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<td>Presenter</td>
<td>Robert Emerick, M.Ed.  Silentinjures™  477 South Harding Drive  Sedona, Arizona 86336  <a href="mailto:robertemerick@silentinjuries.com">robertemerick@silentinjuries.com</a></td>
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**Slide Discussion Notes**

**Slide #1  Broken Silence**

Since earning his Master's degree from the University of Arizona in 1982, Mr. Emerick has developed and managed treatment programs for child sexual abuse survivors and perpetrators in the United States and Canada. His clinical/research practice yielded abuse history factors among adolescent and adult sexual abuse survivors that identify people at higher risk to sexualize their traumatic injuries. These factors, known as the Emerick Scales, are embedded in the Abel Assessment for sexual interests. In addition to his clinical/research practice, he teaches child sexual abuse professionals about the sex offender investigation, treatment, and supervision. The past ten years, he has investigated personal and professional challenges (Silent Injuries) to Child Sexual Abuse professionals and developed curriculum to help professionals reduce vulnerability to potential career related injuries.
Slide #2  Five Seminar Objectives

There are five core objectives to this seminar. The objectives are to:

1. Define exposure to social-sexual deviance as a psychological toxin.¹, ², ³, ⁴, ⁵

2. Understand the sequential injuries children incur from their exposure to social-sexual deviance.⁶, ⁷, ⁸, ³, ⁴, ⁵, ⁸, ⁹, ¹⁰, ¹¹, ¹², ¹³, ¹⁴

3. Understand the abuse process features that yield two distinctly different terror responses from children.², ³, ⁴, ⁶, ⁹

4. Understand the Emerick Scales within the Abel Assessment for sexual interests-³. ³, ⁴, ⁹, ¹⁵, ¹⁶

5. Use Traumatic Injury Profile to plan a strategic Trauma Focused Cognitive-Behavioral Intervention.¹⁷, ¹⁸, ¹⁹, ²⁰

Slide #3  Psychological Toxin

Childhood exposure to social-sexual deviance is not a new social problem. Freud’s efforts to educate Victorian society yielded criticism and ultimately recantation.²¹ Ironically, his disclosure and later recantation now serves as a template for the typical child response to sexual maltreatment.², ²²

Silence is the strategy most children employ to manage their exposure to social-sexual deviance.², ⁷ Whether the decision is motivated by fearing the abuser, distrusting the non-offending adult will respond in a helpful manner, or believing the situation is without remedy, silently harboring the maltreatment is a psychological toxin.¹ As a toxin, it not only disrupts healthy social-sexual adjustment, but over time, it methodically ushers illness to shorten life expectancy.⁸, ¹⁰, ¹¹

Slide #4  Pathways to PTSD

PTSD and sexualized behavior occur more frequently among children exposed to social-sexual deviance than in other clinical groups.², ⁹, ¹²

Childhood exposure to social-sexual deviance, such as physical or sexual maltreatment are among the diverse initial traumas that can cause disruptions to adjustment that culminate in a characteristic symptom cluster known as PTSD.⁹, ⁵, ¹², ¹⁴ For many children, exposure to social-sexual deviance includes multiple maltreatment forms.⁸
Coping responses at the time a person is exposed to social-sexual deviance can aggravate core trauma. Dissociation at the time exposure takes place is a strong predictor of PTSD. Following exposure to social-sexual deviance, the existing data suggests clearly acknowledging the social-sexual deviant knowingly committed a violent act is linked to significantly more PTSD features.

Some researchers conceptualize PTSD as a disorder of ‘failed recovery’. Avoidance is described as the glue that binds PTSD features and carves away at psychological, emotional and physical health. Conversely, the evidence for Trauma-Focused Cognitive Behavioral Therapy as a means to dilute traumatic-stress reaction is compelling.

Slide #5  Sexual Trauma Inventory – Broad Content Areas

The 300 item true-false Sexual Trauma Inventory is a pre-treatment assessment tool designed to clarify health challenges among people exposed to social-sexual deviance as children. It clarifies disruptions to social-sexual adjustment. It is not designed to validate sexual abuse allegations.

Child sexual abuse is a complex process comprising four distinct phases: engagement, grooming, assault and concealment. As a process, each phase sequentially and cumulatively contributes to a child’s abuse interpretation, coping responses during and after the assaults, and subsequent disruptions to healthy adjustment. The inventory comprises five broad categories: 1) knowledge about human sexuality, the child molester, and victimology, 2) exposure to social-sexual deviance, 3) factors that can aggravate core disruptions to healthy development, 4) vulnerability to sensory stimulated intrusive memory, and 5) cognitive, social, and sexual injuries linked to child sexual abuse. The preliminary observations showed exposure to social-sexual deviance is quantifiable, and a significant relationship between subsequent disruptions to healthy adjustment and the molester's sophistication.

Silence is the typical way people manage their childhood exposure to social-sexual deviance. The conclusion that silence is the safest path after exposure creates a psychological toxin that can cause injuries throughout the life experience. When a child does disclose, his/her description is often more reliable than the molester's admission. A study that compared child disclosure, molester self-report, and molester self-report during polygraph testing showed both understated three critical
considerations. The duration and frequency of assaults, the degree of force used to assure compliance and the range of behavior. Nonetheless, child reporting is more reliable than the offender’s self-report.

A desire to use a child’s body sexually is the motivating force to child molestation. Non-consent is the unifying thread to the sexually deviant spectrum the APA calls paraphilias. Among CSA professionals, less than 2% attribute child molesting to something other than a child sexual interest.

It is noteworthy to point out that professionals who choose silence as their coping response to manage disruptions to adjustment after social-sexual deviance exposure are at a greater risk to experience Burnout. Among CSA professionals, Burnout is the equivalence to the Child Abuse Accommodation Syndrome.

Slide #6 Clinical Population

The population comprises people reporting the onset of their maltreatment took place at age thirteen or younger. In addition, the molester was at least sixteen years old, and one's senior by five or more years.

Silentinjuries™ Trauma assessments (N = 525) generated the database of people reporting childhood exposure to social-sexual deviance. The overall assessment population comprised three age groupings:

1. Child, ages 7 up to 12 (n = 60)
2. Adolescent, ages 12 up to 18 (n = 312)
3. Adult, ages 18 thru 71 (n = 153)

Though the overall gender distribution is nearly equal (male = 261 and female = 264), significant group gender differences occur within the age groupings. Most adolescent participants were male (62.8%), and most adult participants were female (78.4%). The females range in age from 7 to 59 (m = 23.98; s.d. = 12.71). The males range in age from 9 to 71 (m = 17.03; s.d. = 9.97). Comparatively, the average age of females is significantly greater than the males’ average age.

Like earlier population studies, almost three-fourths (73%) identified a family member as a molester. Females reported a higher family member incidence rate than males. More than one-fourth (29%) identified at least one molester as a family friend. Again, females reported a higher
incidence rate. Males reported a significantly higher stranger maltreatment rate (26%) than the females (15%).

Males (79%) and females (88%) indicated male molesters accounted for more sexual maltreatment than female molesters. The proportion reporting childhood exposure to a female molester (16.5%) is comparable to other study groups. 32, 30

Like other clinical samples, the largest proportion of people (45.5%) reported their first exposure to social-sexual deviance took place prior to the fifth birthday. 2, 9 A greater proportion of females (57%) than males (35%) are among the early childhood exposure group. This observation is consistent with female children being at a greater risk to experience maltreatment from a family member, friend or acquaintance. 9, 31

Unrelated to gender, most of the people (78%) reported their behavioral health history includes counseling services. The services targeted problematic social behavior (62%), mood disturbance (58%), sexually groping a younger child (37%), trauma (25%), and substance abuse (21%). Consistent with earlier observations, males dominated the sexual misconduct and substance abuse challenges, and females dominated the mood disturbance. 9, 32, 33.

Slide #7 Sexual Trauma Inventory – Composition

Most people (61%) report completing the STI prompted disclosing new abuse related material. This observation is independent of age, gender and behavioral health care history: inclusive of trauma therapy.

One’s baseline knowledge about human sexuality and trauma are critical pre-treatment measures. The need to assess the quality of one’s information is particularly true for people exposed to social-sexual deviance prior to age five. Such early life exposure means that a social-sexual deviant was likely a primary information source. In turn, accurate information can cause cognitive dissonance and resistance. 34 A psycho-educational treatment segment may provide a safer venue to enable one to receive and internalize accurate information. 35, 19

An inverse relationship exists between one’s cognitive injuries and possessing accurate interpersonal violence information. People identifying their maltreatment as a violent act experience more PTSD features than people who harbor self-targeted attributions. 15 Unsurprising, among CSA professionals, a similar relationship exists. 29 As the challenges linked to sex education, reliable information about social-
sexual deviance and subsequent trauma may trigger cognitive dissonance. An educational intervention may ease acknowledging and confronting this injury source.

The Abuse Process scales measure one’s childhood exposure to social-sexual deviance. Exposure to social-sexual deviance forms a normative bell shaped curve. The scales reflect a fixed variable that can contaminate healthy childhood development and act as a lifetime carcinogen. People who report their exposure occurred after the ninth birthday report an abuse process that is significantly less complex than people exposed to social-sexual deviance prior to their ninth birthday. The abuse process is unrelated to the molester’s gender.

**Slide #8**  
**Sexual Trauma Inventory – Engagement (Social Deviance)**

Though sexual deviance motivates the engagement phase, social deviance is what the molester uses to fulfill the engagement phase objectives. Two objectives motivate the molester’s behavior:

1. Conceal child sexual interest;
2. Create opportunity to sexually use a child’s body.

The 8-item Engagement subscale examines a person’s exposure to a social-sexual deviant’s strategies to infiltrate emotional and psychological boundaries. The scale’s contents are the six most common strategies molesters acknowledge and subsequent social impressions. There are five prongs to the engagement phase. Conceptually, this scale measures exposure to social deviance.

As an injury source, the three aggravating factors most strongly linked to complex engagement behavior are in descending order:

1. Reporting terror as a subjective abuse process experience.
2. Pleasing genital sensation(s).
3. The diversity of coping responses to manage maltreatment.

The injuries linked to the engagement phase are typically the oldest and most resistive to healing. Some disruptions to healthy adjustment lay dormant until energized by the onset of puberty. From a sociological perspective, the engagement phase introduces ‘trauma bonding’ as a normative relationship attachment. From a sequential perspective, the engagement phase forms the bedrock to traumatic injury, maladaptive coping responses (e.g., risky behavior) and life-threatening adult diseases.
Intrusive Thoughts is the PTSD feature most strongly related to complex engagement behavior.

**Slide #9**  
**Sexual Trauma Inventory – Grooming (Social-Sexual Deviance)**

For the molester, the grooming phase achieves three primary objectives:

1. Measuring the child’s likelihood to disclose the assaults.
2. Euphemistically labeling deviance to normalize his intentions.
3. Desensitizing the child to physical contact.

The 9-item Grooming subscale examines a person’s exposure to a social-sexual deviant’s strategies to infiltrate physical boundaries. The scale’s contents include behavior that appears to be socially acceptable and behavior that is more clearly recognized as deviant. The grooming scale is the second *social deviance* measure.

Among people completing the Silentinjuries™ Trauma Assessment, wrestling and tickling are the most commonly reported grooming behavior (70%). The other common grooming behaviors they reported are lap sitting (45%), privacy violations while changing clothes (34%), napping together (33%) and bathing together (26%).

Some molesters use pornography to introduce a child to nudity and sexual behavior. Among the youth reporting their developmental history included exposure to only one molester, family members (22%) used pornography less frequently than family friends (27%). Also, pornography is more often used to groom male children than it is used to groom female children.

As an injury source, the three aggravating factors most strongly linked to complex grooming behavior are in descending order:

1. Reporting Terror-1 as a subjective experience linked to the abuse process
2. The diversity of coping responses to manage maltreatment.
3. Silently harboring child maltreatment experiences.

The PTSD features most strongly related to complex grooming behavior are Intrusive Thoughts and Hypervigilence.

**Slide #10**  
**Sexual Trauma Inventory – Assault (Sexual Deviance)**

The assault reflects the molester's child sexual interests.² 6 28 For some molesters, children are an exclusive interest. For others, children are an
episodic interest. For all social-sexual deviants, non-consent is the unifying theme that connects seemingly unrelated sexual behaviors.\textsuperscript{36}

The 8-item Assault subscale examines a person’s exposure to a social-sexual deviant’s overt non-consensual sexual behaviors. Subsequently, the scale is tracking direct exposure to sexual deviance. The assault behaviors range from nude photography to using the person's hand, mouth, anus or genitals. Traditionally, assault behavior is viewed as the most injurious abuse process phase.\textsuperscript{9, 31}

Among people completing the Silentinjuries™ Trauma Assessment, genital groping is the most common assault behavior. The other behaviors are using the child's mouth (52%), using the child's vagina/rectum (51%), and rubbing exposed genitals against the child's exposed genitals (48%).

As an injury source, the three aggravating factors most strongly linked to complex assault behavior are in descending order:

1. The diversity of coping responses to manage maltreatment.
2. Reporting terror as a subjective abuse process experience.
3. Pleasing genital sensation(s).

Considering disruptions to healthy adjustment, people who report exposure to complex assault behavior also indicate terrifying sensory stimuli more frequently disrupts their daily lives. Intrusive abuse memories are more frequently cued by all four sensory systems (e.g., vision, olfactory, tactile and auditory). Compounding one’s reactivity challenges are distorted judgments about the self, other people, and human sexuality.

Intrusive thoughts and hypervigilence are the two PTSD features most strongly linked to complex assault behavior.

As noted throughout the literature, many factors interact in a synergistic way with the assault phase.\textsuperscript{9, 31, 15} The factors include age at onset of the abuse, relationship with the offender and degree of violence used to control the child.

**Slide #11**  
**Sexual Trauma Inventory – Concealment (Social Deviance)**  
The 7-item Concealment subscale is constructed to identify the social-sexual deviant’s strategies to discourage disclosing the abuse.\textsuperscript{2, 6, 36, 24} The concealment subscale is the third social deviance measure.
Like the previous social deviance subscales, this abuse process scale contributes individually to traumatic injuries. As an injury source, the three aggravating factors most strongly linked to complex concealment behavior are in descending order:

1. Reporting Terror-2 as a subjective experience linked to the abuse process
2. Trauma Bond or social challenges subsequent to acknowledging and confronting exposure to a social-sexual deviant.
3. Silently harboring child maltreatment experiences.

Hypervigilence and terrifying intrusive thoughts are the two PTSD features most strongly linked to complex concealment behavior.

Overall, childhood exposure to social-sexual deviance results in measurable disruptions to healthy adjustment. These disruptions occur in the cognitive, emotional, social and sexual domains. Each abuse process phase can cause injury in and by itself or cumulatively. Subsequently, the injury process parallels the geological concept known as sequential horizontal deposits. 38

Slide #12  Sexual Trauma Inventory – Trauma Potentiator

“Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.” 39 Applying this violence definition to childhood exposure to social-sexual deviance yields the undeniable conclusion that all child sexual abuse incidents are violent acts.

The Child Molester Knowledge scale queries one’s information about child molesters. Recognizing child molestation is a sexually motivated act that is systematically committed is an inconvenient truth. In fact, clearly recognizing a molester as a social-sexual deviant can evoke more PTSD features than accommodating the maltreatment and using attributions to avoid painful truths. 21, 2, 3, 15 Among CSA professionals, PTSD features are greatest among men and women who recognize sexual deviance motivates child-molesting behavior and concealment is accomplished using social deviance.” 29
Slide #13  **Sexual Trauma Inventory – PTSD Scales**

*Posttraumatic Stress Disorder* is the development of characteristic symptoms following exposure to an extreme traumatic stressor. For children, sexually traumatic events may include developmentally inappropriate exposure to sexual behavior without overt threats or explicit violence (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (Criterion A2). The second diagnostic feature: Intrusive Thoughts; attends to the vast number of ways the traumatic event can intrude in one’s daily life. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness is the third symptom feature. Persistent symptoms of anxiety or increased arousal define the fourth feature.

Slide #14  **PTSD Observation Rate**

Considering clinical samples of sexually abused children, most studies report PTSD incidence rates of 40% to 50%. Limiting the STI population to people less than 18 years-old and whose STI validity scale score is non-defensive (n = 284), the observed incidence is 45%. The observed incidence rate is 36.6% among all youth regardless of validity scale profile.

Overall, most people (88%) indicate their childhood exposure to social-sexual deviance yielded terror as a subjective experience. Acknowledging terror as a subjective experience is linked to response validity and gender. Males acknowledge terror at a greater rate than females. A linear relationship is noted between response validity and acknowledging terror. Recall, terror is the subjective experience requirement to fulfill PTSD diagnostic criteria, and there are two Terror Types. Though both Terror Types introduce challenges to a developing child, it appears that Terror 2 causes greater disruption to development than Terror 1.

A slightly smaller proportion of people (82%) indicate Intrusive Abuse Memories are disruptive to fulfilling their daily living responsibilities. The degree to which Intrusive Thoughts disrupt a youth’s daily life is unrelated to gender. Of the youth reporting their exposure to social-sexual deviance evoked terror, 84% report Intrusive Abuse Memories poses a daily social and sexual health challenge. Among the youth reporting their childhood exposure to social-sexual deviance did not evoke terror, a significantly
smaller proportion 62% report Intrusive Abuse Memories pose a daily social and sexual health challenge.

Avoidance is a difficult feature to measure. It is a feature that one is unlikely to acknowledge when it is a pervasive trait. Despite the challenge, nearly half the people (48%) acknowledged three or more Avoidant features. Among the people reporting the abuse process evoked terror and Intrusive Abuse Memories are a daily challenge, more than half (55%) acknowledges three or more avoidant features.

Of the youth acknowledging health challenges that fulfill diagnostic Criteria A, Criteria B, and Criteria C, a majority (86%) acknowledged Criterion D features. The diagnostic criterions filled as follows: asymptomatic 3%; one diagnostic criterion 13%; two diagnostic criteria 18%; three diagnostic criteria 32%; and four criteria 34%. Gender did not significantly influence the number of PTSD diagnostic criterions fulfilled.

Slide #15  AASI Item Selection

Two clinical samples combined to form the total population (N = 150) of males for selecting the Emerick Scale items. First, all the males in the Sexual Trauma Inventory Preliminary findings sample (n = 46). Second, males referred to Robert Emerick for either a post-conviction psychosexual risk assessment or treatment (n = 104).

The preliminary findings cut-off scores placed each participant in one of three traumatic injury groupings: mild, moderate or severe. An item discrimination index of .70 set the parameter to identify items that distinguished between mildly and severely injured people. Ultimately, 29 items fulfilled this criterion. Essentially, the Emerick Scale is a critical item listing.

Slide #16  STI Items Fulfilling Selection Criteria

The Emerick Scale items coalesce to form a very strong scale. The age at onset to exposure items are consistent with previous studies that show a strong relationship between younger age at abuse onset and severity of disruption to healthy adjustment.

As noted by Pitchman, et. al., (1992), examining the impact of the child-offender relationship may be better accomplished by looking beyond familial ties. The offender relationship item that best captures exposure to social deviance is having idolized the molester at one point. Coupled with threats to assure silence and at other times extending compliments, the
abuse features many children experience is the ‘trauma bond’ prototype.\(^4\) It requires little imagination to understand the mechanisms at work that draw large proportions of people exposed to social-sexual deviance as children towards a deviant peer.\(^9,40,41\)

Problematic behavior linked to an elevated Emerick Scale score among males and females between thirteen and eighteen years old includes the following: physical aggression toward younger family members; negative peer group; sexual relations with partners 5 or more years old; using molestation memories as a masturbatory stimulus; therapeutic abortion; and attempted suicide.

A strong positive relationship exists between the Emerick Scale items and PTSD features.

**Slide #17**  
**Process of Abuse: Sequential Injuries**

**Slide #18**  
**Acknowledge & Confront Human Erosion Force**

After the silence is broken, restoring health is best achieved using trauma focused cognitive behavioral therapy.\(^17\) Completing the Sexual Trauma Inventory is an effective means to begin openly acknowledging and confronting childhood exposure to social-sexual deviance. The resulting injury profile reliably identifies people at greater risk to sexualize their injuries or habituate a chronic form of PTSD.

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