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Adolescent sexual offenders

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The problem of sexual assaults committed by adolescents is serious and widespread. It is estimated that juveniles account for up to one-fifth of all rapes and almost one-half of all cases of child molestation committed each year. In addition, youth under the age of 18 years have accounted for 10 per cent of the sexual assault/murders since 1976 (Greenfeld 1997). To avoid using 'he/she' pronouns throughout the text, a single pronoun is sometimes used. Since most known offenders are male, 'he' is primarily used; however, when there are gender differences, this is clearly stated. Otherwise we are speaking about both genders.

ETIOLOGY

Although a variety of theories have been proposed to explain the etiology of sexually inappropriate interests and behavior, there is a paucity of empirical support for these theories (Kobayashi *et al.* 1995; Ryan and Lane 1997).

The National Task Force on Juvenile Sexual Offending (1988) identified fourteen different theoretical perspectives of juvenile sexual offending. This task force later developed basic assumptions upon which treatment is based (National Task Force 1993). Although there are many theoretical perspectives, the behavioral and cognitive theories have predominated in the field of juvenile sex offender treatment; some of the other models will also be discussed below.

Social learning theory

Numerous researchers cite social learning approaches as important contributing factors to the development and maintenance of atypical sexual interest (Laws and Marshall 1990). This model suggests that atypical sexual behaviors are learned in the same manner by which other individuals learn sexual behavior and expression, and can be changed by learning a new pattern (McGuire, Carlisle, and Young 1965). Laws and Marshall (1990) posit that sexual patterns are acquired and established through Pavlovian and operant conditioning, learned from observation and modeling and shaped through differential reinforcement. Masturbatory fantasy and orgasm increases higher-order conditioning and reinforces the behavior so that it is made more powerful and refined.

Biological factors

Recently, biological factors have been postulated as playing a role in the development of paraphilias. There is a paucity of such studies in either adolescents or adults. No direct biological measurements have been made in adolescents. Berlin (1988) has commented on the difficulty in performing such measures in adults. Most approaches have relied on examining the efficacy of the selective serotonin reuptake inhibitors in adolescence (Bradford 1993). One recent case study (Galli *et al.* 1998) described the case of an adolescent male with multiple paraphilias, obsessive compulsive disorder and bipolar type II disorder, who responded to treatment with fluoxetine, a serotonin reuptake inhibitor, after failing to respond to long-term residential treatment. This area of research shows promise.

Additional theories

Psychoanalytic theory views perversion as symptomatic of unresolved childhood conflicts (Stoller 1986). Sociobiological theory sites evolutionary perspectives (Ellis and Symons 1990). Money (1984) has theorized that a paraphilia is a mental template or a 'love map that grows awry ... by the displacement of original elements' (Money 1984, p. 178).

Another factor that has been identified to help explain the development of inappropriate sexual interest is a history of physical and/or sexual abuse. A history of physical abuse has been found in 20–30 per cent of adolescents

who have committed sexual offenses and a history of sexual abuse has been found in 40–80 per cent of sexually abusive youth (Hunter and Becker 1999). Although having been abused may be a factor, it is not in itself explanatory since many juvenile and adult offenders were not sexually abused and most children who were victimized do not go on to abuse others.

Exposure to family violence has been cited as a variable which may play a role in the behavior of the adolescent sex offender (Lewis, Shankok, and Pincus 1979) as well as dysfunctional family background (Loeber and Stouthamer-Loeber 1998; Caputo, Frick, and Brodsky 1999) and exposure to community violence (Johnson-Reid 1998).

Becker and Kaplan (1988) have described a model by which deviant sexual behavior and the development of deviant sexual arousal patterns may be explained. This model incorporates individual characteristics, family variables, and social environmental variables as possible precursors to the commission of an adolescent's first deviant sexual act. They posit that following the first sexual offense, there are three paths an adolescent might follow:

1 The dead-end path, in which an adolescent never commits any further deviant sexual behavior. These adolescents are likely to be the ones who suffer from the most negative consequences for the behavior or for whom the behavior may have been exploratory in nature, lacking in violence and related to the lack of a peer partner or as a copycat offense (modeling).
2 The delinquency path, in which an adolescent may commit further deviant sexual acts as part of the general antisocial personality pattern.
3 The sexual interest pattern path, in which an adolescent commits further sexual crimes and develops a paraphilic arousal pattern. These adolescents are likely to be those who found the behavior to be very pleasurable, to have experienced no or minimal consequences, to have experienced reinforcement of the deviant sexual behavior through masturbation or fantasy, and also who have deficits in their ability to related to age appropriate peers. These cases may represent cases of early onset pedophilia.

CHARACTERISTICS

There has been a distinction made between adolescents who molest children and those who target peers or adults. Research has shown that, in general, as with adult offenders, juvenile child molesters tend to have deficits in self esteem and social confidence (Awad and Saunders 1989; Monto, Zgourides, and Harris 1998), whereas those who assault peers or adults are more likely to have other criminal histories and are generally delinquent and conduct disordered and display higher levels of violence and aggression (Kaufman *et al.* 1998).

Clearly, to date there is no one theory that will explain the development of sexually inappropriate interests and behavior. Abel and his colleagues (Abel, Mittelman, and Becker 1985) found that in a group of 411 adults with paraphilias, 58 per cent had begun interest in paraphilias between the ages of 13 and 18. This points to adolescence as the time period during which paraphilias have their onset. As with adult sex offenders, juvenile sex offenders are a heterogeneous group; it is likely that many factors influence the etiology of the offender and that it is multicausal in nature.

ASSESSMENT

Assessment of the adolescent sex offender requires sensitivity and expertise with particular attention to the following areas.

Forensic issues

There are numerous sources of referral and reasons to conduct a specific sexual offender evaluation; therefore, it is of utmost importance that prior to the evaluation it is made clear what the referral source is requesting. For example, there is no empirically validated 'profile' of an adolescent sex offender. Nor can an assessment determine if a specific crime has been committed. Often, assessments are conducted to determine treatment amenability, treatment needs and risk as an outpatient. Regarding risk assessment, clinicians are frequently asked to make predictions. Again, there is to date no empirically validated risk assessment for adolescent offenders. A number of risk assessment instruments have shown promise. One of these is a juvenile sex offender protocol (JSOP) (Prentky *et al.* 2000).

Confidentiality

Prior to beginning any assessment, the juvenile and his or her parents or legal guardian should read and sign consent forms. Limits of confidentiality should be discussed, as well as what the assessment will consist of, any negative effects that could occur, such as anxiety or depression, as well as who the assessment report will be sent to. In addition, release forms should be signed at that time, giving permission to send the report to various other interested individuals, such as the adolescent's individual therapist.

Many adolescents are mandated to receive an assessment and are therefore reluctant to talk about sexual issues and behavior. Most sex offenders do not reliably self-report their deviant thoughts and behavior (Kaplan *et al.* 1990). In addition to these difficulties, since many assessments are for the legal system, the adolescent does not trust the evaluator.

Within the field of specialized sex offender treatment and evaluation, there are guidelines for evaluation

(Association for the Treatment of Sexual Abusers 1997) and a 21-factor guide to assessment (Ross and Loss 1991; Ryan and Lane 1991). These guidelines advise that evaluation should be conducted post-adjudication because if evaluations are conducted pre-adjudication, juveniles are then placed in a position where, if they reveal information, it may be used against them in a report going to the court (Hunter and Lexier 1998).

Prior to an assessment, there should be a review of materials. Information should be obtained wherever possible from outside sources, such as court reports, police documents, victim's statements and collateral interviews with family members. In addition, any psychiatric or psychological records should be reviewed.

The clinician should also be sensitive to and have an understanding of ethnic, religious, sociological and cultural backgrounds of the youths they evaluate. An evaluation should include a general diagnostic assessment as well as a specialized battery of tests for sexual interest and behavior. The structured interview collects information concerning demographic characteristics, family background, criminal history, social history, drug and alcohol history, a history of all sexual behaviors including all deviant sexual behaviors and fantasies and a history of sexual and/or physical abuse. A detailed assessment for adolescent sex offenders has been described (Becker and Kaplan 1988). In addition, the clinical interview should include a detailed description of the sexual offense including what the adolescent's thoughts and feelings were prior to and following the offense. The assessment should also include the following.

Psychiatric history

A number of adolescent sex offenders present with comorbid psychiatric problems which may respond favorably to pharmacological interventions. Several studies have found high rates of conduct disorder (Kavoussi, Kaplan, and Becker 1988; Galli *et al.* 1999), depressive and psychotic symptoms (Lewis, Shankok, and Pincus 1979), and mood disorders and attention deficit with hyperactivity disorder (Galli *et al.* 1999). It is also important to assess for psychopathology, peer relations, anger impulse control, behavioral problems, intelligence and cognitive ability.

Family assessment

Areas of concern in family assessment which should also be evaluated are over-involvement, isolation, intergenerational sexual and/or physical abuse, emotional deprivation, abuse of power, family members' perceptions of sexual abuse and reaction of family to disclosure (Thomas 1997). In assessing the family, it is also important to assess the current living arrangements in order to determine if the offender has access to his or her victim.

Self-report measures

In addition to a general psychological assessment, specific sex offender instruments have been developed for assessment. These are:

1 The Adolescent Cognition Scale (Hunter *et al.* 1991). This is a true–false test developed to determine if the adolescent has any faulty beliefs regarding sexual behavior. An example would be 'if a young child does not tell others about having sex with me, it means they really like it and want to keep doing it.' Research has suggested that sexual offenders develop belief systems which support continued sexual behavior with children.
2 The Adolescent Sexual Interest Card Sort (Becker and Kaplan 1988) is a self-report test with sexual vignettes which the adolescent rates as arousing or not arousing on a five-point scale. The card sort gives the patient an opportunity to indicate deviant sexual interests without having to disclose them verbally to the interviewer (Hunter, Becker, and Kaplan 1995).

Other general assessment instruments that are used with this population are the following:

- MMPI-A (Archer 1997).
- Child Behavior Checklist (Achenbach, McConaghy, and Howell 1987).
- The Beck Depression Inventory (Beck *et al.* 1961).
- Matson Evaluation of Social Skills in Youngsters (Matson, Esveldt-Dawson, and Kazdin 1983).
- The Multiphasic Sex Inventory (Nichols and Molenda 1984).

Adjunctive assessment tools that are used to assess this population are the polygraph and the plethysmograph.

Plethysmography is used to measure sexual arousal by measuring erection responses to erotic stimuli (audiotapes or slides) in the laboratory. In general, this assessment is used with youth over age 16 years, who report multiple paraphilic interests and who have extensive sexual offending histories in order to help develop treatment needs (Becker *et al.* 1992; National Task Force 1993).

Regarding *polygraphy*, to date there are few empirical data available on the use of the polygraph with juvenile sexual offenders, the procedure being used more often with adult offenders (Blasingame 1998; Ahlmeyer *et al.* 2000).

TREATMENT

In recent years, many specialized programs have been developed to treat the adolescent offender (Knopp 1982). Research indicates that treatment should be highly structured and designed specifically for sexual offenders (Ryan and Lane 1997). Peer groups are the preferred

method of treatment by 98 per cent of juvenile and adult sex offender programs (Knopp 1982).

Various treatment modalities have been utilized with adolescent sexual perpetrators. Freeman-Longo and his colleagues (1995) surveyed the main treatment models used with juvenile offenders by providers. The models reported in this survey were cognitive-behavioral (41 per cent), relapse prevention (36 per cent), psychosocio-educational (14 per cent), psychotherapeutic (5 per cent), family systems (2 per cent), sexually addictive (1 per cent), and psychoanalytic (1 per cent).

Currently, the most accepted form of treatment is cognitive behavioral therapy with relapse prevention. Behavioral literature for adult offenders utilizes three principal approaches to the treatment of paraphilic behavior, which have been incorporated and modified for the treatment of adolescents. These are:

1 Decreasing atypical arousal through covert sensitization and satiation (Barlow, Leitenberg, and Agras 1969).
2 Increasing arousal to peers.
3 Teaching appropriate peer related skills by social skill training, sex education and assertiveness training (Tollison and Adams 1979; Barlow and Abel 1976).

Specific behavior therapies

The primary goal of each of the following techniques is to help the offender reduce his sexual arousal to inappropriate sexual fantasy. Preliminary research from one study indicates that a deviant sexual arousal pattern is common among adolescent offenders who have molested young boys and who have a history of sexual victimization themselves (Becker 1988; Becker, Kaplan, and Tenke 1992).

A cognitive behavioral outpatient treatment program for adolescent sexual offenders has been described by Becker, Kaplan, and Kavoussi (1988) and Becker and Kaplan (1993) in which they examined the utility of a seven-component cognitive behavioral weekly outpatient treatment program. The components of this program include:

- *Covert sensitization*: This is a form of therapy originally used with an adult offender population (Abel *et al.* 1984). It is a behavioral technique that is used to pair deviant sexual urges with highly negative social consequences by teaching the adolescent offender to associate and anticipate real life negative consequences of the sex offense with the urge to offend. By frequent pairings of the deviant fantasy and a negative event, the fantasy acquires negative images and becomes less pleasurable.

It is common for male adolescents to believe that the offending 'just happened.' This technique also teaches the adolescent his specific chain of events and the steps that occurred from the beginning of the offenses to the end to help him identify the earliest aspects of the deviant act in order to be able to stop before his urges get out of control. Each adolescent develops his own script of: (i) risk factors; and (ii) negative consequences in therapy. After the script has been developed with the therapist, the adolescent then in private records his verbalization of this script, which the therapist then reviews with him. Each successive audiotape builds on the previous one, including more and more details and emotional material as the adolescent becomes aware of it. In the audiotape, first the risk factor script is verbalized and then the adolescent says the word 'switch' to transition into the negative consequences script, which is then verbalized. An example would be: (i) risk factor 'I am feeling really angry that I have to baby-sit, I want to be out partying. I think I will play wrestling with this little boy and teach him a lesson.' 'Switch.' (ii) consequences, 'I am really scared sitting here in jail. I want to go home. All of this is happening because I took my anger out on the little boy I was baby-sitting for.'

- *Verbal satiation*: Satiation is a technique used to reduce sexual arousal to inappropriate fantasy. This procedure has been modified from the technique used with adult offenders called masturbatory satiation (Abel *et al.* 1984). Verbal satiation teaches the adolescent offender how to use inappropriate fantasies in a repetitive manner to the point of boring himself or satiating his own fantasies. This procedure has been found to be effective with a group of adolescent sex offenders (Kaplan, Becker, and Tenke 1991).
- *Cognitive restructuring*: When adolescents engage in deviant sexual behaviors, they develop beliefs or faulty cognitions in order to rationalize their behavior. Cognitive restructuring is a process of confronting and changing these rationalizations or distortions. This treatment was originally conducted with adult offenders (Abel *et al.* 1984) and has been modified for adolescents.

Additional behavioral methods that are used to help adolescents rehearse methods of coping with deviant urges are thought-stopping and rehearsal of the positive consequences of non-offending.

Non-sexual components of treatment

Treatment programs also incorporate other modalities aside from the above-mentioned behavioral methods. These include:

- *Social skills training*: The interpersonal skills of the adolescent perpetrator are an important factor in treatment. Deficits in these skills may result in alienation and a lack of appropriate peer-aged relationships. The goals of this treatment component are to

help the juvenile develop pro-social skills. Many adolescent offenders are under-socialized, while others have adequate social skills but use them to manipulate others. Topics covered in this component of treatment are effective ways of communication, listening skills, initiating conversations, body language and sharing feelings.

- *Anger control and assertive training*: Failure to manage anger in a constructive way increases the likelihood of the juvenile perpetrator displacing his aggressive impulses onto a victim. The goal of this component of treatment is to help the adolescent recognize his feelings and to develop alternate appropriate responses that are socially acceptable. Many adolescents either react to anger by responding aggressively or by being passive rather than assertive. Many adolescents have difficulty recognizing their own anger. This component of therapy addresses these problems.
- *Sex education*: Adolescent offenders have been shown to have deficits in sexual knowledge, beliefs and attitudes (Kaplan, Becker, and Tenke 1991) and to believe in many myths regarding human sexuality. The purpose of this component of therapy is to help adolescent sex offenders better understand themselves by focusing on social, sexual and health issues currently facing them. The goals of this component of therapy are to: (i) increase knowledge about adolescent sexual development, anatomy and physiology; (ii) broaden knowledge about sexual myths and learn ways to prevent unwanted pregnancy and sexually transmitted diseases; and (iii) to become more aware of attitudes and clarify values about sexuality. Additional factors that should also be addressed are distorted beliefs about appropriate sexual behavior and sexual knowledge, values, and attitudes. A study by Rotheram-Borus and her colleagues (1991) found that adolescents in a male adolescent sex offender population scored significantly lower than male adolescent runaways in general knowledge about AIDS and were not able to discriminate safer sexual behaviors from those that were less safe. Since HIV is a threat in our society and to the adolescents being treated, it is suggested that AIDS education be added to any sex education curriculum.
- *Victim empathy*: Empathy has been identified as an important factor in sexual offenders (Marshall, O'Sullivan, and Fernandez 1996). However, there is little empirical research on empathy training for adolescent offenders. One recent study (Way 1999) suggested that unresolved maltreatment issues may be associated with lower empathy for victims. Victim awareness and increased understanding of negative impact of abuse may help motivate these adolescents to work on treatment. According to Ryan (1999) and Barbaree, Hudson, and Seto (1993), treatment in a developmental/contextual perspective allows the juvenile to recognize the needs of others.

Additional therapies

The following section will briefly describe the most popular of the non-cognitive behavioral treatments. However, there is little or no empirical research that supports their use.

- *Psychodynamically oriented psychotherapy*: Although group treatment is recommended for all sexual perpetrators (National Task Force 1993), many adolescents may also benefit from individual therapy which can help them deal with their own victimization as well as personality problems and interpsychic conflicts.
- *Family systems therapy*: Here, the emphasis is on family therapy and family dynamics. According to Thomas (1997), who proposes a five-stage model, one pre-requisite must always be that the sexually abusive youth is also in a specific therapy. Thomas states that for adolescent perpetrators, the goals of family therapy are to provide support for the sexually abusive youth, to help them continue in treatment, to identify and interrupt the family patterns that allowed or supported the sexual abuse, to improve family relationships and to maximize family strengths, and provide information for relapse prevention (Thomas 1997).
- *Sexual addiction model*: According to a survey by the Safer Society (Freeman-Longo *et al.* 1995), only four programs that were surveyed (1 per cent of the total) identified the addiction or 12-step program model as being used primarily with adolescents. This model proposes that an adolescent is 'addicted to sex.' The treatment is similar to the 12-step programs used by alcoholics and drug users (Carnes 1991; Carnes 1992).
- *Relapse prevention model*: Relapse prevention (Pithers 1990; Laws, Hudson, and Ward 2000) is helpful in the final stages of treatment. In this component, the adolescent identifies high-risk situations and thinking and develops methods of coping with them and understanding his or her sexual abuse cycle. The adolescent also identifies specific situations to avoid.

TREATMENT OUTCOME

There are many different recidivism rates in the sex offender field, which have led to confusion and pessimism. Part of this has to do with treatment methods which vary from study to study. There are widely disparate populations (prison populations versus outpatients). Much research is preliminary in nature with imperfect statistical design.

Becker and Kaplan (1988) reported one year post-treatment follow-up data which indicated that treatment is effective according to self-report, rearrest and plethysmographic data. Of the first 300 adolescents evaluated, 58.3 per cent (n = 205) entered treatment, although only

27.3 per cent (n = 56) attended 70–100 per cent of the scheduled therapy sessions. Recidivism rates of one-year post-treatment were low. According to self-reports and reports from parents and criminal justice agencies only 9 per cent had recommitted sexual crimes (Becker 1990). In a more recent study Hunter and Figueredo (1999) found that up to 50 per cent of juveniles in an outpatient program were expelled during their first year, but only 4.9 per cent for sexual delinquency. Lower levels of denial at the intake predicted compliance with treatment.

In a recent review of treatment outcome studies Alexander (1999), in examining studies of 1025 juvenile sexual offenders, found a recidivism rate of 7.1 per cent of treated subjects. In examining recidivism rates by type of intervention, she found that group behavioral treatment had a 6.8 per cent recidivism rate, and relapse prevention a 9.8 per cent recidivism rate. When separating juveniles treated in prisons from those treated in hospitals, the former subgroup had a 6.9 per cent recidivism rate, those from hospitals an 8.5 per cent rate, and those from outpatient clinics a 6.3 per cent rate. Recidivism rates rose over time for juveniles. According to these data, juveniles responded well to treatment: 'The demonstrated efficacy of juvenile offender treatment programs is a strong argument for their continued existence.' (Alexander 1999, p. 110).

CONCLUSION

There is increasing awareness of the need for early specialized therapeutic intervention with adolescent sexual perpetrators. Cognitive behavioral therapy appears to be the most effective treatment for these youth, and the most available treatment in the United States. Early intervention, while adolescents are in the early stages of the development of their sexually aggressive behavior, is critical, since patterns of such sexual interest and behavior become ingrained at this time. Not only can these aggressive patterns be addressed and treated through such early intervention, but further victimization can also be prevented.

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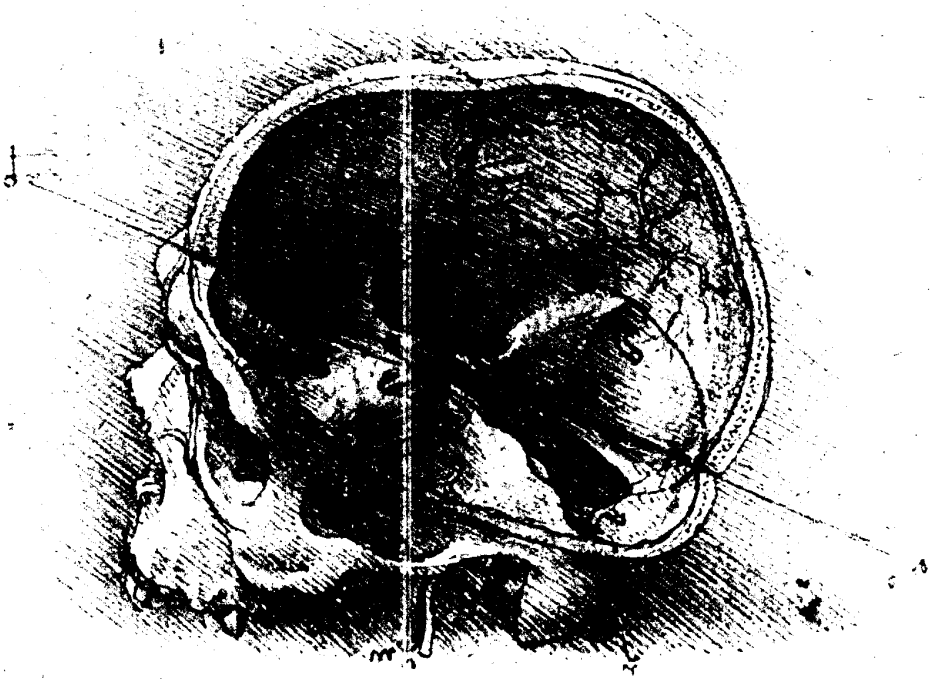

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