Directors Nominations

ATSA is currently seeking professionals with a clinical, research, and/or academic background in the field of sexual violence to serve in leadership positions on the Board of Directors. This Call for Nominations is one of the ways you, as a member of ATSA, can influence the policy and direction of our organization. This is your organization and we appreciate your input.

The member nominating and the nominee for the two Regional Representative positions must both reside within the region for which the nomination is being made.

If you are interested in serving on the Board or know of potential candidates for the identified elected positions, please take a moment to complete the nomination form and e-mail, fax, or mail it to the ATSA office.

All nominations must be received by 4:00 pm, PDT on April 14, 2009.

Midwest and Southwest Regional Representatives:
Responsibilities and requirements:
- To represent all ATSA members, with special emphasis on the region of residence.
- To assist newly developing State Chapters; maintain consistent contact with the existing State chapters within their region; report to the Executive Board all concerns of State chapter members; and maintain contact with all Public Policy State contacts within their region.
- To be responsible for the direction of the Association; for the development of policy; and to provide expertise in all functional areas of ATSA.
- To exhibit working knowledge of the field of sexual violence; to have the ability to problem solve and work collaboratively; and to demonstrate a commitment to ATSA’s goals and objectives.
- To participate actively on the Organization and Development committee; to attend two face-to-face Board of Directors meetings yearly (involving some travel), as well as to participate in on-going Board business via teleconference and electronic discussion group, and to attend regional meetings as necessary.
- To adhere to the Board of Directors job description and the Board of Directors Code of Ethics.

Please click here to download the nomination form or download the form at the members’ only site. All nominations must include the required narrative and may be e-mailed, faxed or mailed to ATSA.

All nominations must be received in the ATSA office by 4:00 pm, PDT on April 14, 2009.

A.T.S.A.
4900 SW Griffith Drive
Suite 274
Beaverton, Oregon 97005 U.S.A.
Phone: (503) 643-1023
Fax: (503) 643-5084
E-mail: atsa@atsa.com
Sometimes in our lives we all have pain
We all have sorrow
But if we are wise
We know that there’s always tomorrow

from “Lean On Me”; Words and Music by Bill Withers (1972)

Linda Rathjen
Volunteer, Circles of Support & Accountability
Abbotsford, BC, Canada

Editor’s Note: The following is a reprint of Linda Rathjen’s part of the plenary address “Calm in the Eye of the Storm: Circles of Support & Accountability” given at last fall’s annual ATSA conference. Linda is a community volunteer in a CoSA project in British Columbia, Canada. For those interested in reading more about CoSA, please follow these links:

It’s amazing how certain events in our lives become defining moments—“a ha” moments, tipping points—that, in retrospect, alter the courses of our lives forever. Such has been my experience with Circles of Support & Accountability (CoSA). This “thing” that I signed up for, this “program” that was to be just a small part of my life, has become my passion, possibly my life’s calling. Being a part of CoSA has been one of the most difficult things I have ever done, but it has also been one of the most rewarding. My three-year journey with CoSA has been terrifying, exhilarating, stretching, and gratifying.

I had been a volunteer in the prison system for many years, so I thought that being a part of CoSA wouldn’t be that big of a deal. But, when our coordinator sat us down and read us Arthur’s (not his real name) file, misgivings crept in. I felt that there was not much hope for successful reintegration. Consequently, on our drive to the prison to be introduced to him, I remember thinking, “The best-case scenario I can see coming out of this is that he gets out of jail, we watch him like a hawk, and as soon as we see him going sideways we turn him back in to the police, he’d be back behind bars again, and the community would be safe—we’ve done our duty.”

Meeting Arthur changed my thinking. As we were getting to know him, I realized that he was a human being who probably had a lot of pain in his life. He had done some terrible things, but was created in the image of God, as was I. He was a person who was loved by God, and how could I do any less? At that moment my attitude began to shift. I now had a glimmer of hope.

I, and five others, accepted to become part of Arthur’s Circle, and a Covenant was signed. We agreed to give him support and keep him accountable for one year. He, in turn, agreed to be in community with us, and to be held in accountability.

The first day of Arthur’s freedom was a dizzying series of events. He needed to report to police, probation, medical, and social services; he had to apply for ID; he needed food, clothing, and housing. Added to the mix
was the uneasy sense of the regard for our own safety. We were instructed to have a male member of the Circle with us at all times, and to not let Arthur know our last names, our phone numbers, or addresses. We were dealing with an unknown, his picture was in the media, flyers were sent out, and police predicted that he wouldn’t make it past a month without getting sent back. In fact, the police contacted us several times that first week, saying that there were “sightings” of Arthur in restricted areas—did we happen to know where he had been during those times? We were always able to verify that he had not breached his conditions.

That first few weeks, each of us volunteers tried to have at least one connection with Arthur a day—shopping, medical, taking him to a local flower show, or even just a phone call. The task at hand was sometimes overwhelming—how would he ever find a place to rent? Two motels had already kicked him out when they found out who he was. And, how would my friends or my church react, if or when they found out what I was doing? And what about my own safety, and that of my family?

As the weeks progressed, we were able to find Arthur more permanent housing, and in discussion with our coordinator, we felt that it was OK to be with him without the presence of another male, as long as there were two of us. As Arthur continued to show respect for our boundaries and consistency in his positive behavior, we moved to meeting one-on-one with him, constantly making it clear to him, over and over again, that there was not a romantic relationship with him and anyone in the Circle, and that there never would be. Once the boundaries had been firmly established, we moved very carefully to disclosing more personal information—our telephone numbers, more information about our families, always monitoring for signs of heightened risk factors. When the time came for his birthday celebration, everyone involved felt we were ready to take the next step to have him come into our home. That extension of trust was overwhelming to him. As we affirmed him, and celebrated life with him, he felt like a human being again, rather than a monster. There was joy and disbelief that we were doing this all for him. There were tears on all sides as we sang him the Bill Wither’s lyrics, “Lean on me, when you’re not strong, We’ll be your friend, we’ll help you carry on. . .”. Arthur had truly come to cherish his Circle.

Every day we had to think on our feet when faced with new situations. Our hyper-vigilance took an interesting turn when, on Arthur’s second day out, a rather large lady with very small clothes on, walked by—and one Circle member reacted by reaching from the back seat of the car and grabbing Arthur’s ears to turn his head away, while the other Circle member simultaneously pulled his hat down over his eyes. It resulted in a comical scene, which we have had a lot of laughter over since. OK, we over-reacted. But, how do you to integrate someone who has hurt others? Our typical response to sex offenders is to remove them from any contact with people who could be considered potential victims. But, since risk factors often include isolation, fear and secrecy, we felt that a better way would be to teach and model appropriate relationships in structured, high-boundary situations. We would need to constantly monitor his responses with other people. We felt that it was more dangerous for Arthur to be isolated than to have him befriended. We needed to figure out how to create community, with accountability.

The time finally came for Arthur to be introduced to my family. Again, he was overwhelmed by being treated as a normal human being, having an ordinary family dinner together, laughing and cracking jokes, playing games, being allowed to interact with people who were accepting him, not shunning him. It did something special for his soul that day. Now, Arthur has spent part of Christmas Day each year with us, and he has spent some holiday time with me and my husband. We have met numerous of his family members. He attends church with us, and has experienced much love and acceptance there. As a Circle, we’re always looking for an excuse for a celebration, and on his first anniversary, he had a list of 36 people he wanted to invite!

But, as I stated at the beginning, this has also been one of the most difficult things I have done in my life. This is not easy integration. Aside from the obvious safety issues, there are other challenges. There are personality issues. We’ve been irritated, annoyed, disappointed. There’s exasperation when we’re confronted with the
same critical thinking errors over and over again. We have tried to get Arthur professional counseling, with minimal success, and are on the third attempt. I’ve been so frustrated at Arthur’s lack of initiative, that I’ve made my own list of goals for him—as if that’s gonna work! We are constantly monitoring the signs of his crime cycle: Is there increased loneliness and isolation? Is he perceiving intimacy inappropriately? How is he doing with his boundaries? Then there’s the challenge of balancing correction and affirmation. And, how does one weigh out the balance between him needing us, and him becoming too dependent on us? And, then the really big one—does he truly “get” what he did to his victims, to his family, to his community, to us? There’s also the time factor—in the last three and a half years of being in CoSA, I have probably invested almost 1000 hours in Arthur. And, even though I initially committed to working with Arthur for one year, I now realize that I am committed to him for life—he will always need people like me.

The paradox of this “intrusion” on my life is that I am not the same person that I was three years ago. My life easily becomes crammed with the trite, the insignificant, but my soul has become awakened to what is important in life—where I want to spend my time. CoSA has become a part of the big-picture life task that I was created for. I’m realizing that people are more important than things. Sharing in the anguish of Arthur’s soul enriches my life. Jean Vanier, a Canadian philosopher and founder of the L’Arche communities for people with intellectual disabilities, states, “The process of teaching and learning. . . involves movement, back and forth. The one who is healed and the one who is healing constantly change places.” I am starting to allow myself to share of my struggles and weaknesses and let Arthur see me as a real person, not perfect. That is community. I have found God in Arthur—and I can now thank him for coming into my life.

Why do I do this? I have two reasons:

The first is my duty to God—I believe that no matter what the circumstances or actions, there is still a spark of the Divine in each soul. However ugly the image is of God, however broken it is, we must try, with determination and courage and with faith and hope to find that little corner and try to spark it for greater renewal. I want to make a difference in one person’s life, a person who is considered one of the “lepers” of our society. The second is my duty to my fellow man. I believe my community is safer because of CoSA. When Arthur was asked on his anniversary as to why he has been successful in the community this time, as opposed to other times, he replied, “I’ve never had good friends before. How could I ever do anything that would hurt these people?” So, when the phone rings, and I see that it’s Arthur, and I don’t feel like talking with him AGAIN, I am reminded that this could be the phone call that he needs to prevent him from slipping back into his crime cycle, and how could I do less, than give him those few minutes of my time, in exchange for the safety of my community?

CoSA is an “in the trenches” kind of work—sometimes, it’s “empty conversation”; sometimes, it seems like “pointless activity”, but all in the name of purposeful relationship. CoSA is not a program—it is a relationship—a radical relationship, based on “wrap-around care”. It is a process, not a service, based on the premise that no human being is disposable. It is compulsory compassion, intentional community.

As COSA volunteers, we are from any walk of life: male, female, young, old, professionals, or laypersons, who realize that our present system of “release and abandon” is not working, and who want to do something to make things better. CoSA follows the Biblical instruction of “Do not let evil triumph over you, but triumph over evil with good”. CoSA depends on faithful and virtuous action to be treated as a blueprint. The goal is to help the Core Member, helping him to do everything possible so that there will be no more victims.

Speaking of victims, one defining moment came to me during that intense first week. I was questioning myself and my actions—did I have this backwards? Why was I not putting all this effort into helping victims, rather than helping an offender? Were my priorities not misplaced? After much soul searching, the realization came to me that I was helping victims. I was doing my part to protect them from further harm. I was doing my part to
protect my 18-year-old daughter by making my community a safer place.

My three-year journey has led me to many extremes, from the desperation of trying to find a place for Arthur to sleep the first night, to the triumph of helping him move into his own apartment two years later...From seeing his isolation and aloneness, to witnessing him being invited to five turkey dinners last Christmas...From fearing any kind of physical contact from Arthur, to hearing him explain to his aunt how the hugs from his Circle members are very meaningful (but, he has learned that they are from his sisters, and not his sweethearts)...From the realization of the enormity of my commitment, to the realization of the enormity of the value to my community.

I am energized by the mission of Circles of Support & Accountability to help offenders reintegrate and help in leading them to a place of "offenders no more," by helping them find what they really need—community—where we say, “We accept and adopt you with all the difficulties that you bring to us, because what are the alternatives?” My core belief as a Circle member has been tested, defined, and refined. I have been challenged to live out my belief that every person has a part of God deep within them, and because of that, they are of great value to God.

So Arthur, go ahead,

Lean on me, when you’re not strong
   And I’ll be your friend
   I’ll help you carry on
   For it won’t be long
   ’Til I’m gonna need
   Somebody to lean on.
The Dynamics of Clinical vs. Spiritual Care

Rev. Rick Sloan
Chaplain, Florida Civil Commitment Center

The Journey

Life is a journey, especially for those who have chosen a career in civil commitment. I think of the renowned poet Robert Frost and his poem “The Road Not Taken,” when I think of my many colleagues. The last three lines of his poem say, “Two roads diverged in a wood, and I took the one less traveled by, and that has made all the difference.” For those of us in institutional settings, we can understand choosing a road less traveled. To maintain a high level of rehabilitational efficiency takes an individual who genuinely cares for others on a very human level. While many in our society live by the addage “out of site, out of mind,” as it relates to the incarcerated, clinical and pastoral staff are dedicated to bringing hope of healing to a population that is often forgotten about. This is particularly true of men deemed to be “sexually violent predators” or given other socially-strong appellations. While my personal journey has been challenging, I have chosen to find a sense of accomplishment and satisfaction that can only come from knowing you’ve done something extraordinary. The journey we face as caregivers may involve ridicule from those who might not understand why we chose to help those who’ve hurt others. These others also have difficulty understanding why we would spend our time trying to figure out the sexually (or otherwise) deviant mind. I believe that this journey begins in one’s heart and, whether you are a Clinician or a Chaplain, we are all guiding human beings to a brighter light and, hopefully, a better society.

Let me begin by telling you a story that takes place in the Midwestern United States. It involves a young 8-year-old boy who lacked self-confidence but, as is the case for most boys this age, he was full of energy. His elder brother, who was 15, had taken him swimming on a sunny, summer afternoon. Some of the places for swimming in this region were places of both shallow and deep water. Some of these swimming holes had steep drop-offs, which could instantly plunge a wader into 15 to 20 feet of water. When the young boy arrived with his brother, he began to play around the shore while his older brother immediately went to the cliffs to dive with his older buddies. It wasn’t long until all who were there began to hear splashing and screaming. It was the little boy, who had strayed into one of those steep drop-offs. He was drowning. As he splashed and floundered, the little boy remembered going down once, twice, and during the third time he thought, “This is my last... I’m going to die!” He remembered seeing many adults standing around him, but it seemed that no one was attempting to save him. All were simply glaring at him. Each time he came up for breath, he screamed for help and he couldn’t understand why others would not help! At that moment of his final breath, the little boy recalled his elder brother’s loving hands grasp around his chest and lunge him forward onto the shallow sand. The elder brother had heard the distinct cries for help and, while all the other adults around thought the youngster was “only playing,” the older boy knew his sibling’s cry for help. Swimming across the lake, he made it just in time. While many around didn’t understand what was happening to the little boy, there was one who understood and saved a life. I know the story well because the little boy was me! If my brother had not been able to recognize my cry for help, I would have been lost. It occurs to me that this is often the case with the offenders with whom we work. Sifting out the genuine cries for help from the passive-aggressive attempts at manipulation requires a skill set that I continue to develop.

But, this is the journey of life. Being able to take our experiences and turn them into tools for good. In many ways, I believe this is the evolution of how many of us came to work in settings where there are so many
broken people, locked up with little hope, *drowning* without someone willing to swim the distance, to hear their cry, and to do what’s possible to breathe hopefulness into hopelessness. There are those who are “out of tune” with broken humanity’s cry for help and, because of this, they choose to stand aside—either uncaring, unchanging, or perfectly prepared to let others do the rescuing!

**The Case for Union**

There is a necessary union between the spiritual side and the clinical side. As Facility Chaplain at the Florida Civil Commitment Center in Arcadia, Florida, I see residents each and every day who are spiritually depleted because of their circumstances. The spiritual side of a person is important. It is that energy which can affect our emotions and desire to become a better person. While some may not believe in the spiritual side, I believe it is intricately tied to the mind, intellect, and the emotions of a person. If this is the case, then the wellness of a person’s intellect (that is, the faculty of the mind by which one knows or understands) and their emotionally state (their feelings about themselves and others around them) will be affected by the spiritual views one may or may not hold. Clinicians work to create wholeness within the minds and emotions of residents while Chaplains work to create wholeness within their spirit. At times, the lines differentiating these elements may seem a bit blurry. However, as a Chaplain, I see a clear connection and ongoing need for Clinicians and Chaplains to form a union in working to create wholeness within the residents of the institutional community.

It is possible that some of my Clergy colleagues may not understand how “secular” psychology and theology combine to create a mix that produces healing. I not only believe that they can—they must. Forging relationships that impact human lives is never easy, but “easy” is not likely to be found on the road we travel. Numerous studies have shown the need for union between the healthcare provision and spiritual guidance. A number of these studies can be found in a book entitled, *Here Is My Hope: A Book of Healing and Prayer: Inspirational Stories from Johns Hopkins Hospital*. The authors share observations from one such study:

A 1998 Johns Hopkins study by psychiatrist Peter Rabins found that when caretakers of people with Alzheimer’s disease had emotional support, including religious faith, they were better able to handle difficult tasks and emotional stresses, which sometimes translated into a delay in the need to institutionalize family members with Alzheimer’s. (Randi Henderson & Richard Marek [2001], Doubleday, p. 5).

For more than 25 years, I have been involved in the spiritual care of broken human beings. I have seen the alienation of many who could have benefited from the physical side being addressed in cohesion with the spiritual side; however, this did not happen because of misperceptions created by some in the “religious world.” As professional caregivers, our goal must be to bring wholeness to broken people, however and from whichever viewpoint we feel comfortable. There must be a balance struck between those who are true believers and those who may not believe at all. That balance, I believe, is discovered through an understanding of what the Clinician does versus the spiritual care provider. When approached as being on the same team—with the same goals and objectives—then progress can always be made. However, some are unwilling to compromise their belief system, to the point that the proverbial saying becomes reality when the baby is truly “thrown out” with the bathwater!

The best way I can describe the acceptance of another’s belief system is through another personal experience of mine. This experience occurred during my Clinical Pastoral Training, when I served two different hospitals and a hospice in Naples, Florida. All of those in my training group would have our times to be on-call for 24 hours with the hospitals. We had to be prepared for whatever we were called upon to do, whether in ICU, the Emergency Room, or on a particular hospital wing. Early on, we were asked to be prepared to possibly perform a baptismal ceremony for a deceased infant. Because my personal theology had been to not baptize infants and, especially, those who were already deceased, I faced a challenge. As I looked at infant baptism and the reality of doing such a thing for parents who had lost a child, I asked myself, “What purpose would this serve?” When I began to consider this question and speak with the medical personnel involved with such


situations, I discovered that the emotional and spiritual dynamic would be great for families losing children at birth. My determination was to choose to be prepared to baptize the deceased infant, if called upon; simply because this type baptism impacted the emotional wellbeing of the grieving parents and other family members. I came to accept that my personal theological beliefs were not nearly as important as was helping these parents who had lost their babies! Although I was never actually called upon to do so during my time of training, I became prepared to baptize a deceased infant. In fact, it remains a disappointment to me that I never got to follow through on my mental and emotional preparation.

I recognize that I may be “turning off” some “religious people” by now. However, for me, it’s about ministering to the broken parts and not indoctrinating the broken people. Whether you are a Clinician or spiritual caretaker, your own peculiar idiosyncrasies sometimes need to take a back seat to the process of creating “wholeness”—which my clinical colleagues tell me is all the rage in contemporary sex offender treatment (e.g., Good Lives). Yes, there may be “proper” pathways to wholeness, but let us not forget that there may be a few more pathways than what we have personally experienced. Let us strive for unity and common ground between healthcare and spiritual care providers. Our purposes are one.

Why Some Care

Some people like a challenge. It’s part of their psyche to see life through the lens of accomplishment versus defeat. When a Clinical Psychologist sees dysfunction, he or she wonders how it can be fixed. Part of the hope for life is facing the challenge of learning how to help human beings get well. For some, it may be an experience in their past that propels them into serving others and helping those who have been incarcerated or otherwise institutionalized. For others, it can be a part of the long and winding road of life. This road ultimately leads them to an understanding that the most important things in life are not “what I have”, but “who I help”. In his book *Purpose Driven Life: What on Earth Am I Here For?*, Rick Warren states, “I have been at the bedside of many people in their final moments...and I have never heard anyone say, ‘Bring me my diplomas! I want to look at them one more time. Show me my awards, my medals, that gold watch I was given.’” (Warren [2007], Zondervan, p. 126).

When we come to understand this truth, then we are no longer afraid to risk caring. The Clinician and the Clergyperson have common ground in this area. They are people who care about broken humanity, no matter the form that brokenness takes. Once your heart is moved toward helping broken people, it just comes naturally. Sure, there are some who are involved in this journey for alternative reasons; however, I believe that the true Clinician, like a genuine Chaplain, will only continue to be successful in such an environment of brokenness, if they truly care.

I’ve gleaned much from the stories given to us by the man Jesus, who lived in Palestine approximately 2000 years ago. He told of a father who was very wealthy and had two sons. On one occasion, the youngest said to his father, “give me my portion of inheritance.” The father, being a loving father, relinquished the goods that belonged to his son. As the story goes, the son took all of his inheritance and wasted it on foolish living. After taking his inheritance and making terrible decisions, he found himself eating among pigs, simply to satisfy his hunger. He longed for the days when he had plenty in his father’s house. All the while, the father sat on the front porch of his house, waiting day after day, for his son to return home. Finally, the day came when the father saw a figure on the horizon. Could it be? Yes, it was his long departed son who realized the error of his ways and made a decision to return to the prosperity of his father’s house. The father jumped to his feet and ran down the road with arms stretched wide open. He brought his son home and had the biggest party you could have ever imagined!

The question is...“Why was the father so accepting of the wayward son upon his return?” I believe the answer can be discovered in one simple fact: This was his son; his own flesh and blood. For many of us, we become much more understanding and involved when we take the time to forge relationships with the “broken”. When I look at a person who needs help, an incarcerated person or, simply, someone who has been
beaten down by life circumstances (whether victim or perpetrator), I must see a human being who has some redeeming value. A practicing Clinician is called to care by virtue of career choice—he or she is part of the greater family of caregivers. These caregivers are called to try to help and assist in finding a positive solution in a negative situation.

A Chaplain’s calling is the same. The men with whom I work (labeled “sexually violent predators” by Florida’s legislature) have been wholeheartedly rejected by society. Yes, maybe they deserve their plight and society’s judgement. Yet, if we didn’t care, who would? To me, the greatest paradox is seen in the fact that those who work hardest to help the incarcerated are, at times, the target of the incarcerated. Still, we continue to care. Why? Because this is what we do. We have chosen to make society more palatable by choosing a career corralled behind a razor wire fence. Yes, you may feel like Robert Frost in his poem “choosing the road less traveled.” Yet, on this road, together we can find fulfillment as we join to have a positive impact on others. Shakespeare said, “He that will have a cake out of the wheat must tarry the grinding!” (from History of Troilus and Cressida). Never forget, the cake will come!
Paedophilia: The Actual vs. The Constructed?
Is a change of terminology needed?

Dr. Kieran McCartan
Senior Lecturer in Criminology
University of the West of England, Bristol

In recent years the paedophile has become a major social issue with the general public constantly being bombarded with stories, cases, and media representations of paedophiles and paedophilia (Cohen, 2003; Greer, 2002; McAlinden, 2006a; McCartan, 2008a; Silverman & Wilson, 2002; Thomas, 2005). In this piece I am going to question our understandings of paedophilia, media representations of paedophilia, and how this leads to the label “paedophile” as a social construction, as well as the affect that this may have on our understanding of the nature and manifestations of the behaviour/disorder.

Previous research shows that the paedophilia is a complex and ambiguous term (Howitt, 1995; La Fontaine, 1990; McCartan, 2008b; van Dam, 2001), with the general public not really understanding its true nature, or even wanting to (McCartan, 2004; Silverman & Wilson, 2002); which is compounded by academics, professionals, and practitioners all having a different take on the issue (Howitt, 1995; Leberg, 1997; O’Donohue, Regev & Hagstom, 2000; Silverman & Wilson, 2002; Van Dam, 2001; Thomas, 2005; Assinder, 2006, June 20: www.bbc.co.uk; Hinsliff, 2008, February 17: www.guardian.co.uk; ‘No.10 admits Megan’s Law problems’, 2006, June 19: www.bbc.co.uk; Dodd, 2000, July 24: www.guardian.co.uk; Morris, 2000, July 31: www.guardian.co.uk; ‘Sarah’s Law to Start in Months’, 2007, April 9: www.thesun.co.uk; Travis, 2007, April 11: www.guardian.co.uk).

There seems to be a consensus that paedophilia is a sexual attraction towards children (McCartan, 2008b), but this is a difficult concept to define. Are we discussing only people who sexually offend against children; or people with a sexual attraction to children who may never display it; or people who view child sexual abuse imagery but do not abuse children; or people who film/record child sexual abuse imagery but are not sexual interested and do not abuse children themselves; or all of them? Are we talking about men or women as being paedophiles, or both? Are we discussing all children as being potential victims of paedophiles, or are paedophiles only interested in certain types of children, or certain ages of children? Why do people become paedophiles, is it because of individual psychopathology, or personal experience of childhood sexual abuse, or is it genetic or developmental, or a combination of all? Hence, begging the question, is paedophilia individualistic and, therefore, defying generalisation?

These issues make an already complex and controversial area more difficult, by promoting the realisation that paedophilia might be more than a couple of socially and sexual disordered individuals, while simultaneously running the risk of watering down the current definition of paedophilia and reducing its practicality. Thus, it could be argued that paedophilia has lost its meaning, as the term has been used extensively and, often, inappropriately to attempt to incorporate a multitude of child sexual and related offences. Is it therefore safe to say that the term paedophilia relates more to the psychological mindset of the offenders rather than the actual offence they commit, and the way that they commit it?

Therefore, the question must be raised: Is paedophilia actually two things, the physical act and the socially constructed term? We cannot, nor should we want to, deny that the physical and sexual abuse of
Children happen. Childhood sexual abuse is an all too common and secretive activity in modern society (O'Grady, 2001; West, 2000; Simmons et al., 2002; Nichols, Kershaw, & Walker, 2007), meaning that it is difficult to uncover, prosecute, and treat. However, we have to consider what actually constitutes physical sexual abuse. Does this only relate to the penetrative abuse, or any does any form of sexualised touching or fondling also fall inside this remit? How about the watching or viewing of sexually abusive images? The voyeur has not actually molested the child sexually, but someone else has done so in order to produce the material that the voyeur is watching. The appropriate and rational argument is that all forms of sexualised physical abuse of children is abusive and therefore damaging, but we have to question whether all these forms of sexualised violence and exploitation fall under the banner of paedophilia, and not just child sexual abuse?

It is my contention that the main issue with the term paedophilia is that it has become a socially constructed and loaded term (McCartan, 2008a), with much child sexual abuse being labelled as paedophilia, whether it actually adheres to the terminology or not (i.e., the photographing of a wife under the age of 18 by her husband over the age of 18, the 16 year old boyfriend sleeping with his 15 year old girlfriend—behaviours which many unsophisticated raters might classify as being paedophilic in nature). This begs a question as to whether the term paedophilia has lost is meaning, relevance, and usefulness?

Social Constructionism is a school of thought which suggests that social and cultural practices change over time and space via the meaning attached to them by society and social interaction (Giddens, 1991; Burr, 1995; Berger & Luckman, 1966). Our understandings of childhood, childhood sexuality and as such paedophilia are all pristine examples of this, as they have significantly changed in western over the last century (Postman, 1994; Jenkins, 1996; Cunningham, 1995); but especially within the last 30 years in regard to paedophilia. Although this is, in some ways, positive as it contextualises, adapts, and integrates current concepts of paedophilia into modern society; it may also be an issue as it can move the social meaning of the term away from its professional meaning. This shift in meaning around paedophilia has happened in two ways. First, the social understanding of paedophilia is not in line with the professional definition. Second, the forms of behaviour, psychology, and offending related to paedophilia have outstripped the professional definition. Research has indicated that paedophilia and child sexual abuse have adapted in regard to advancements in technology—especially with innovations such as the camera, camcorders, and the internet (Taylor & Quayle, 2003). Even though our attention to paedophilic offending behaviour has advanced and adapted in recent years, this does not necessarily mean that there is more actual physical child sexual abuse than previously (West, 2000). What we have seen appears to be a greater public exposure to, a greater media reporting of, better police investigating of, and more government funding in regard to paedophilia.

One of the major factors in social constructionism of paedophilia comes from the way that it is used in common social parlance; especially, through the media. The media plays an important role in our society; particularly, in terms of shaping and changing social opinion—either implicitly or explicitly—through the framing of the conversation (Howitt, 1995; Tulloch & Lupton, 2001). This is particularly pertinent in regard to paedophilia, as the media mislabels and poorly communicates child sexual abuse stories to the public, using “child sexual abuse” and “paedophilia” interchangeably (Thompson, 2005; Rind et al, 2001). The media tends to depict paedophiles as anyone—generally over the age of 16—who sexually abuses or views images of any child—generally under the age of 16—regardless of their actions. In recent years, the media has started to shift towards describing all child sexual abusers as paedophiles. This includes such configurations as the 15 year old student and the 21 year old teacher, or the 15 year old girlfriend and the 17 year old boyfriend. But, are they really paedophiles? This is particularly worrying as the media often (mis)represents paedophiles as evil, sadistic strangers often being in a position of trust (Silverman & Wilson, 2002), which we know is not necessarily the case (Howitt, 1995). Newspapers—tabloid and broadsheet—often use emotive language to discuss paedophilia, with headlines such as: ‘Kelly’s weirdos’ (Blackman, 2006, 20 January; www.mirror.co.uk), ‘Vile sickos skulking in high places’ (Parsons, 2003, 20 January; www.mirror.co.uk), ‘Britain’s got perverts’ (Patrick, & Nathan, 2007, 16 June 16; www.thesun.co.uk), ‘My brave girl caged a monster’ (Coles, 2007, 13 January; www.thesun.co.uk),
'Pervs on the loose' (‘Pervs on the loose’, 2007, 2 August; www.thedailystar.co.uk), ‘Mobs and monsters’ (Younge, 2000, 14 August; www.guardian.co.uk), and ‘Child-killers on the loose’ (McKie, 2000, 7 September; www.guardian.co.uk). This type of emotive language also continues within the main bodies of most mainstream media stories, with paedophiles being described as perverts, monsters, and beasts (Thompson, 2005; Greer, 2002). This arguably inappropriate representation has contributed to the public’s misperception of paedophilia (McCartan, 2004; McCartan, in press), leading to a shift in the social construction of the term paedophilia in modern society. The problematic nature of this current shift in the social construction of paedophilia is compounded by the fact that neither the public nor the media see any difference between the different forms of child sexual abusers, their different forms of abuse, or the severity of their actions. This is somewhat understandable, as people do not want to engage with this topic, and it is easier to label all sex offenders as sick, perverted monsters’ rather than trying to come to terms with individual actions. However, it is imperative that we remember that societal understandings of paedophilia are important because they help to shape government policy and practice; especially, in terms of funding and, therefore, can impact upon professional practice (e.g., treatment), prosecution, and reintegration.

This leads on to a side issue that impacts on the socially constructed nature of paedophilia—and, therefore, public comprehension and appropriate usage of the term—that the practitioners who work in this area cannot reach a consensus in regard to what paedophilia actually is (McCartan, 2008b). Many of the issues that we have already discussed in this article are also discussed in professional debates. Thus, if we as a body of informed professionals—both academics and practitioners—cannot reach an agreement in regard to paedophilia (and where paedophilia sits in regard to child sexual abuse, generally), how can we expect society to do so? Does this therefore mean that we (the professionals) need to start debating and discussing what paedophilia actually means, and how this relates to offenders, offending, prosecution, treatment, and reintegration?

If we accept that “paedophilia” has become “socially constructed”, we must accept that the definition has changed, that is, being used outside of its remit and, often, inappropriately. Essentially, it has lost its meaning. Consequently, we must as ourselves: What do we want paedophilia to cover as a term? Is the current definition realistic in this regard? Further, do we need to consider recanting the term “paedophile” to instead use “child sexual abuser”, or is this too generalist and vague? Or, do we need to disregard paedophilia as a term, accept the socially constructed nature of it, and re-brand it—in a manner similar to the way that “psychopath” was refashioned in the UK to DSPD (Dangerous person with Severe Personality Disorder)?

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INTRODUCTION

Kurt Freund, M.D., D.Sc. (1914–1996), was one of the most influential researchers in the areas of sexual orientation, gender identity, and paraphilias in the latter half of the twentieth century. Freund was born into a German-speaking Jewish family in Czechoslovakia, and he conducted his pioneering research on penile plethysmography (phallometry) while living and working in Prague. He fled from Czechoslovakia to Canada in 1968, in the wake of the “Prague Spring,” and accepted a position at the Clarke Institute of Psychiatry (now the Centre for Addiction and Mental Health; CAMH) in Toronto. Shortly after arriving at the Clarke Institute, he began developing the first English-language version of his self-report questionnaire for erotic preferences and gender identity in men.

It is possible to partly reconstruct the chronology of his efforts at questionnaire development through various dates printed in the bottom margins of certain questionnaire pages. Freund’s questionnaire was organized into sections. The pages comprising each section were stapled together; thus each section was physically separate from the other sections. Most of the sections contained items on one topic or a few related topics (e.g., voyeurism and exhibitionism). The dates on which each questionnaire section was revised were printed in the bottom margin of the first page of the section.

Freund’s questionnaire sections for pedophilia and hebephilia, voyeurism and exhibitionism, sadism and masochism, fetishism, and transvestism and transsexualism all have date stamps indicating that they were revised for the first time on October 15, 1971. This suggests that his questionnaire development must have been well under way prior to the autumn of 1971.

The last major revision, according to the date stamps, was completed during April 3–9, 1974. This version was referred to in Freund’s laboratory as Questionnaire III (Q-III). This is the only version of the questionnaire for which computerized data still exist; in other words, the laboratory’s electronic database at the CAMH currently includes Freund questionnaire data for subjects going back to 1974.

Major changes to Q-III after 1974 consisted primarily of additions. Freund added a new section on courtship disorders (voyeurism, exhibitionism, toucheurism, frotteurism, telephone scatologism, and preferential rape) on July 17, 1980—the same week that I began work at the Clarke Institute—and with his encouragement I added a questionnaire section on transvestism and autogynephilia in the next month. In later years, Freund occasionally inserted extra items into various sections, when he became dissatisfied with an existing item or perceived the need for an additional one.

Freund eventually needed a better name than Q-III for the purpose of describing the instrument in publications. I suggested Erotic Preferences Examination Scheme (EPES), which he readily adopted. The EPES has never been published in its entirety, and there would be little purpose in doing so at this point. Many of its multi-item scales have been published in scholarly journals or book chapters, often in appendices or tables. These include scales intended to assess parent-child relations, childhood gender identity, gynephilia (the erotic
preference for physically mature females), androphilia (the erotic preference for physically mature males), and degree of heterosexual experience.

It is not my purpose to collect and review all of the EPES scales here. My purpose in this document is to bring together, in one place, all of the scales corresponding to the specific paraphilias listed in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM). I am doing this partly for historical purposes and partly because the scales’ contents illustrate many of the points an experienced clinician might cover in interviewing a potentially paraphilic patient. These scales have not been copyrighted for commercial purposes, and any clinician or researcher who wishes to use them as they are, or to quote them, or to modify them for his or her own purposes is free to do so.

The individual scales (with scoring weights in parentheses after each response-option) are presented in the next section, and some psychometric data about the scales is presented after that. In the remainder of this introduction, I want to make a few miscellaneous comments about the scales and the items they comprise.

The first thing to point out is that the EPES is designed for men. Freund never attempted, at least after moving to Canada, to produce a parallel version for women. That is because the majority of Freund’s patients were sex offenders, and the overwhelming majority of sex offenders are men.

The wording of some of the items seems awkward or mildly odd, for example, “Has cutting or imagining to cut someone’s hair ever excited you sexually?” English was Kurt Freund’s third or perhaps fourth language, after German, Czech, and possibly French. He usually attempted to get native English-speaking colleagues to proof-read his written English for him and to suggest more idiomatic expressions, but a certain stilted quality remains in many of the items.

Some of the items seem potentially confusing for a patient-population in which many individuals have Grade 10 educations or less, for example, “Since you were 13 how old were you when you first touched the privates of or kissed or caressed a child under 7 years of age, to whom you felt sexually attracted?” It is important to understand that Freund often went over the questionnaire items with his patients, explaining the meaning of the various questions until they understood what was being asked. He was interested in the actual answer, not in the patient’s immediate reaction to the question.

There is a final item matter about which I can only speculate. Some of the individual items seem to have been designed, from the very beginning, with a multi-item scale in mind. The Masochism Scale, for example, consists primarily of such items: “Has imagining that you were being humiliated or poorly treated by someone ever excited you sexually?” “Has imagining that someone was choking you ever excited you sexually?” “Has imagining that you have become dirty or soiled ever excited you sexually?”

Other items, in contrast, seem very queerly worded for elements in multi-item scales. An example is this item from the Voyeurism Scale: “Since you were 16, if you secretly watched people making love, did you feel you were: (a) the male, (b) the female, (c) either one, (d) neither one, or (e) never watched (except for movies, plays, etc.).” The item seems to be looking for information beyond the patient’s proclivity for watching unsuspecting strangers in intimate situations. Freund’s original purpose in writing such items might have been to gather information about the predominant behavior, emotion, or cognition associated with a paraphilia, or to identify subtypes within paraphilias. When he impressed them into service in multi-item scales, he simply ignored the superfluous information. Thus, response-options (a), (b), (c), and (d) in the foregoing item are all scored as “1” and option (e) is scored as “0.”

Freund made no attempt, in writing these items, to mislead or distract the patient from the meaning of the item or its implications. The items were designed on the sole principal of face-validity. Of course Freund understood as well as anyone that patients, especially those accused of criminal sexual behavior, are not candid about their erotic interests. Patients’ scores on these scales are influenced both by whether they have a paraphilia and by whether they are willing to admit a paraphilia if they have one. Freund chose to stress the latter source of variance when he called his measures of pedophilia and hebephilia the *Pedo Admitter Scale* and the *Hebe Admitter Scale* rather than the *Pedo Scale* and the *Hebe Scale*.

Freund was also well aware of the repetitiousness of the items in some of the scales; he commented wryly about that on one occasion I remember. That repetitiousness results, in part, from the fact that paraphilias
are essentially monosymptomatic conditions. He did vary item content when he could. He included, for example, items about love as well as items about lust in his pedophilia and hebephilia measures.

As I have already explained, Freund often went over patients’ questionnaire responses with them and help them complete the questionnaire if they had difficulty answering the items on their own. He naturally used their responses to key items (along with their sexual offense histories and their phallometric results) in making clinical diagnoses. He did not, to the best of my knowledge, habitually use the computed scale totals for diagnostic purposes. He therefore did not conduct much, if any, research to identify cutting scores for the various scales, so cutting scores for classifying a patient as paraphilic or non-paraphilic are not available. The computed scale totals were primarily for the purposes of research rather than individual diagnosis.

It is necessary to know one aspect of Freund’s standard operating procedure in order to understand what psychometric data are and are not available. I have already explained that the EPES was physically divided into sections. Freund did not give every patient every section. In general, he gave patients only those sections that were relevant to their clinical presentations. Thus, a patient who presented with exhibitionism would not get the section on fetishism (unless he also acknowledged fetishism). A patient who presented with fetishism, on the other hand, might also be given the section on sadism and masochism without his having mentioned those interests spontaneously, because fetishism is commonly found in association with sadism and masochism. Freund did this for a variety of practical reasons, one being that patients who had no interest in a particular paraphilia (e.g., transvestism or pedophilia) were sometimes upset and offended to be asked about cross-dressing or sexual feelings toward children. The upshot of this is that it was never feasible to conduct a grand, omnibus factor analysis of all paraphilia measures on all patients. Thus, the available psychometric data are alpha reliability coefficients.

These scales, whatever their psychometric flaws, did yeoman’s service in a large number of studies, which I have not attempted to list comprehensively in this document. They still offer, at the very least, a starting point for the further development of self-report scales that canvass patients’ sexual desires as well as their sexual actions.

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**SCALES**

**SEXUAL MASOCHISM**

*Masochism Scale* (Freund, Steiner, & Chan, 1982)

1. If you were insulted or humiliated by a person to whom you felt sexually attracted, did this ever increase their attractiveness?
   1. yes (1)
   2. no (0)
   3. unsure (0)

2. Has imagining that you were being humiliated or poorly treated by someone ever excited you sexually?
   1. yes (1)
   2. no (0)
3. Has imagining that you had been injured by someone to the point of bleeding ever excited you sexually?
   a. yes (1)
   b. no (0)

4. Has imagining that someone was causing you pain ever aroused you sexually?
   a. yes (1)
   b. no (0)

5. Has imagining that someone was choking you ever excited you sexually?
   a. yes (1)
   b. no (0)

6. Has imagining that you have become dirty or soiled ever excited you sexually?
   a. yes (1)
   b. no (0)

7. Has imagining that your life was being threatened ever excited you sexually?
   a. yes (1)
   b. no (0)

8. Has imagining that someone was imposing on you heavy physical labor or strain ever excited you sexually?
   a. yes (1)
   b. no (0)

9. Has imagining a situation in which you were having trouble breathing ever excited you sexually?
   a. yes (1)
   b. no (0)

10. Has imagining that you were being threatened with a knife or other sharp instrument ever excited you sexually?
    a. yes (1)
    b. no (0)

11. Has imagining that you were being tied up by somebody ever excited you sexually?
    a. yes (1)
    b. no (0)
SEXUAL SADISM (Freund, Stein, & Chan, 1982)

Sadism Scale

1. Did you ever like to read stories about or descriptions of torture?
   a. yes (1)
   b. no (0)

2. Did you usually re-read a description of torture several times?
   a. yes (1)
   b. no (0)
   c. don’t remember (0)

3. Were you:
   a. very interested in descriptions of torture (1)
   b. a little interested (0)
   c. not at all interested (0)
   d. never read such descriptions (0)

4. Between the ages of 13 and 16, did you find the sight of blood:
   a. exciting (1)
   b. only pleasant (1)
   c. unpleasant (0)
   d. did not affect you in any way (0)

5. Has beating somebody or imagining that you are doing so ever excited you sexually?
   a. yes (1)
   b. no (0)

6. Have you ever tried to tie the hands or legs of a person who attracted you sexually?
   a. yes (1)
   b. no (0)

7. Has cutting or imagining to cut someone’s hair ever excited you sexually?
   a. yes (1)
   b. no (0)

8. Has imagining that you saw someone bleeding ever excited you sexually?
   a. yes (1)
   b. no (0)
9. Has imagining someone being choked by yourself or somebody else ever excited you sexually?
   a. yes (1)
   b. no (0)

10. Has imagining yourself or someone else imposing heavy physical labor or strain on somebody ever excited you sexually?
    a. yes (1)
    b. no (0)

11. Has imagining that someone was being ill-treated in some way by yourself or somebody else ever excited you sexually?
    a. yes (1)
    b. no (0)

12. Has imagining that you or someone else were causing pain to somebody ever excited you sexually?
    a. yes (1)
    b. no (0)

13. Has imagining that you or somebody else were threatening someone’s life ever excited you sexually?
    a. yes (1)
    b. no (0)

14. Has imagining that someone other than yourself was crying painfully ever excited you sexually?
    a. yes (1)
    b. no (0)

15. Has imagining that someone other than yourself was dying ever excited you sexually?
    a. yes (1)
    b. no (0)

16. Has imagining that you or someone else were making it difficult for somebody to breathe ever excited you sexually?
    a. yes (1)
    b. no (0)

17. Has imagining that you or someone else were tying up somebody ever excited you sexually?
    a. yes (1)
    b. no (0)
18. Has imagining that you or somebody else were threatening someone with a knife or other sharp instrument ever excited you sexually?
   a. yes (1)  
   b. no (0)

19. Has imagining that someone was unconscious or unable to move ever excited you sexually?
   a. yes (1)  
   b. no (0)

20. Has imagining that someone had a very pale and still face ever excited you sexually?
   a. yes (1)  
   b. no (0)

FETISHISM

_Fetishism Scale_ (Freund, Stein, & Chan, 1982)

1. Do you think that certain inanimate objects (velvet, silk, leather, rubber, shoes, female underwear, etc.) have a stronger sexual attraction for you than for most other people?
   a. yes (1)  
   b. no (0)

2. Has the sexual attractiveness of an inanimate (not alive) thing ever increased if it had been worn by, or had been otherwise in contact with:
   a. a female (1)  
   b. a male (1)  
   c. preferably a female but also when in contact or having been in contact with a male (1)  
   d. preferably a male but also when in contact or having been in contact with a female (1)  
   e. a female or male person equally (1)  
   f. contact between a person and a thing never increased its sexual attractiveness (1)  
   g. do not feel sexually attracted to any inanimate thing (0)

3. Did the sexual attractiveness to you of such a thing ever increase if you wore it or were otherwise in contact with it yourself?
   a. yes (1)  
   b. no (1)  
   c. have never been sexually attracted to inanimate things (0)

4. Were you ever more strongly sexually attracted by inanimate things than by females or males?
   a. yes (1)  
   b. no (0)
5. What was the age of persons who most increased the sexual attractiveness for you of a certain inanimate object by their contact with it?

a. 3 years or younger (1)
b. between 4 and 6 years (1)
c. between 6 and 11 years (1)
d. between 12 and 13 years (1)
e. between 14 and 16 years (1)
f. between 17 and 40 years (1)
g. over 60 years (1)
h. contact between a person and a thing never increased its sexual attractiveness (1)
i. have never been sexually attracted to inanimate things (0)

6. Is there more than one kind of inanimate thing which arouses you sexually?

a. yes (1)
b. no (0)
c. have never been sexually attracted to inanimate things (0)

7. Through which of these senses did the thing act most strongly?

a. through the sense of smell (1)
b. through the sense of taste (1)
c. through the sense of sight (1)
d. through the sense of touch (1)
e. through the sense of hearing (1)
f. have never been sexually attracted to inanimate objects (0)

8. At about what age do you remember first having a special interest in an inanimate thing which later aroused you sexually?

a. younger than 2 (1)
b. between 2 and 4 (1)
c. between 5 and 7 (1)
d. between 8 and 10 (1)
e. between 11 and 13 (1)
f. older than 13 (1)
g. have never been sexually attracted to inanimate objects (0)

________________________

TRANSVESTISM

Cross-Gender Fetishism Scale (Blanchard, 1985)

1. Have you ever felt sexually aroused when putting on women’s underwear, stockings, or a nightgown?

a. yes (1)
b. no (0)
c. have never put on any of these (0)
2. Have you ever felt sexually aroused when putting on women’s shoes or boots?
   a. yes (1)
   b. no (0)
   c. have never put on either of these (0)

3. Have you ever felt sexually aroused when putting on women’s jewelry or outer garments (blouse, skirt, dress, etc.)?
   a. yes (1)
   b. no (0)
   c. have never put on any of these (0)

4. Have you ever felt sexually aroused when putting on women’s perfume or make-up, or when shaving your legs?
   a. yes (1)
   b. no (0)
   c. have never done any of these (0)

5. Have you ever masturbated while thinking of yourself putting on (or wearing) women’s underwear, stockings, or a nightgown?
   a. yes (1)
   b. no (0)

6. Have you ever masturbated while thinking of yourself putting on (or wearing) women’s shoes or boots?
   a. yes (1)
   b. no (0)

7. Have you ever masturbated while thinking of yourself putting on (or wearing) women’s jewelry or outer garments?
   a. yes (1)
   b. no (0)

8. Have you ever masturbated while thinking of yourself putting on (or wearing) women’s perfume or make-up, or while thinking of yourself shaving your legs (or having shaved legs)?
   a. yes (1)
   b. no (0)

9. Has there ever been a period in your life of one year (or longer) during which you always or usually felt sexually aroused when putting on female underwear or clothing?
   a. yes (1)
   b. no (0)
   c. have never put on female underwear or clothing (0)
10. Has there ever been a period in your life of one year (or longer) during which you always or usually masturbated if you put on female underwear or clothing?
   a. yes (1)
   b. no (0)
   c. have never put on female underwear or clothing (0)

11. Have you ever put on women’s clothes or make-up for the main purpose of becoming sexually excited and masturbating?
   a. yes (1)
   b. no (0)

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**AUTOGYNEPHILIA**

*Core Autogynephilia Scale* (Blanchard, 1989)

1. Have you ever become sexually aroused while picturing yourself having a *nude* female body or with certain features of the nude female form?
   a. yes (1)
   b. no (0)
   c. have never pictured this (0)

   If you have answered “yes” to question 1, please answer questions 2–6. Otherwise skip to question 7.

2. You became sexually aroused while picturing your nude female breasts.
   a. yes (1)
   b. no (0)
   c. have never pictured yourself with nude female breasts (0)
   d. skipped (0)

3. You became sexually aroused while picturing your nude female buttocks.
   a. yes (1)
   b. no (0)
   c. have never pictured yourself with nude female buttocks (0)
   d. skipped (0)

4. You became sexually aroused while picturing your nude female legs.
   a. yes (1)
   b. no (0)
   c. have never pictured yourself with nude female legs (0)
   d. skipped (0)
5. You became sexually aroused while picturing your nude female genitals (private parts).
   a. yes (1)
   b. no (0)
   c. have never pictured yourself with nude female genitals (0)
   d. skipped (0)

6. You became sexually aroused while picturing your female face.
   a. yes (1)
   b. no (0)
   c. have never pictured yourself with a female face (0)
   d. skipped (0)

7. Which of the following pictures of yourself has been most strongly associated with sexual arousal?
   a. as a nude woman (1)
   b. as a woman dressed only in underwear, sleepwear, or foundation garments (for example, a corset) (1)
   c. as a fully clothed woman (1)
   d. have never become sexually aroused while picturing yourself as a woman (0)
   e. have never pictured yourself as a woman (0)

8. Have you ever been sexually aroused by the thought of being a woman?
   a. yes (1)
   b. no (0)

PEDOPHILIA

Pedo Admitter Scale (Freund, 1981)

Scoring note: Freund (1981) states that each item can attain no higher score than 1. Some items have homosexual and heterosexual alternatives (denoted by A, B, or C). In such cases, the score of only one alternative is counted. Thus, for example, positive responses to all three items 2A, 2B and 2C would add 1 to the total score, not 3.

1. Since you were 16, have you ever been as attracted, or more attracted, sexually by anybody or anything other than by females age 13–40?
   a. yes (1)
   b. no (0)

2. [A] Have you ever been equally, or more, attracted sexually by a boy age 6–11 than by females or males age 17–40?
   a. yes (1)
   b. no (0)
2. [B] Have you ever been equally, or more, attracted sexually by a girl or boy under age 6 than by females or males age 17–40?
   a. yes (1)
   b. no (0)

2. [C] Since age 16, have you ever been equally, or more, attracted sexually by a girl age 6–12 than by females age 17–40?
   a. yes (1)
   b. no (0)

3. [A] When did you first feel equally or more sexually attracted to a boy 11 or younger than towards females or males 13 or over?
   a. before age 16 and this sexual attraction continued after age 16 (1)
   b. when you were between 16 and 20 (1)
   c. when you were between 21 and 30 (1)
   d. when you were between 31 and 40 (1)
   e. when you were between 41 and 50 (1)
   f. when you were older than 50 (1)
   g. no such strong feelings towards boys 11 or younger (after you were age 16) (0)

3. [B] When did you first feel equally or more sexually attracted to a girl 11 or younger than towards females or males 13 or over?
   a. before age 16 and this sexual attraction continued after age 16 (1)
   b. when you were between 16 and 20 (1)
   c. when you were between 21 and 30 (1)
   d. when you were between 31 and 40 (1)
   e. when you were between 41 and 50 (1)
   f. when you were older than 50 (1)
   g. no such strong feelings towards girls 11 or younger after you were age 16 (0)

4. Since you were 16, have you ever felt sexually attracted towards:
   a. girls younger than 12 but not boys of this age (1)
   b. boys younger than 12 but not girls of this age (1)
   c. mainly girls younger than 12 but also boys of this age (1)
   d. mainly boys younger than 12 but also girls of this age (1)
   e. both girls and boys younger than 12 about equally (1)
   f. neither girls nor boys younger than 12 (0)

5. [A] How old was the youngest boy who attracted you sexually since you were 16?
   a. younger than 6 years (1)
   b. between the ages of 6 and 8 (1)
   c. between the ages of 9 and 11 (1)
   d. boys younger than 12 have never attracted you sexually since age 16 (0)
5. [B] How old was the youngest girl who attracted you sexually since you were 16?
   a. younger than 6 years (1)
   b. between the ages of 6 and 11 (1)
   c. girls younger than 12 have not attracted you sexually since you were 16 (0)

6. [A] How old were the boys (or men) toward whom you felt the strongest sexual attraction since you were 16? Indicate the approximate midpoint of the age bracket of highest attractiveness to you by one number only; this number should represent the approximate midpoint of the age bracket of highest attractiveness. (Example: if you felt for instance most attracted to boys age 7 to 10, indicate either age 8 or 9 whichever you feel to be more appropriate). If you were not sexually attracted to males put “0.” ____ (ages 1–11 = 1, age 12 or higher = 0)

6. [B] How old were the girls (or women) toward whom you felt the strongest sexual attraction since you were 16? Indicate the age bracket of highest attractiveness to you by one number only. This number should represent the approximate midpoint of the age bracket of highest attractiveness. (Example: if you felt for instance most attracted to girls age 7 to 10, indicate either age 8 or 9, whichever you feel to be more appropriate.) ____ (ages 1–11 = 1, age 12 or higher = 0)

7. Since you were 13 how old were you when you first touched the privates of or kissed or caressed a child under 7 years of age, to whom you felt sexually attracted?
   a. between 13 and 16 (1)
   b. between 17 and 20 (1)
   c. between 21 and 30 (1)
   d. between 31 and 40 (1)
   e. between 41 and 50 (1)
   f. older than 50 (1)
   g. before reaching the age of 13, and this happened at least once again after age 13 (1)
   h. since age 13, have never touched the privates of or kissed or caressed a child younger than 7, to whom you felt sexually attracted (0)
   i. have never felt sexually attracted to a child of this age (0)

8. Since you were 16, how old were you when you first touched the privates of or kissed or caressed a child between 7 and 11 years of age to whom you felt sexually attracted?
   a. between 16 and 20 (1)
   b. between 21 and 30 (1)
   c. between 31 and 40 (1)
   d. between 41 and 50 (1)
   e. older than 50 (1)
   f. before reaching the age of 16, and this happened at least once again after age 16 (1)
   g. since age 16, have never touched the privates of or kissed or caressed a child, between 7 and 11 years of age, to whom you felt sexually attracted (0)
   h. have never felt sexually attracted to a child of this age (0)

9. [A] Since you were 16, have you ever been in love with a girl 11 or younger?
   a. yes (1)
   b. no (0)
   c. unsure (1)
9. [B] Since you were 16, have you ever been in love with a boy 11 or younger?
   a. yes (1)
   b. no (0)
   c. unsure (1)

10. Since you were 16, how did you like girl or boy 11 or under to respond to your sexual advances?
   a. to resist your advances or be afraid or pretend to be afraid (1)
   b. to give in easily to your advances (1)
   c. their reaction was unimportant to you (1)
   d. have never felt sexually attracted to a boy or girl 11 or under since you were 16 (0)

11. If you felt sexually attracted to a girl or boy age 11 or under, which of the following would you have liked to do most?
   a. touch their chest with your hands (1)
   b. touch their privates with your hands (1)
   c. touch their rear end with your hands (1)
   d. touch their chest with your mouth (1)
   e. touch their privates with your mouth (1)
   f. touch their rear end with your mouth (1)
   g. touch their chest with your privates (1)
   h. touch their thighs (upper legs) with your privates (1)
   i. touch their privates with your privates (1)
   j. show your privates only (1)
   k. have never felt sexually attracted to a girl or boy age 11 or under (0)

12. Since you were 16, have you ever masturbated while touching girls or boys 11 or younger?
   a. yes (1)
   b. no (0)

HEBEPHILIA

Hebe Admitter Scale (Freund, 1981)

Scoring note: Freund (1981) states that each item can attain no higher score than 1. Some items have homosexual and heterosexual alternatives (denoted by A or B). In such cases, the score of only one alternative is counted. Thus, for example, positive responses to both items 2A and 2B would add 1 to the total score, not 2.

1. Since you were 16, have you ever been as attracted, or more attracted, sexually by anybody or anything other than by females age 13–40?
   a. yes (1)
   b. no (0)
2. [A] Have you ever been equally, or more, attracted sexually by a boy age 12–16 than by females or males age 17–40?
   a. yes (1)
   b. no (0)

2. [B] Since age 20, have you ever been equally, or more attracted sexually by a girl age 13–14 than by females age 17–40?
   a. yes (1)
   b. no (0)
   c. you are under age 20 (0)

3. [A] When did you first feel equally or more sexually attracted to a girl 12 to 13 than to females or males 14 or over?
   a. before age 20 (and this sexual attraction continued after age 20) (1)
   b. when you were between 21 to 30 (1)
   c. when you were between 31 to 40 (1)
   d. when you were between 41 to 50 (1)
   e. when you were older than 50 (1)
   f. no such strong feelings towards girls 12 to 13 after you were age 20 (0)
   g. you are not yet older than 20 (0)

3. [B] Since age 18, about how old was the youngest male to whom you could have felt some sexual attraction?
   a. younger than 6 (0)
   b. between 6 and 11 (1)
   c. between 12 and 16 (1)
   d. between 17 and 19 (0)
   e. older than 19 (0)
   f. did not feel sexually attracted to males (0)

4. [A] How old were the boys (or men) toward whom you felt the strongest sexual attraction since you were 16? Indicate the age bracket of highest attractiveness to you by one number only; this number should represent the approximate midpoint of the age bracket of highest attractiveness (Example: if you felt for instance most attracted to boys age 7 to 10, indicate either age 8 or 9 whichever you feel to be more appropriate). If you were not sexually attracted to males put “0.” ____ (ages 12–16 = 1, older or younger = 0)

4. [B] How old were the girls (or women) toward whom you felt the strongest sexual attraction since you were 16? Indicate the age bracket of the highest attractiveness to you by one number only. This number should represent the approximate midpoint of the age bracket of highest attractiveness (Example: if you felt for instance most attracted to girls age 7 to 10, indicate either age 8 or 9 whichever you feel to be more appropriate.) ____ (ages 12–15 = 1, older or younger = 0)

5. [A] Since the age of 20 have you ever been in love with a girl of 12 or 13?
   a. yes (1)
   b. no (0)
   c. unsure (1)
5. [B] Since you were 18, have you ever been in love with a boy of 12 to 14?
   a. yes (1)
   b. no (0)
   c. unsure (1)

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**VOYEURISM**

_Voyeurism Scale_ (Freund, Watson, & Rienzo, 1988)

1. Since you were 16, have you ever had a greater desire to secretly watch people of your preferred sex who were undressed or partly undressed (not including pictures, movies, etc.), than to have sexual contact? If so, would you rather watch:
   a. one person alone (1)
   b. people fondling and playing with each other (without intercourse) (1)
   c. people having intercourse (1)
   d. always preferred to have sexual contact since age 16 (0)

2. Since you were 16, if you secretly watched people making love, did you feel you were:
   a. the male (1)
   b. the female (1)
   c. either one (1)
   d. neither one (1)
   e. never watched (except for movies, plays, etc.) (0)

3. Since you were 16, did you ever masturbate (play with yourself) to a climax (ejaculation) while you were secretly watching people having sexual contact, or who were undressed or partly so (not including pictures, movies, etc.)?
   a. yes (1)
   b. no (0)

4. Since you were 16, have you ever masturbated while remembering other people’s sexual activities you have seen?
   a. yes (1)
   b. no (0)

5. Since age 16, and apart from viewing pictures or movies, have you ever spent a substantial amount of time trying to observe females nude or partly nude, or to observe them urinating, having intercourse with a man or in some other normally private act?
   a. yes (1)
   b. no (0)
6. Since age 16, have you ever masturbated while watching or trying to observe a girl or woman who was unaware of your presence?
   
   a. yes (1)
   
   b. no (0)

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**EXHIBITIONISM**

*Exhibitionism Scale* (computed, but not published, by Freund as a scale; responses to some individual items analyzed in Freund, Watson, & Rienzo, 1988)

1. About how old were you when you first reached a climax while imagining, or dreaming, that someone you liked was looking from a distance at your privates?
   
   a. younger than 13, and this happened at least once again when older (1)
   
   b. between 13 and 16 (1)
   
   c. between 17 and 20 (1)
   
   d. between 21 and 30 (1)
   
   e. between 31 and 40 (1)
   
   f. between 41 and 50 (1)
   
   g. older than 50 (1)
   
   h. never (0)

2. About how old were you when you first had the urge to expose your privates to a person from a distance?
   
   a. before you were 13, and at least once again when older (1)
   
   b. between 13 and 16 (1)
   
   c. between 17 and 20 (1)
   
   d. between 21 and 30 (1)
   
   e. between 31 and 40 (1)
   
   f. between 41 and 50 (1)
   
   g. older than 50 (1)
   
   h. never (0)

3. If there would not have been any risk of detection would you have most liked to expose your privates from a distance to:
   
   a. always the same person (1)
   
   b. a few times to the same person (1)
   
   c. always to a different person (1)
   
   d. never had the urge to expose (0)

4. Who would you have most liked to expose your privates to?
   
   a. people nude or only partly dressed (1)
   
   b. people wearing clothes (1)
   
   c. it would have made no difference (1)
   
   d. no desire to do this (0)
5. The first time you exposed your privates from a distance, to someone of the sex you prefer, was it because:
   a. you were married but did not have sexual intercourse often enough (because your wife was sick, pregnant, or separated, etc.) (1)
   b. you were unmarried and had little opportunity for sexual intercourse (1)
   c. you were worried about other things (1)
   d. you exposed your privates as described above, but as far as you know it was not because of the reasons mentioned (1)
   e. you have not exposed your privates in the way mentioned above (0)

6. If nothing unpleasant would have happened as a result, would you have preferred that the person you exposed your privates to from a distance be:
   a. someone you knew well (1)
   b. someone you knew only slightly (1)
   c. someone you did not know (1)
   d. it didn’t matter to you whether or not you knew the person (1)
   e. never had the urge to expose (0)

7. Would you have preferred to expose your privates to:
   a. one person alone (1)
   b. more than one person at a time (1)
   c. makes no difference (1)
   d. have never had the urge to expose (0)

8. Which sex did you prefer to expose your privates to?
   a. males (1)
   b. females (1)
   c. both at the same time (1)
   d. their sex didn’t make any difference (1)
   e. never had the desire to expose (0)

9. How would you have preferred a person to react if you were to expose your privates to him or her?
   a. with fear (1)
   b. with admiration (1)
   c. with anger and disgust (1)
   d. that he or she would have shown their privates also (1)
   e. that he or she would want to have sexual intercourse with you (1)
   f. kind of response didn’t matter as long as there was one (1)
   g. it wouldn’t have mattered if the person reacted or not (1)
   h. never had the desire to expose your privates (0)

10. If you have exposed to someone from a distance, did you ever want to touch his or her private parts also?
    a. yes (1)
    b. no (1)
    c. have never exposed my privates from a distance (0)
11. Right after you had exposed your privates to someone from a distance, did you ever wish to have intercourse:

   a. with the same person you had exposed to (1)
   b. with another person who was about the same age and sex as the person you had exposed to (1)
   c. with someone who was much younger, of the same sex as the person you had exposed to (1)
   d. with someone who was much older, of the same sex as the person you had exposed to (1)
   e. with someone who was not the same sex as the person you had exposed to (1)
   f. never wanted to have intercourse right after exposing (1)
   g. have never exposed your privates from a distance (0)

12. Imagine you were forced to have sexual intercourse after exposing your privates to someone from a distance, would you choose:

   a. the person you had exposed to (1)
   b. someone else (1)
   c. can’t imagine myself exposing to someone from a distance (0)

13. Did you ever masturbate to a climax (ejaculation) while imagining that you were exposing your privates from a distance?
   a. yes (1)
   b. no (0)

**ALPHA RELIABILITY COEFFICIENTS**

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Hebe Admitter  9  HmPH, HtPH  152  .74  Freund, 1981
Voyeurism  6  HtC, CDP  385  .83  Freund et al., 1988
Exhibitionism  13  HtC, CDP  559  .98  Unpublished data from EPES, analyzed March 11, 2009

aTTP, transsexual and transvestite patients; HtC, heterosexual controls; HmC, homosexual controls; HmP, homosexual patients; HmPH, homosexual pedo- and hebephiles; HtPH, heterosexual pedo- and hebephiles; CDP, courtship disorder patients (voyeurs, exhibitionists, toucheurs, preferential rapists); SP, sadistic patients; HyP, erotically hyperdominant patients; MP, masochistic patients.

bBlanchard (1985) used scoring weights for the response-options that were determined with the optimal scaling procedure for multiple-choice items outlined by Nishisato (1980). Blanchard (1988) suggested the substitution of a simple dichotomous scoring scheme (as presented in this document), but he did not provide any recalculation of the Cross-Gender Fetishism Scale’s reliability using such a scheme. Blanchard (1992) calculated an alpha reliability coefficient of .94 for this scale, using the original optimal scaling weights, in a study of 427 transsexual and transvestite patients. In preparing the present document, I recalculated the reliability coefficient on the same 427 patients using the dichotomous weights and again obtained a value that rounded to .94. The dichotomous weights are clearly just as good and are much simpler.

REFERENCES

The Big Drop in Sex Crimes

Sandeep Mishra & Martin Lalumière
University of Lethbridge, Alberta, Canada

Authors’ Note: We would like to thank Christine Michell, Vern Quinsey, and Michael Seto for their very useful comments on this article.

Introduction

In the early 1990s, rates of sexual crimes began to decrease substantially in both the United States and Canada. From 1991 to 2001, sexual assault rates decreased 25 percent in Canada, and 28 percent in the United States (see Figure 1). In the United States, during the period 1990 through 2004, rates of sexual abuse of children declined 49 percent, and teenage sexual assaults decreased by 67 percent (Finkelhor & Jones, 2006). What explains this notable drop in sex-related crimes over the 1990s? In this article, we describe the results of a recent study that re-frames this question more broadly, and provides some potential explanations for this decline.

Figure 1. Sex crime rates in the United States and Canada.
The Crime Drop

Homicide is the best measure for investigating general variation in crime rates because it is less subject to reporting or recording bias compared to other crimes. Although the United States and Canada have very different homicide rates, both countries experienced similar declines in homicide in the 1990s (USA: 43 percent; Canada: 33 percent; see Figure 2). Other violent crimes and property crimes also declined during the 1990s. Data from the Federal Bureau of Investigation’s Uniform Crime Reports suggests that arrest rates for total, violent, and property crimes declined for all age groups, ranging from 20 percent (age 65+), to 57 percent (age 20-24). Geographically, both metropolitan and rural areas of the United States and Canada experienced declines in crime. In fact, the decline in crime was not specific to any particular type of crime, methodology of crime reports, demographic characteristics, or geographical areas, suggesting that the decline in sexual crime observed in the 1990s is part of a much larger, more general phenomenon (Fox, 2005; Levitt, 2004; Ouimet, 2002, 2004).

Figure 2. Homicide rates in the United States and Canada.

Since the crime drop phenomenon has come to the forefront of criminologists’ attention, various explanations have been developed and tested (e.g., Blumstein & Wallman, 2005; Levitt, 2004). These explanations include demographic effects (aging population, increased access to abortion in the 1970s, increased use of incarceration), public policy shifts (increased number of police officers, innovative policing strategies, gun control), and socioeconomic factors (strong economy, decrease in the illegal drug trade). Many of these explanations are able to explain some portion of the decline in crime in the 1990s, but none are completely satisfactory in explaining the widespread and robust drop in crime in both the United States and Canada (Zimring, 2006). These explanations also largely ignore a
very important aspect of the decline in the 1990s that has not been addressed until recently—the decline in general risky behavior.

**Who Commits Crime?**

Most data suggest that criminal offenders do not specialize in particular types of crime. Rapists, for example, do not engage solely in sexual crimes but, rather, engage in a broad range of criminal, antisocial, and risky behavior (reviewed in Lalumière, Harris, Quinsey, & Rice, 2005); although, specialization is underestimated in rap sheet data. In fact, most evidence suggests that, on average, criminals are generalists, engaging in not only crime, but risky and antisocial behavior more broadly. Several theories specify a strong link between general risky behavior and crime (e.g., Daly & Wilson, 2001; Gottfredson & Hirschi, 1990; Jessor, 1991). Studies of individuals who engage in criminal behavior have revealed that they tend to score high on such personality traits as poor self-control, impulsivity, and thrill seeking—traits that have also been significantly associated with a general propensity to take risks. Several studies have also documented the co-occurrence of criminal and other risky behaviors within individuals (Caspi et al., 1997; Grasmick, Tittle, Bursik Jr., & Arneklev, 1993; Jones & Quisenberry, 2004; Junger & Tremblay, 1999; Lalumière & Quinsey, 1996). Together, these findings support the notion of a general construct of deviance or problem behavior encompassing both criminal and risky behavior, an idea that has been delineated in several theories of criminal and risk behavior (e.g., Gottfredson and Hirschi’s General Theory of Crime and Jessor’s Problem Behavior Theory).

Because criminal behavior appears to be part of a broader tendency to engage in risk-taking behavior, it is possible that previous explanations for the crime drop have been too narrow in focus. These explanations have focused solely on crime declines (sometimes, even on crime-specific declines, like theft), when the appropriate target of explanation may actually be a much more general phenomenon. If crime and risky behavior are linked at the individual level, as they appear to be, then risky behavior should follow a similar temporal pattern to crime rates at the national level. In particular, the drop in crime in the 1990s should not be observed for just crime but, rather, for the broad constellation of problem behavior of which crime is a part. Furthermore, rates of crime and risky behavior should exhibit statistical covariation not only in the 1990s, but over longer periods of time as well.

**The Crime (and Risk) Drop**

We tested these predictions in a recent study published in *Social Science and Medicine* (Mishra & Lalumière, 2009). We collected 65 indicators of risky behavior in various domains, including violence, accidents and behaviors related to accidents, sexual behaviors, substance use, and school dropout. We broadly defined risky behavior as “impulsive, reckless behavior that maximizes short-term gains (e.g., sexual gratification, emotional arousal, relief of negative feelings) with potential for immediate or future costs (e.g., car accident, unwanted pregnancy)” (Mishra & Lalumière, 2009, p. 40). The 65 indicators of risky behavior (or outcomes of risky behavior) we were able to obtain were comprised of national-level rates of behavior collected by various agencies in the United States and Canada, and reflect trends for both the general population, and teenagers specifically (because they are a particularly risk-prone group).

In the domain of sexual behavior, an examination of rates of sexual risk taking in the 1990s in both Canada and the United States reveal a drop that parallels that of sexual crime rates. Risky sexual behaviors in teenagers such as sex with multiple partners, not using condoms, and teenage pregnancies (an outcome of risky sexual behavior) have decreased 24, 22 and 27 percent respectively in the United States from 1991 to 2001. In Canada, teenage pregnancies have decreased 20 percent in the same time period. Even some (but certainly not all) sexually transmitted diseases have decreased in prevalence.
over the same time period (e.g., syphilis is down 78 percent in the U.S. and 31 percent in Canada). Overall, 17 of 21 sexual risk indicators showed a decline in the 1990s (see Table 1).

**Table 1. Changes in risky sexual behaviors, 1991-2001.**  
(Data from Mishra & Lalumière, 2009)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>% Decline</th>
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<tr>
<td>Ever had sex (T)</td>
<td>-16</td>
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<tr>
<td>Had first sex before 13 (T)</td>
<td>-55</td>
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<tr>
<td>Sex with 4+ partners (T)</td>
<td>-24</td>
</tr>
<tr>
<td>Currently sexually active (T)</td>
<td>-12</td>
</tr>
<tr>
<td>No condom use (T)</td>
<td>-22</td>
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<tr>
<td>No birth control pill use (T)</td>
<td>+3</td>
</tr>
<tr>
<td>Teen pregnancies (T)</td>
<td>-27</td>
</tr>
<tr>
<td>Teen pregnancies (T) (CA)</td>
<td>-20</td>
</tr>
<tr>
<td>Live teen births (T)</td>
<td>-27</td>
</tr>
<tr>
<td>Live teen births (T) (CA)</td>
<td>-38</td>
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<tr>
<td>Induced abortions</td>
<td>-19</td>
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<tr>
<td>Induced abortions (CA)</td>
<td>+6</td>
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<tr>
<td>Teen induced abortions (T)</td>
<td>-44</td>
</tr>
<tr>
<td>Teen induced abortions (T) (CA)</td>
<td>0</td>
</tr>
<tr>
<td>AIDS</td>
<td>-43</td>
</tr>
<tr>
<td>Syphilis</td>
<td>-78</td>
</tr>
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<td>Syphilis (CA)</td>
<td>-31</td>
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<tr>
<td>Gonorrhea</td>
<td>-48</td>
</tr>
<tr>
<td>Gonorrhea (CA)</td>
<td>-51</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>+52</td>
</tr>
<tr>
<td>Chlamydia (CA)</td>
<td>-2</td>
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</table>

*Notes:* Data for teenagers are noted with (T); data for Canada are noted with (CA).

When we investigated risky behavior more generally, it was clear that not only sexual risk-taking decreased in the 1990s, but other types of risk-taking as well. We found that 49 of 65 risk indicators exhibited declines in the 1990s: Risky behavior in the domains of violence (6 of 7 indicators declined), accidents and behaviors related to accidents (9 of 9 indicators declined), and school dropout (2 of 2 indicators declined) all showed drops in the period from 1991 to 2001, ranging from 2% to 78%. An exception to this general pattern was substance use; only 15 of 26 indicators declined. Excluding substance use, 34 of 39 indicators of risky behavior showed declines through the 1990s (a discussion of why substance use is an exception is beyond the scope of this article).

To investigate whether the decline in risky behavior over the 1990s was an isolated trend, and whether risky behavior and criminal behavior co-vary together over longer periods of time, we correlated the homicide rate for a given country with each of the indicators of risky behavior for the same country. Homicide was chosen because it is the most reliable indicator of variation in crime rates over time and place. We found that most indicators of risky behavior (with the exception of substance use indicators) were significantly associated with homicide rates not only during the period of parallel decline in the 1990s, but also for longer periods of time, some extending up to 56 years in length (determined by the longest time series of data we could obtain). Together, our results indicate that the
crime drop of the 1990s was not an isolated phenomenon, but was part of a much more general phenomenon encompassing most risky behavior in various domains.

**What Caused the Crime and Risk Drop?**

Although we set out to explain the decline in sex crimes from 1991 to 2001, it is clear that the proper target of explanation is not sex crime, or even crime in general, but risky behavior specifically. Consequently, explanations for the crime drop in the 1990s must also necessarily explain why risky behavior declined more generally during the same period. Explanations must also be able to address the remarkable generality in the decline in crime for all age groups and geographic areas studied thus far. Of the explanations listed earlier, only some are able to address the general decline in risky behavior.

Population demographic changes, such as an aging population, the legalization of abortion in the 1970s (which would lead to fewer “at-risk” individuals 20 years later), and increased incarceration, are able to explain part of the general decline in risky behavior. Most criminal offenders tend to engage in significant amounts of risk-accepting behavior. If the number of offenders in the general population decreases, then fewer risky behaviors would be observed at the population level (which combines all age groups in overall statistics). That all age groups showed a decline in criminal behavior, however, cannot be accounted for by most explanations based on population demographic changes. Also, the declines in crime and risky behavior in Canada paralleled those observed in the United States—a fact that is also incompatible with some explanations involving population demographic changes; for example, Canada did not experience an increase in number of incarcerated offenders during the crime drop (Zimring, 2006).

Most of the other explanations for the decline in crime in the 1990s are unable to explain declines in risky behavior. Public policy shifts and innovative policing strategies, such as an increased number of police officers, are unlikely to have affected risky behaviors in general. For example, it is hard to imagine how an increase in number of police officers on the streets could affect teenagers’ choices to use condoms, or to drop out of school. Socioeconomic factors that were specific to certain times and places are also unlikely candidates to explain the general drop in risky behavior in the 1990s. The receding of the crack cocaine trade, for example, likely played an important role in declining crime rates in some urban centers in the United States, but crack cocaine was never a serious problem in Canada and, thus, cannot explain much of the decline (Zimring, 2006).

Although economic explanations have characteristics that make them appealing candidate explanations for the widespread decline in risky behavior—economic conditions affect almost everyone in a population, for example—they have been largely ineffective in explaining variation in crime rates (reviewed in Levitt, 2004). Most economic explanations focus on absolute indicators (e.g., GDP per capita, unemployment rate, median income). It is possible that more relative economic indicators, such as income inequality, may provide better economic explanations for variation in risky behavior and crime. Income inequality is a very strong predictor of homicide rates and early parturition, for example (Wilson & Daly, 1997), lending some support to this notion. High income inequality may affect risky behavior by inspiring people to discount the future.

Some researchers have described crime and risky behavior as analogous outcomes of steep discounting of the future. Discounting the future refers to the tendency to prefer immediate rewards over larger, more distal rewards. It is possible that the perception of the quality or length of one’s future affects decisions to engage in risky behavior, and such decisions may in fact be “rational” in certain circumstances (e.g., Daly & Wilson, 2001; Mishra & Lalumière, 2008). If someone has nothing to lose, it may not be surprising to see that person engage in risky or criminal behavior that may result in the acquisition of resources, status, or sexual opportunities. Cues of limited local life expectancy or large income inequality may make risky behavior an attractive option to those in such nothing-to-lose
conditions, making risk-taking a “rational” choice in some circumstances. In a classic study, Wilson and Daly (1997) found that lower life expectancy was associated with significantly higher homicide rates in Chicago neighborhoods, lending support to this notion. The drop in crime may, therefore, be attributed to lesser discounting of the future or a more positive view of future prospects in the 1990s. If the future looks positive, long, and full of opportunities, risky behaviors become less attractive options (Mishra & Lalumière, 2008).

If crime and risky behavior are influenced by perceptions of the future, and less positive future prospects are associated with increased crime and risk-taking (e.g., high competition, income inequality, short life expectancy—Wilson & Daly, 1997), then the period of decline in risky behavior should have been preceded and accompanied by cues signaling better future prospects. We have collected some preliminary data suggesting that this might indeed be the case. If people are more oriented toward the future, they should be more interested in personal health and longevity. Since the early 1990s, teenagers have been living healthier lives by exercising more, and eating more fruits and vegetables (contrary to frequent media reports). The prevalence of diagnostic tests for long-term chronic diseases, such as diabetes and cancer (indicating that people are investing in their long-term future), has also increased during that time span, in spite of a drop in the incidence of many diseases. Depression rates, which likely reflect pessimism about future prospects, decreased by over 25 percent in Canada since the early 1990s (Patten, 2002).

Above, we discussed how local life expectancy has been associated with homicide rates. Local life expectancy has also been significantly associated with the timing of reproductive decisions among women. Wilson and Daly (1997) found that disproportionately high birth rates were observed among younger mothers in Chicago neighborhoods that had the lowest life expectancies (and the reverse in neighborhoods with higher life expectancies). If people have a short time horizon, it makes adaptive sense to reproduce while there still is an opportunity to do so. After all, one cannot reproduce if one is dead. Thus, if people’s time horizons were on average perceived as being longer during the period of the crime and risk drop, then reproductive decisions likely changed during the same time period.

We already demonstrated in our analyses that teen pregnancies and live births have declined substantially in both the United States and Canada since 1991 (Mishra & Lalumière, 2009). Other reproductive and parenting behaviors have also changed remarkably during the period of the crime drop. Since the early 1990s, women have waited longer to have children. Being able to delay having children is an option only available to those that believe they will have adequate resources to raise a child in the future, suggesting a perception of good future prospects. Decreases in birth rates have been observed for mothers of all ages, except for those aged 30 to 44—who have a reproductive future is short (data from the U.S. National Center for Health Statistics). Even divorce rates have decreased since the early 1990s, suggesting that people may be investing more in long-term relationships (something that would likely not be observed if people had a shorter or more negative view of their future).

Conclusions

The decline in sexual crimes has continued to this day, although less dramatically. In the United States, forcible rape declined 28% from 1991 to 2001, and 6% from 2001 to 2007. In Canada, sexual assault rates have declined 25% from 1991 to 2001, and 17% from 2001 to 2007. Indicators of risky sexual behavior have followed similar patterns, either exhibiting further declines since the 1990s, or staying stable at a historically low rate. Our demonstration of the generality of the crime and risk drop offers the opportunity to derive novel hypotheses about the causes of the decline and about explanations for variation in crime rates in general. Several indicators associated with longer time horizons and better future prospects have exhibited expected changes during the period of the crime drop suggesting that, as of the early 1990s,
people may have developed a more optimistic interest in long-term, future-oriented behaviors rather than behaviors reflecting short-term, immediate rewards focused on the present. Further research is necessary to address the causes of the decline in crime and risky behavior of all forms. The current economic crisis, although unfortunate, may offer an opportunity to test these new ideas. We suggest that a consideration of crime and risky behavior as analogous outcomes of similar causal processes can lead to the derivation of novel, testable hypotheses about the decline of crime in the early 1990s, in addition to general variation in crime rates over time.

References


Professional Issues Committee Update

Kurt M. Bumby and Robert J. McGrath, Co-chairs

Fellow ATSA members,

As noted in the President’s Message in the Winter 2009 issue of the Forum, the Professional Issues Committee is embarking on the revision of the *Practice Standards and Guidelines for the Evaluation, Treatment, and Management of Adult Male Sexual Abusers*. Your perspectives and insights are invaluable to us and, as such, we invite the membership to provide the committee with any critical substantive comments that you believe should be considered during the revision process. Please direct your remarks to Kurt Bumby, Co-Chair, at bumbyk@yahoo.com, reference the specific section and page number, if applicable, and include your contact information so that we are able to follow up with you if additional clarity is needed. We respectfully request that any comments are received no later than April 30, 2009.

Thank you,

Kurt M. Bumby, Co-Chair

Robert J. McGrath, Co-Chair
### New ATSA Members

Welcome to Our New ATSA Members

The following members were approved in February 2009.

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<thead>
<tr>
<th>Name</th>
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<th>State/Mail</th>
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<tr>
<td>Glenn W. Ahava, Ph.D.</td>
<td>Lafayette, LA</td>
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<td>Winston Hopkins, M.S.</td>
<td>Mauston, WI</td>
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<td>Portsmouth, NH</td>
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<td>Billings, MT</td>
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<td>Nottingham, England</td>
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<td>Fall River, MA</td>
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<td>Newton, PA</td>
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<td>Mansfield, OH</td>
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<td>Douglas H. Spraungel, Psy.D.</td>
<td>Minneapolis, MN</td>
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<td>Jamaica Plain, MA</td>
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<td>Brooklyn, NY</td>
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<td>Sherry Wilcox, M.S.W.</td>
<td>Concord, NH</td>
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