Adolescent Sex Offenders: Identification and Intervention Strategies

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Abstract:

Adolescent sex offenders increasingly are involved in the mental health delivery system. Because researchers have concluded that between 34 and 60 percent of all sexual offenses are perpetrated by adolescents, it is imperative that mental health counselors possess the knowledge and skills to appropriately identify and treat these adolescents. The authors provide information on current assessment and intervention considerations in working with this population.

Article:

A plethora of literature has examined the occurrence of child and adolescent sexual abuse and the need for sexual abuse prevention efforts (Barth & Derezotes, 1990; Camp & Thyer, 1993; Krivacska, 1990; Lakey, 1994; Worling, 1995). Historically, mental health counselors have been well trained in reporting responsibilities and treatment needs of children, adolescents, and adults who have been sexually victimized (Krivacska, 1990). Over the past decade, however, the phenomenon of adolescents and children being the perpetrators of such activity has become increasingly recognized (Cashwell, Bloss, & McFarland, 1995; Friedrich, 1990; Gil & Johnson, 1993; Straus, 1994).

Prevalence Rate

Tens of thousands of adolescents may meet the criteria for sex offenders, although estimates vary widely depending on the source of the data and research methods (Straus, 1994). Data from the Federal Bureau of Investigation (1987) suggested that adolescents under the age of 18 account for 15 percent of the arrests for forcible rape and 16 percent of the arrests for other sexual offenses. The arrest rates for rape among 13 and 14 year olds doubled between 1976 and 1986, from 20 to 40 arrests per 100,000. For this same age group, the arrest rates for less serious sexual offenses (e.g., exhibitionism and fondling) increased by 80 percent during this same time period. Similarly, adolescents are responsible for an estimated 50% of child sexual abuse cases, and this estimate may be conservative because of a reluctance to report adolescent offenders (Kempton & Forehand, 1992). Current estimates suggest that more than 70,000 boys and 110,000 girls are victims of adolescent perpetrators each year (Ryan, 1991). French (1988) reported that 70% of adolescent perpetrators receive no services or incarceration for their offenses. This statistic is startling in light of findings that, without treatment or incarceration, a sex offender perpetrates an average of 581 acts against an average of 380 victims over the course of the perpetrator's lifetime (Abel, Mittelman, & Becker, 1985; Becker & Abel, 1985).

Etiology

There are numerous theoretical explanations for adolescent sex offenses. While none of these theories fully explain the onset of offending behavior, taken together the theories provide a strong foundation for understanding the perpetrator. The majority of these theories are based on the assumption that offending behaviors by children and adolescents are a reaction to their own physical or sexual abuse. While there is empirical evidence that some adult sex offenders share a history of childhood sexual abuse, empirical estimates

range from 10 to 80 percent (Gil, 1993). Worling (1995) found that 75% of offenders who had assaulted at least one male child reported being sexually abused compared to 25% of offenders who did not assault a male child. Similarly, estimates vary as to the incidence of childhood physical abuse among perpetrators. However, it is clear that not all victims of childhood sexual abuse or physical abuse become offenders later in life.

While a comprehensive review of etiological theories of deviant adolescent sexual behavior is beyond the scope of this article, readers are referred to Gil (1993) who provides a strong overview of these theories. Finkelhor and Browne (1985) conceptualized four domains in which childhood sexual abuse can have long-term consequences: traumatic sexualization, stigmatization, betrayal, and helplessness. Based largely on learning theory, Finkelhor and Browne's framework suggests that children who are sexually abused learn that sexual behavior is necessary to meet their needs and often confuse the sex act with intimacy (i.e., caregiving and caregetting). However, Garland and Dougher (1990) argued that such a hypothesis is overly simplistic and misleading and called for continued research in this area.

Similarly, various authors have discussed the behavioral reenactments of children who have been traumatized (Friedrich, 1990; Sgroi, Bunk, & Wabrek, 1988; Terr, 1990; Van der Kolk, 1989). Terr (1990) suggested that when children reenact a traumatic event, the reenactments tend to be literal and repetitive. Various authors (Breer, 1987; Friedrich, 1990; Stevenson, Castillo, & Sefarbi, 1990; Van der Kolk, 1989) have argued that these behavioral reenactments of the traumatic event are often unconscious. Breer (1987) argued that victims identify with the aggressor and reenact the traumatic event as the perpetrator to reduce the anxiety and the feelings of helplessness associated with the victimization experience (Stevenson et al, 1990; Stuart & Greer, 1984).

Yates (1987) focused on the familial environment of children who have been sexually abused, emphasizing such characteristics as separation anxiety, physical abuse, and rejection. Yates (1982; 1987) argued that these children become dependent on sexual relationships to maintain their integrity and self-esteem, essentially centralizing and emphasizing their sexual selves.

Although these etiological theories attempt to explain adolescent sexual offenses, continued research is needed to more fully explain this phenomenon. More clear, however, is that there are a number of barriers to effective service delivery to adolescent sex offenders by counselors.

Barriers to Effective Services

Barriers to effective services are rooted in counselors' inability to deal appropriately with the issue of adolescent sexual perpetration. According to Friedrich (1990), there are several such barriers. First, recognizing and accepting children as sexual beings is often disconcerting to counselors. This barrier may be eliminated by educating counselors about the sexual development of children (Friedrich, 1990) and developmentally appropriate sexual behavior (Gil & Johnson, 1993).

A second barrier is that parents of the perpetrator may react to their child in ways that interfere with the treatment process. Parents may feel responsible for their child's behavior and experience feelings of guilt and shame. These feelings may lead parents to undermine intervention attempts. In such cases, family counseling or counseling for the parents may increase the effectiveness of treatment for the offender (Friedrich, 1990). Finally, there traditionally has been much disparity between the treatment of offenders and victims. Typically, treatment for victims focuses on the counselor-client relationship and is supportive. Conversely, treatment for offenders has focused less on the therapeutic relationship and more on confrontation. This presents a unique challenge to mental health counselors to integrate these two loci of treatment given that many, if not most, offenders have been victimized themselves. However, these two approaches (supportive and confrontational) share the common focus of establishing clear responsibility and positive control. For those offenders who have also been abused in some way, mental health counselors must strive for an appropriate balance between support and confrontation (Friedrich, 1990).

IDENTIFICATION OF PROBLEM SEXUAL BEHAVIOR

Often, adolescent offenders are evasive, manipulative, secretive and have problems in the area of sexuality. Consequently, they are among the most difficult clients to assess (Breer, 1987). However, in order to properly identify and treat sexual offenders, it is essential to determine whether the sexual behaviors for which they were referred are age-appropriate or whether they are problematic and require intervention (Gil & Johnson, 1993).

Assessing Problem Sexual Behavior

Johnson and Feldmeth (1993) categorized sexual behaviors into four groups based on the appropriateness of the sexual behaviors. Children in Group I engage in childhood exploration which is considered normal because their interest in sexual behaviors is consistent with their curiosity about other parts of life. When the child is told to discontinue these behaviors, the behaviors gradually decrease or stop. Many children in Group II have been sexually abused or overexposed to sexual stimulation and therefore struggle to meaningfully integrate their experiences. Their sexual behaviors are often indicative of confusion, anger, shame or anxiety. The sexual behaviors of the children in Group II are often easy to stop with consistent, nonjudgmental, and proactive counseling because the behaviors do not represent a long pattern of secretive and manipulative behavior. Children in Group III also are often victims of sexual abuse. They exhibit more focused and extensive patterns and usually engage in age-inappropriate and typical adult sexual behaviors. Group III children hold a matter-of-fact attitude toward their sexual behavior with other children. Finally, children in Group IV often associate sexually aggressive behaviors with feelings of anger, loneliness, or fear. They exhibit coercive and pervasive sexual behaviors which extend beyond the realm of developmentally appropriate childhood exploration or sex play. Also, these behaviors tend to escalate in intensity and frequency.

There are a number of factors that can be assessed to more fully assess the appropriateness of sexual behavior. First, it is important to assess knowledge about healthy adolescent sexuality and sexual abuse for both the perpetrator and the family. Second, the openness of family communication in general, and more specifically regarding sexuality issues, also should be assessed. Third, family factors such as cohesiveness and emotional expressiveness are important factors and should be assessed. Fourth, it is important to assess the impulse control of the perpetrator to make decisions about the treatment process and setting (i.e., whether safety needs of the community are jeopardized by outpatient treatment). Fifth, assessing the social skills of the perpetrator may provide important information about treatment needs. Finally, the presence of non-sexual antisocial behavior, substance abuse, or other psychological disorders should be assessed. Through such a comprehensive assessment, the counselor becomes more able to understand the offender and treatment needs.

A Working Typology of Adolescent Sex Offenders

Persons who are untrained in working with adolescent sex offenders tend to (a) ignore serious behavior problems as normal sexual experimentation, (b) lump all adolescent offenders together and treat all the same, or (c) use an adult offender classification system. It is important to recognize adolescent sex offenders as a population separate from adult offenders and recognize the heterogeneity of adolescent offenders. O'Brien and Bera (1986) provided a working classification of adolescent sex offenders that includes seven types of offenders. While classification is often less clear-cut in practice (i.e., many offenders may fit more than one category), the typology provides direction for assessment and intervention with offenders.

The first type of offender, the naive experimenter, is typically between the age of 11 and 14 and has had little history of acting-out behavior. The naive experimenter is sexually inexperienced and engages in a limited number of sexually exploratory acts with a younger child. There is no force or threat in the sexual activity. Naive experimenters may be treated within the community on an out-patient basis. Treatment typically ends at the end of a short-term, intensive treatment and education program. The major goals of treatment with the naive experimenter are to provide a concrete education in healthy adolescent sexuality and sexual abuse for both the perpetrator and the family, and to develop more open family communication on sexuality issues to reduce the likelihood of inappropriate sexual exploration in the future.

The second type of offender, the undersocialized child exploiter, is characterized by chronic social isolation and lack of social skills. The sexual offenses are likely to be chronic and include manipulation, rewards, or other enticements. The undersocialized child exploiter is motivated to offend by a need for greater self-importance and intimacy. Undersocialized child exploiters are typically family-centered rather than peer-centered and role reversals within the family are not uncommon. Thus, it is typical for counseling with this type of offender to include interventions with any family members who are abnormally dependent. For treatment to be effective, the family may need to change their structure and style of communication. Also, it may be important to teach communication skills to the offender, who typically has inadequate or poor peer social skills. In situations in which community safety concerns have been met, treatment may occur within the community. When safety concerns have not been met (e.g., sibling incest where the victim remains at risk), residential treatment may be required.

The third type of offender, the pseudo-socialized child exploiter, demonstrates good social skills, has little history of problem behavior, and is apt to present as self-confident. Relative to other types of offenders, the pseudo-socialized exploiter is likely to have been a victim of ongoing years of abuse. The motivation for the offense is a desire for sexual pleasure through exploitation, and the offender often rationalizes the offense with little guilt or remorse. The goal of treatment includes breaking through the mask of social grace put on for the family and society. Compared to other types of offenders, the pseudosocialized exploiter often lacks real motivation for change because of a history of effectively compartmentalizing behaviors and rationalizing offenses. There seems to be a strong possibility that pseudo-socialized offenders will be lifelong offenders. While this type of offender may be seen within the community, noncompliance often dictates referral to a residential treatment program.

The fourth type, the sexually aggressive offender, often comes from an abusive and chaotic family. This type of offender is more likely than any other type to have a history of antisocial behavior, poor impulse control, and substance abuse. The sexual offenses involve force and are motivated by a desire to experience power by domination, to express anger, and to humiliate the victims. Often, treatment includes the family's tendency to undermine the counseling goals of the adolescent. Typically, treatment is provided within a residential treatment program, is of a longer-term than for other types of offenders, and includes intensive individual, peer group, and when possible, family counseling.

The fifth type of offender, the sexual compulsive offender, is often in an emotionally repressive and rigidly enmeshed family. The sexual offenses are highly repetitive and compulsive in nature. Offenses are more likely to be "hands-off" (i.e., voyeurism or exhibitionism) than is true for other types of offenders. Often, the motivation for this type of offender is the alleviation of anxiety. Counseling issues are similar to working with other compulsive or addictive behaviors and include specification of the cognitive-emotional-behavioral sequence that leads to the offending behavior and developing interventions in that sequence that can be practiced in individual, group, and family counseling. The compulsive offender may be treated within the community unless the sexual behavior is so compulsive that the client cannot remain nonabusive in an outpatient setting.

The sixth type of offender, the disturbed impulsive offender, likely has a history of various psychological disorders, severe family dysfunction, substance abuse and significant learning problems. The offenses are most often impulsive and reflect a disturbance of reality testing. Typically, treatment includes psychological testing and compilation of a complete family history. The typical referral is to an inpatient psychiatric unity or a residential treatment program. Outpatient treatment is not appropriate unless distortions in reality are controlled through medication or, in the case of substance abuse, through abstinence while in treatment.

The seventh type of offender, the group-influenced offender, is likely to be a younger adolescent with little or no previous delinquent history who engages in the sexual offense while in the company of a peer group. The motivation for the offending behavior is likely to be peer pressure and the desire for approval. Mental health counselors should separate the offenders if they are referred at the same time, and compare and contrast the

stories with the victim's report to develop a clear picture of what really happened. This assessment approach aids in confronting each offender about inconsistencies, rationalizations, projections, and blame with the goal being for each offender to take responsibility for the abuse and impact on the victim. Typically, interventions with group-influenced offenders may occur in an outpatient treatment program. It is important to consider, however, that there may be one person in the group who initiated the group behavior and, consequently, may best fit another typology (e.g., sexual aggressive). In such a case, referring this youth to a residential treatment program would be appropriate.

COUNSELING INTERVENTION

Individual counseling alone often is considered to be less effective with the adolescent offender population than group or family counseling. However, mental health counselors may find that individual counseling is an important supplement to group and family counseling (Breer, 1987).

Individual Interventions

In individual counseling with adolescent sex offenders, mental health counselors must address a range of problems to provide holistic treatment. First, the offender's denial must be reduced and acceptance of responsibility for the offense must be increased (Davis & Leitenberg, 1987; Kahn & Lafond, 1988). Ryan, Lane, Davis, and Isaac (1987) asserted that the offender's denial must be confronted and the offense admitted before treatment can proceed. These authors suggested that the level of confrontation must bring the offender to a level of personal discomfort sufficient to stimulate disclosure and facilitate change.

Second, the offender's understanding of the impact of the assault on the victim must be increased (Davis & Leitenberg, 1987). According to Burgess, Hartman, McCormack, and Grant (1988), the offender needs to reexperience the pain associated with personal victimization in order to develop empathy for other victims. Specific victim empathy sessions can be used to sensitize the offender to the impact of offending behaviors and reduce the objectification of people. These sessions can include reading victim impact statements, confrontations with the victim, and viewing movies about victims (Ryan et al., 1987). The development of empathy decreases the likelihood of further sexual offenses (Friedrich, 1990).

Third, the offender needs to develop insight into specific motives and events that precipitated the offense (Davis & Leitenberg, 1987). The goal is for the offender to become aware of the triggers which begin the cycle toward offending and immediately engage in new thinking and behaviors in order to interrupt this cycle and prevent further sexual offenses (Ryan et al., 1987).

Fourth, counseling should focus on the offender's own victimization experiences (Davis & Leitenberg, 1987) and how this impacts the offender's current lifestyle (Kahn & Lafond, 1988). This includes dealing with any damage that may have occurred to the offenders sexuality or perceptions of sex (Krivacska, 1990). The offender's childhood victimization should be detailed in order to establish baselines for thoughts, feelings, and behaviors (Burgess et al., 1988). Issues of shame, unworthiness, and powerlessness also must be addressed in this context (Barker, 1990).

Fifth, education about human sexuality, sexual values, and sex roles should be provided (Becker, Kaplan, & Kavoussi, 1988; Davis & Leitenberg, 1987; Ryan et al., 1987). Treatment for offenders should emphasize taking responsibility for sexually assaultive behavior and learning socially appropriate behaviors to replace sexually deviant behaviors.

Sixth, deviant arousal patterns must be changed (Kahn & Lafond, 1988). Various techniques such as masturbatory-reconditioning procedures and averse-conditioning procedures can be used for eliminating deviant arousal patterns and fantasies (Davis & Leitenberg, 1987). Fantasies should be elicited and interpreted with the purpose of neutralizing their motivational potential for sexually acting out (Burgess et al., 1988).

Finally, cognitive restructuring should be a component in the individual counseling treatment plan (Becker et al., 1988). Cognitive restructuring should focus on destructive beliefs and myths regarding sexual abuse of children and rape (Davis & Leitenberg, 1987). Cognitive restructuring is used to confront distortions which enable and support deviant fantasies and behaviors (Ryan et al., 1987).

Group Intervention

Group interventions are useful in developing interpersonal skills and affective expression, teaching sex education, and exploring sex-role issues (Rencken, 1989). Additionally, group counseling offers the adolescent support and provides immediate relief from the anxiety caused by feeling isolated (Breer, 1987). Nicholaichik (1991) reported that peer support within an adolescent sex offender treatment group is an important therapeutic factor because it instills confidence and encourages disclosure.

In addition to providing support and an opportunity to learn and practice different social skills, group counseling provides a powerful form of confrontation from peers (Breer, 1987; Scavo & Buchanan, 1989). This type of confrontation is useful because members of an offenders' group often make dishonest comments in order to appear cooperative (Margolin, 1983). Often, group members confront each other about these dishonest statements. Thus, the group process stimulates the involvement of members, allowing them to practice the skills involved in understanding another person.

According to Lombardo and DiGiorgio-Miller (1988), group techniques that are specifically related to the offending behavior are among the most powerful. These authors suggested six techniques to be used in group counseling with adolescent sex offenders, including (a) talking about the offenses in detail as reviewing the story several times can interrupt the fantasy/gratification cycle; (b) having the client outline the steps which led to the offense and looking for recurrent cues in patterns of offending behavior; (c) focusing on feelings before, during, and after the offense to offer incentive to gain control over behaviors previously thought to be uncontrollable; (d) dramatization through role-play allowing the members to act out and focus on important dynamics and emotions involved in the offending behavior; (e) guided imagery, imagining and altering scenes of offenses toward more appropriate scenes, and experiencing feelings more vividly; and (f) Illusion Theater cards providing visual representations of various physical interactions which stimulate discussion and educate about appropriate interactions.

Family Intervention

A working knowledge of common family dynamics among adolescent sex offenders is useful. One of the major challenges of effective service delivery with this population is to break through the denial of both the perpetrator and family members. Straus (1994) delineated eight family issues that should be assessed and addressed during the treatment process.

Age appropriate involvement. Families of adolescent sex offenders often lack age-appropriate involvement with their children. Physical, emotional, psychological, or sexual boundaries may be blurred or nonexistent. Treatment efforts may need to help families develop more appropriate boundaries for their parent-child interactions.

Isolation. Families of adolescent sex offenders may perceive the outside world as so hostile that they close the family unit off from others. This may lead to family secrecy, lack of community support systems, and a loss of reality checks. These families often have multiple family secrets and the adolescent's sex offenses may be only the most recent cause of shame and embarrassment. Family secrets often are pervasive and span many generations. One challenge in working with these families is that family members see the danger of the family secret is in the telling rather than the keeping, a mindset that must be confronted and challenged.

Family stress. Families of adolescent offenders often suffer from extreme external and internal stress and typically have many different types of problems (e.g., financial and legal difficulties, extended family conflict) that must be addressed. These stressors deplete the family's resources and coping mechanisms.

Intergenerational abuse. A fourth issue is the presence of intergenerational sexual and/or physical abuse. It is not uncommon for the offender to have been abused by older family members and for the parents to have been victimized as well. This issue may contribute to the denial frequently exhibited by families.

Communication. Families of adolescent sex offenders suffer frequently from impaired communication styles. Family communication tends to be indirect and obscure. Family members (including the offender) often have trouble experiencing and expressing emotions and communicating directly.

Family structure. Adolescent sex offenders often receive conflicting messages from parents. One pattern involves one distant, unavailable parent and one intrusive, overcontrolling parent (Straus, 1994). Put another way, one parent is disengaged from the offender while the other parent is in an enmeshed relationship with the offender. One goal of family counseling is to move both parents to a more moderate level of interaction with the offender.

Emotional needs. A seventh issue is the emotional deprivation of the offender. Emotional needs for nurturance and closeness typically are not met in these families. The goal becomes either to help the family develop these skills or, where this does not seem feasible, to find alternatives (e.g., community support programs). However, it is important to consider the risk of the adolescent offending again prior to encouraging participation in a community program.

Power. Finally, the issue of power is often a central theme, albeit usually unconscious, in the families of adolescent sex offenders. Parents in these families often feel powerless. When this is so, the parents tend to abdicate their responsibilities, or engage in power struggles with the adolescent.

CONCLUSIONS

Adolescent sex offenders perpetrate a substantial percentage of the sexual victimizations. Mental health counselors should develop the requisite knowledge, skills, and self-awareness to effectively deal with this challenging population and clinical issue.

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