

**A MANUAL FOR UNDERSTANDING AND TREATING
ADOLESCENTS WHO COMMIT SEXUAL OFFENSES**

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TABLE OF CONTENTS

Chapter 1	Understanding Adolescents Who Commit Sexual Offenses	p. 3
Chapter 2	Assessment: Preparing for and Conducting Interviews	p. 13
Chapter 3	Assessment Tools	p. 33
Chapter 4	Treatment	p. 37
Chapter 5	Specific Treatment Modalities	p. 43
Chapter 6	Summary and Conclusions	p. 78
Bibliography		p. 80

CHAPTER ONE

Understanding Adolescents who commit Sexual Offenses

Introduction

The purpose of this manual is to provide clinicians with an understanding of a population of adolescent males who engage in inappropriate sexual behavior and commit sexual crimes and of how to treat them with cognitive-behavioral treatment. This manual is based upon treatment methods developed and utilized with adolescent sex offenders at the Sexual Behavior Clinic at New York State Psychiatric since 1991.

Although the exact prevalence of sexual offenses committed by juveniles is unknown, because many crimes go unreported, data from the national Incident-Based Reporting System indicates that one out of every five sexual assaults of adults and one third of sexual assaults involving victims less than 12 years of age involve an offender less than 18 years of age (Snyder & Sickmund, 2006). Reports from victims indicate that both males and females commit sexual offenses. However, since there is still relatively little research on female adolescent sex offenders, this manual will focus primarily on adolescent males.

Defining the Problem

Although there are numerous theories, the reasons adolescents commit sexual offenses or develop deviant sexual interest patterns are largely unknown. Any theory that explains sexual behaviors should be comprehensive and include biological, psychological and social variables.

The legal definition of sexual crimes varies from state to state. As a general principle, clinicians define sexually abusive behavior as any sexual behavior which is coercive (non-consensual) with a peer-aged individual, or in which there is at least a five year age differential. However, this definition can vary. The Diagnostic and Statistical Manual of Mental Disorders-IV-TR (American Psychiatric Association, 2000) states that a diagnosis of Pedophilia is only appropriate to be given to youth who are at least 16 years old and at least 5 years older than the child or children with whom they engaged in sexual behavior. If a 14-year-old adolescent engages in sexual activity with a 13-year-old adolescent, but the 13-year-old is developmentally disabled and the 14-year-old is not, this may also constitute sexually abusive behavior. This is because the 13-year-old may not have the cognitive capacity to consent to such behavior. If one adolescent knowingly intoxicates another adolescent and then engages in sex with that person, knowing that alcohol or drugs impair the person's cognitive processes, his or her ability to consent may be impaired. Consequently, the adolescent may be charged with a sexual offense. The age at which an individual can consent to engage in sexual activity also varies from state to state; therefore, it is important that clinicians be aware of the age of consent in their state. For example, in some states it is illegal for a 17-year-old to have sex with a 15 or 16-year-old, even if it is consensual. Many youth are not aware that they can be prosecuted for under-age sex.

The DSM-IV-TR (American Psychiatric Association, 2000) also states the in the case of pedophilia, the individual needs to suffer from recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger) for over a period of at least 6 months. The

fantasies, sexual urges, or behaviors must also cause clinically significant distress or interpersonal difficulty such as problems with in social, occupational, or other important areas of functioning.

Incidence and Prevalence

Although the exact incidence and prevalence of sexual offenses committed by adolescent offenders is unknown, it can be estimated from several sources, including victim reports. Finkelhor & Dziuba-Leatherman (1994) utilized a nationally representative sample of 2,000 youth and reported that 5.6 percent of the girls and 1 per cent of the boys reported having been sexually abused. Forty -one percent of the abusers were less than 18 years of age. Statistics are also available from other sources. The FBI's National Incident-based Reporting System indicates that one third of sexual assaults of children less than 12 involves an offender under 18 years of age, and that one in five assaults involves a youth perpetrator less than 18 (Rennison, 2001).

Etiology

The reasons adolescents engage in sexually inappropriate behaviors are largely unknown. Although numerous theories have been proposed to explain the causes of inappropriate sexual behavior and interests, to date there is no empirically tested model regarding the etiology of juvenile sexual offending or the development of atypical sexual interest patterns. Psychoanalytic theory views sexual perversion as an expression of unresolved problems in childhood development (Storr, 1970). Socio-biological theory views sexual arousal and interest from an evolutionary perspective (Symons, 1979). Some

researchers have suggested a cycle of abuse in which an offender's own victimization becomes a model for his future behavior (Van der Kolk, 1989). Some believe that a lack of attachment bonds in childhood is an etiological factor in the sexual interest of children (Marshall, 1989).

Social learning theory has also been posited as an important contributing factor to the development and maintenance of a paraphilia, in that sexual interests can be learned (Bandura, 1977; Burton, 2000). Kinsey and his colleagues (Kinsey, Pomeroy, Martin, & Gebhard, 1975) (p. 644) concluded that "the sexual capacities which an individual inherits at birth appear to be nothing more than the necessary anatomy and the physiologic capacity to respond to a sufficient physical or psychological stimulus.... but apart from these few inherent capacities, most other aspects of human sexual behavior appear to be the product of learning and conditioning."

Laws and Marshall (1990) suggested a model that deviant sexual behaviors are learned in the same manner by which other persons learn non-deviant sexual behavior and expression. They hypothesized that sexual arousal 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 becomes more powerful and refined.

Probably none of these theories alone fully explain the development of sexual behaviors in those who engage in inappropriate sex. This is especially likely to be true when trying to determine the situations or reasons that a specific child develops in their

own unique way. Rather, there are many reasons or causes for adolescents engaging in sexually abusive behavior.

Through clinical experience in working with juvenile sex offenders, it has been learned that they constitute a heterogeneous group in regard to their own sexual development. One reason an adolescent may engage in sexually abusive behavior is because he is socially isolated as a result of poor self-esteem and a lack of competency in social skills. A history of maltreatment during childhood, including physical and/or sexual abuse, has been cited in the literature as being found in the backgrounds of adolescent sexual offenders (J.A. Hunter, Goodwin, & Becker, 1994; Murphy, DiLillo, Haynes, & Steere, 2001; G. Ryan, 1989). Reports indicate that a prior history of physical abuse was found in twenty-five to fifty percent of adolescent sexual offenders, and that between forty and eighty percent of adolescent sexual offenders have been sexually abused (G. Ryan, Sandy, Davis, & Isaac, 1987; Smith, 1988).

These examples are just a few of the many possible "motivators" that lead to adolescents engaging in inappropriate sexual behaviors. However, it is often likely to be a combination of many factors in most cases. Taking an individual approach to the assessment of each youth with sexual problems is important. This will allow one to better determine the appropriate individualized intervention and treatment approach that should be taken if one is needed. Assessing for each of these motivators and questioning about the alleged offender's psychological, social, and biological backgrounds and experiences, are important.

Sexual Development

Prior to adolescence, children show curiosity about sex, think about sexual issues and engage in sexual play. For example, Kinsey and his colleagues (Kinsey, Pomeroy, Martin, & Gebhard, 1953; Kinsey, et al., 1975) found that about 45% of adult women and 57% of adult males recalled participating in forms of sex play prior to the age of twelve. Childhood sex play is not usually considered psychologically harmful. Money (1980) proposed that childhood sex play is a developmentally positive psychosocial experience. Childhood sex play occurs most frequently among close friends or relatives (i.e., cousins) and includes activities with children of the same sex as well as the opposite sex (Goldman & Goldman, 1982). Thus, self-discovery and peer interactions are important factors in the development of sexuality.

There are other influences in shaping early sexual development, including positive modeling. Bandura (1977) proposed the social learning theory that holds that individuals model behavior according to what they observe. This is in concert with Yates's (1978) beliefs. Therefore, the media and the family environment that one is exposed to can have a great impact on attitudes.

Proposed Models for the Development of Atypical Sexual Behaviors

At present, various models exist in the literature to describe the development of atypical sexual behaviors in youth. Ryan, et al. (1987) theorized a model of a sexual assault cycle. This cycle begins with an adolescent offender having a negative self-image that results in an increased probability of maladaptive coping strategies when confronted with negative responses to his behavior. The negative self-image also leads the individual to predict a negative reaction from others. To protect against this anticipated rejection, the

adolescent becomes socially isolated and withdrawn, and begins to fantasize to compensate for his or her feelings of lack of control or powerlessness. The fantasies may provide the opportunity to visualize the offense. Finally, the juvenile carries out the sexual offense, and in doing so, increases his negative self-image and thoughts of rejection. This then starts a vicious repetitive cycle. It has not yet been thoroughly and empirically evaluated as to exactly why some adolescents respond to negative self-images by becoming sexually abusive, while the majority does not.

Becker and Kaplan's model (Becker & Kaplan, 1988) for the development of inappropriate sexual behavior patterns incorporated individual characteristics, family variables, and social-environmental variables, as well as possible precursors to the commission of the adolescent's first inappropriate sexual act. Following the first sexually inappropriate behavior, they hypothesized that there are a number of paths an adolescent might follow.

On the path that is labeled the "dead-end path," on which the adolescent may never commit any further inappropriate sexual behaviors. Adolescents who fall into this category include those whose sexual activities may have been exploratory in nature, lacking in violence, related to the lack of a peer partner, or as a copycat offense. It is believed that such adolescents are usually at low or no risk for further re-offending. It is still important, however, that they receive some degree of counseling to teach them sexual values, the difference between appropriate and inappropriate sexual behaviors, and empathy regarding the impact that their behavior has had on their victim(s).

The second path is called the "delinquency path." An adolescent may commit other inappropriate sexual acts as part of a general anti-social personality or conduct disorder

pattern. It is proposed that youth who follow this path are those who commit sexual crimes during the course of committing other delinquent acts. In general, it is felt that these youth engage in crimes of opportunity. That is, if the opportunity to sexually abuse or assault someone exists, they may take advantage of it.

The third path is referred to as the "inappropriate sexual interest pattern path." In this path, an adolescent commits other sexual crimes, and may develop one if not more paraphiliac arousal patterns. It is believed that these are adolescents who: 1) found the behavior to be very pleasurable; 2) experienced no or minimal consequences in relation to the commission of the sexual offense; 3) experienced reinforcement of the inappropriate sexual behavior through masturbation activities and using inappropriate fantasies; and 4) are deficient in their ability to relate to age-appropriate peers.

It is likely that youth who commit a sexual offense fit into one of the above three categories. Further research, however, is needed to validate these proposed pathways. Additionally, it is possible that a particular adolescent could start in one of the first two pathways, and then develop paraphilic interests due to not being offered appropriate personalized treatment or intervention, and deflect, therefore, into the third pathway. Through experience, however, the authors believe that it is likely that these are three distinct groups.

Understanding the Need for an Individualized Approach

Youth who engage in inappropriate sexual behaviors are a heterogeneous group. There is a dearth of well-controlled studies comparing outcomes of treated versus non-treated adolescent sex offenders, as well as different forms of treatment options. There is

still little prospective data on either risk factors or developmental pathways to sex offending behaviors. Empirical typologies are still in their infancy, and the field is just starting to see the birth of actuarially derived risk assessment tools for these youngsters.

This manual is written to help the practitioner and those who work with teenage youth who engage in problematic sexual behaviors of all kinds. Some of these youth may commit multiple sexual offenses or only on one occasion. Some may develop patterns of inappropriate or deviant sexual thoughts or behaviors. Some may engage in a problematic sexual behavior because of stress in their life, or an opportunistic situation that presents itself. It is important to not interpret each of these situations as the same, but to individualize the approach to their assessment and treatment. Likewise, it is important to individualize the recommendations about them to the courts. Society and those working in the field of sexual pathology need to see these youth as the unique individuals that they are.

This manual is meant to define and describe the assessment and treatment strategies the author has used in an outpatient setting with post-pubescent juveniles who have been referred because they had engaged in sexually inappropriate behavior or had committed sexual offenses.

The manual begins with a discussion of the importance of an assessment on the adolescent and his family and moves on to risk assessment and other forms of written assessments. Cognitive-behavioral interventions are discussed. The manual concludes with recommendations for future areas of research.

We hope that clinicians will find this manual useful in developing an individualized treatment plan for their adolescent clients or patients and find the recommendations made regarding treatment interventions useful in their practices.

CHAPTER TWO

Assessment: Preparing for and Conducting Interviews

Given the heterogeneity of an adolescent sex offender population, it is imperative that an individualized assessment be conducted and treatment plan be developed for each adolescent. As much information as possible regarding the inappropriate behavior and history of the adolescent and his caregivers should be obtained prior to the interview.

There are various points at which a clinician might be asked to conduct an assessment of a juvenile who has engaged in sexually inappropriate behaviors. They include: 1) a pretrial or pre-sentence evaluation to determine the juvenile's risk to the community and whether residential or community-based treatment is appropriate; 2) an evaluation at the time treatment is initiated to determine the type of treatment needed and develop an individualized treatment plan; 3) an evaluation to determine the client's readiness for exit from a program; and 4) assessments during treatment follow-up periods.

Valuable diagnostic information can be obtained via face-to-face interviews with the adolescent and the adolescent's caregivers. Prior to the interview, collateral sources of material should be reviewed, and informed consent obtained from both the parents and the adolescent.

Collateral Sources

Prior to meeting with the juvenile and his parents and conducting the interviews, it is critical that the clinician obtain information from the referral sources(s) regarding the

nature of the alleged charges brought against the adolescent. This includes the victim's statement to the police and/or taking detailed information from the referral source. In addition, police reports, prior legal records, psychiatric, psychological and medical reports, and school records should be obtained when possible. It is critical that the clinician obtain information regarding the alleged sexual offense or inappropriate behavior from individuals other than the offender and the offender's family. Frequently, juvenile offenders (as with any age offender) will either minimize or deny sexual abusive behavior. Consequently, if the clinician relies solely on the juvenile's or family's report of the behavior, an accurate and detailed assessment may not be forthcoming.

There are a number of factors that influence the adolescent's level of honesty, including embarrassment, fear of further legal reprisal, and punishment from parents. One also has to keep in mind that the parents, however, may also deny that any force was used and downplay the seriousness of the offense(s), or may deny that the offense occurred.

The Clinical Setting

Prior to working with adolescents who have sexual behavior problems, clinicians should consider the setting in which services are to be provided and even meet with him. The physical set-up of the office is important, given that on occasion some youth who have co-morbid psychological problems may become violent. When possible, the therapist or evaluator always should be nearest to the door for easy access; there should not be objects readily available on a desk or a bookshelf that an adolescent can use as a weapon

Informed Consent

Prior to beginning the interview, informed consent should be obtained from both the adolescent and his parent(s) or guardian. Although an actual informed consent form is not necessary in all settings, it is a good way to document that a discussion on the issue of informed consent occurred, as to the risks, benefits, alternatives, and side effects of the assessment or the treatment to be offered.

Consents may also include an agreement between the adolescent and the therapist as to what will be shared with the parents or the referent. Also, the juvenile should be informed if the information he shares during the evaluation is confidential and can be accessed by members of the criminal justice system. What is being suggested is more than the standard of care in most cases, but is ultimately the most complete way to proceed.

The interviewee and his family need to be informed that if they provide the evaluator with the specifics of any sexual offenses that they have committed, the evaluator will be obligated to respond according to the mandating reporting laws in that jurisdiction. The interviewee should also be told that if he or she tells the interviewer of intent to harm himself or another person, the interviewer would act to protect. By informing the adolescent what the limits of confidentiality are, it is less likely that he will feel betrayed. Rapport could easily be threatened if the interviewer needed to break confidentiality.

Establishing Rapport

Due to the difficult nature of the topic to be discussed, it is critical that the clinician be comfortable in talking with adolescents and with asking specific detailed questions regarding the juvenile's sexual behavior. Likewise, the juvenile should be comfortable with the clinician.

If the adolescent does not have a clear understanding of why you are meeting with him, it is important to explain the reason for the evaluation, the limits of confidentiality, and to whom a report will be provided. It is usually helpful to ask the adolescent how he feels before obtaining any personal information, and informing the adolescent that it is not the evaluator's role to pass moral judgment on them, that doing these kind of evaluations is your area of expertise, that he should use words and terms that are comfortable for him, and that the information he provides, in all probability, involves behaviors that the evaluator has heard about before.

Before addressing difficult material, the clinician should ascertain if he has been unable to manage his behavior in the interview setting. First, ask the adolescent to identify whether in prior interviews he has had difficulty controlling his behavior and under what circumstances that occurred. Next, ask what strategies he has found helpful in managing his behavior. Third, suggest that if he is having difficulty managing his behavior, the interview can be terminated or another person can be brought into the room.

During the interview, starting with less threatening or invasive material and then progressing to more difficult subjects allows time for rapport to build. Most adolescents have a difficult time in answering sexual questions. It is not uncommon to need to repeatedly set the adolescent at ease before he will open up about the alleged sexual act(s). Not emotionally over-responding to issues discussed, whether negative or positive, sets a healthy atmosphere for disclosure. It helps assure the adolescent that it is safe to talk more, as it will not upset or surprise the clinician.

Interviewer Characteristics

In the process of information gathering, characteristics of the interviewer may impact the responses of the adolescent. There has been much speculation on how the gender of the interviewer can affect responses of clients; however, little empirical data has been collected on the subject. Kaplan, Becker, & Tenke (1991) interviewed 264 inner-city adolescent males who were undergoing an evaluation at their clinic. The adolescents were questioned as to their preference and comfort in talking about sex with a male versus a female interviewer. Overall, these adolescents said that they were more comfortable with a female interviewer. Of the 135 adolescents who did not have a history of abuse, 53% did not express a preference. However, of those adolescents who had themselves been victims of sexual and/or physical abuse, 49% preferred a female interviewer. Individuals who were victimized by males showed the greatest preference for a female interviewer, although those abused by females also preferred a female interviewer. These results suggest that self-disclosure about sexual material may be facilitated when interviewers of both genders are available.

It is recommended that when working with adolescents of various cultures, therapists increase their knowledge of cultural specific areas. When there are cultural and/or racial difference between therapist and client, the therapist may not be aware of the client's experiences and norms, and culture specific issues may be invisible to the therapist. The clinician should try to be responsive to socio-cultural factors and contexts. For example, issues of poverty, racism, and exposure to violence must be taken into consideration in working with inner-city youth. When assessing families and youth from other cultures, there can be culture clash and intergenerational clashes regarding values and acceptable behavior. First, the clinician should ask the adolescent about his culture.

Reading literature to gain culture specific knowledge and, when possible, seeking consultation and supervision that is culture specific can also be helpful.

A collaborative style, as opposed to a confrontational one, is recommended in all aspects of interviewing and treatment (Marshall et al., 2005). Marshall (2005) examined the relationship between therapist characteristics and treatment-induced changes in adult sexual offenders. He found that a confrontational style was negatively related to increased competency in coping, and that 10 therapist features predicted beneficial changes. Those features included empathy, warmth, being directive, use of open-ended questions, and encouraging participation. Proeve (2003) stated “confrontation is likely to impact negatively on client self-esteem, shame, and on clients who have an insecure attachment style” (p. 255). Therefore, it is recommended that the interviewer be professional and non-judgmental, show warmth and empathy, and adopt a directive style during the evaluation.

Starting the Interview

Once the adolescent understands the purpose of the session, the limits of confidentiality, and rapport has been established, the interviewer should inform the adolescent what materials he or she has reviewed preliminary to their meeting (e.g., police reports, victim statements, juvenile court records, and mental health records). By doing this, the interviewer can reduce the adolescent’s degree of denial and minimization.

It is important to assess the individual characteristics, family variables, and social-environmental variables that may contribute to the person’s behavior. Specific individual factors may include having been neglected or emotionally, physically, or sexually victimized. Co-morbid psychological problems, personality traits, distorted beliefs about

appropriate sexual behavior, deficits in sex knowledge, values and attitudes, history of delinquency, gender-role conflicts, and psychosocial deficits should be assessed. Family risk factors may include intra-familial violence, poor parent management techniques, and criminal behavior by family members. Social and environmental factors may include having had inappropriate or poor role models, bonding with delinquent peers, and considerable exposure through the media, community, or other sources to violent and coercive models. The major goals of an assessment are to determine etiological factors that may have contributed to the behavior, the strengths of the adolescent and the family that may be relied upon in treatment, and how best to help the adolescent and his family. Greater detail regarding specific questions to ask is provided in the following section.

The Clinical Interview

During the initial clinical interview, if an adolescent refuses to answer a question, he need not be pressed, but instead can go on to the next question and return to the unanswered one later, or in a subsequent interview. If an adolescent denies committing the alleged crime, again he does not need to be pressed at first. Rather, one can ask about the situation again later in the interview, or can conduct a series of interviews. Sometimes adolescents may find it “easier” to blame the victim or outright deny the alleged action, than to accept the responsibility for his behavior. It can be helpful to attempt to identify what barriers exist to the adolescent accepting responsibility for the offense (e.g., shame, embarrassment, fear of loss of parental love, fear of being taunted by peers, fear of potential consequences) and discuss these during the interview.

The adolescent clinical interview begins with the clinician obtaining information, which is routinely gathered as part of a thorough general clinical interview, including questions about his family, school, friends, demographic information, hobbies, developmental years, and present life circumstances. Many adolescents will feel safer to discuss their thoughts and behaviors.

It is critical that both the adolescent and the interviewer have a clear understanding of the correct sexual terminology used. The interviewer should model comfort in using sexual terms. It is important to clarify what is actually meant by these terms, and to educate the client about the proper medical terminology or definitions, then asking what word they use. The terminology used by the clinician, whether slang or professional, should depend on his or her own comfort.

The Sexual History

Once rapport has been established, the topic of sexuality can be discussed. The interviewer usually begins the sex history by asking the adolescent about how he first learned about sex or any sex education, and then asking about non-norm-violating, non-illegal sexual behavior with peers. These questions include such information as when he first learned there was a difference in male and female anatomy, when he first started puberty, when he first had a “crush” on someone else, when he first kissed anyone, when he first engaged in non-genital sexual experiences, the age at which he engaged in his first genital sexual experience, and the number of sexual partners he has had. The interviewer also obtains information on the gender, age, and relationship (relative or non-relative) of each sexual partner the juvenile has had. The interviewer also asks the juvenile who

initiated the sexual activity, and whether it was pleasurable or unpleasurable, wanted or unwanted, frustrating or satisfying.

The interviewer then can assess the juvenile's reported frequency of masturbation, types of sexual fantasies, and sexual attractions. The adolescent can be asked what percentage of his sexual fantasies is about females and what percentage is about males. Then each gender can be broken down by age group, determining what percentage are about prepubertal children, what percentage are about other adolescents, and what percentage are about adults. Determining the age range of sexual fantasies and actual sexual behavior is important. The adolescent is also asked to provide information regarding the specific content of his sexual fantasies, including who initiates the sexual behavior, the types of sexual acts that occur, and whether there is any degree of coerciveness in the sexual fantasies. Many adolescents deny that they masturbate or have sexual fantasies, especially in an initial interview.

The interviewer also questions the adolescent about his use of sexually explicit material, and about what impact these may have on his sexual arousal. The content the materials contained should be explored as well as a detailed history of computer and internet usage. The clinician should also inquire as to whether the adolescent has used a computer for sexual purposes, such as video, sexting, and use of chat rooms. Additionally, one should ask about the impact alcohol and drugs have on his sexual arousal.

In starting to ask about the sexual offense, it is important to inform the adolescent that there is a wide range of sexual activities and experiences in which people engage. The clinician begins by questioning the adolescent as to how many times he has engaged in a variety of sexual behaviors that would be considered illegal or against what is considered

acceptable in his community. Such behaviors would include obscene phone calls, obscene letters or electronic communications, voyeurism, transsexualism, transvestism, exhibitionism, fetishism, frottage, pedophilia, public masturbation, rape, sadism, masochism, necrophilia, bestiality, coprophilia, and urophilia. It is important to ask about things that one would not always initially assume an adolescent may have fantasized about or engaged in, such as a history of sadistic acts of torture, control, or even murder (Johnson & Becker, 1997). The explanation of each type of sexual act should be used, rather than the actual title of the act. Also, rather than asking the adolescent whether or not he has engaged in any of those behaviors, the clinician assumes that the adolescent may have engaged in some form of the behavior being assessed, and consequently asks the question in a “positive” way. For example, the clinician should question the adolescent, asking for example, “At what age did you first have ideas or fantasies about peeking into the windows of a stranger?” After the adolescent has responded, the clinician would then ask, “How old were you the first time that you actually did peek into a person’s window to see them in the act of dressing, undressing, or in a sexual act?” In this way, it opens the door to the adolescent responding affirmatively to situations that have occurred, making it acceptable to admit to the behavior, and harder to deny. If an adolescent indicates that he has engaged in or fantasized about one of these behaviors, more specificity should be obtained such as the number of times, who the person was, the conditions under which the behavior occurred, whether they were under the influence of alcohol or drugs, and their feelings before, during, and after engaging in the behavior.

The totality of the adolescent’s sexual experiences, both those considered normative and those considered illegal or inappropriate, are then listed and a chronological sexual

history lifeline can be constructed. For each sexual behavior, the following information is obtained: 1) age and sex of the victim or partner; 2) relationship (known, stranger, relative) to the victim; 3) self-reported number of acts; 4) amount and type of aggression used; 5) where the offense occurred; 6) whether or not sexual fantasies preceded or followed the behavior; 7) age at which the fantasies began; and 8) the adolescent's self-report of his current self-control on a scale of 1 to 100. It is important to obtain detailed information on how he selected his victims(s), how he engaged his victim(s), and what occurred just before, during and after the sexual offense(s).

Clinicians should also inquire as to whether the adolescent has had any difficulty getting an erection when he wanted one, or any difficulty ejaculating when he wanted to. Also, one should inquire as to whether there is anything about his genitals that concerns him, and under what circumstances he uses condoms.

It is important to ask about every possible sexual behavior, because clinical experience has shown that if the adolescent is not asked about the specific behavior, he will usually not divulge this information. It is recommended that the adolescent be engaged as much as possible in helping the interviewer construct the sexual lifeline. Sometimes by visually depicting and then looking at the sexual lifeline, the adolescent will recall information that he had not initially volunteered or that the interviewer had not questioned him about. It is also helpful to conclude the sexual history by inquiring of the adolescent as to whether there are any categories of sexual fantasies or behaviors that he has engaged in or fantasized about that the interviewer failed to ask about. Finally, the interviewer could add on the sexual lifeline information provided by other sources, such as victims, parents,

or the referral source. The adolescent can then be asked to explain any discrepancies between these collateral sources of information and the information he has presented.

For those clinicians who have not received formal training in taking sexual histories, it is recommended that they observe experienced interviewers, and then role-play taking sexual histories and obtaining feedback. Other aspects of the interview that take on increased importance when taking a sex history include being attentive to one's own nonverbal cues. One's body posture and facial expression should remain neutral. If the adolescent feels that the interviewer is uncomfortable with the information he is providing, he might not divulge any further information. For those adolescents who enjoy psychologically manipulating people or find pleasure in another person's pain, an interviewer's discomfort may have the opposite impact, and the adolescent may embellish his report to increase the interviewer's unease. This is sometimes the case when the interviewee demonstrates a sadistic nature to his personality.

Personal History of Abuse

During the assessment, information is also obtained regarding whether the adolescent has himself been the victim of sexual abuse, physical abuse, emotional abuse or neglect. It is usually difficult for adolescent males to respond positively to the question "Have you ever been sexually abused?" Consequently, one can ask the adolescent to report every sexual experience that he has ever had. Follow-up questions would include how old he was, how old his "partner" was, whether the partner was related to him, the gender of the partner, who initiated the sexual behavior, how he felt about the sexual activity, and finally, whether he would describe the behavior as being abusive.

It is important to note that numerous boys who have been abused by females do not describe the behavior as being sexually abusive. In a number of cases, the adolescent has stated he felt he was “lucky” that an older female initiated him into sexuality. Upon further questioning, however, it has been found that in a number of cases, the adolescents were anxious during these encounters with women. They often did not know what to expect. For a number of these boys, their first sexual experience was shrouded in secrecy. It is important to note that not all youth who commit sexual offenses have a history of sexual abuse and therefore clinicians should not assume such a history exists. This information is pertinent, however, since it has been shown that adolescent offenders who have been sexually abused had an earlier onset of their own offense behavior, had more victims, were likely to abuse both males and females, and tended to show more psychopathology and interpersonal problems (Cooper, Murphy, & Haynes, 1996).

Those boys who were molested by males were more likely to identify the behavior as being sexual abuse. It has been the authors’ experience that some adolescents are uncomfortable in discussing sexually abusive experiences during the initial interview, and will later disclose the abuse during the course of their treatment, after they have begun to trust the therapist. An adolescent may need individual sessions to discuss this, and gradually, he may reveal his abuse history. Information regarding physical abuse can also be difficult to obtain during the clinical interview. Often, an adolescent does not describe himself as being physically abused if he felt he was deserving of the physical abuse. One method that has been found helpful in obtaining this type of information is by asking the youngster, “When you do something wrong, how do your parents discipline you?”, and/or asking if anyone has ever done something to him that caused him to be hurt, or made him

feel uncomfortable. In addition to inquiring about abuse during the clinical interview, structured assessments may be helpful as well.

Psychiatric/Psychological Evaluation

It is important to evaluate the adolescent to determine whether there are any co-morbid psychiatric disorders that may interfere with the adolescent being able to control his behavior or to participate effectively in treatment (Kaplan & Krueger, 2003; Kavoussi, Kaplan, & Becker, 1988).

Developmental and Learning Disabilities

It is critical in developing an individualized treatment plan for the adolescent that his level of cognitive functioning be assessed so that material is presented to him at a level that is congruent with his abilities. Learning disabilities should also be assessed.

Medical and Substance Abuse History

As part of the clinical interview, the clinician should inquire as to the general health of the adolescent, as well as any major illnesses or hospitalizations he has had. The same information should be obtained from the parents or guardians. It is particularly important to determine whether the adolescent has sustained any head injuries or experienced any seizures during the course of his life.

Social Skills

A variety of research suggests that juveniles who commit sex offenses may have social skills deficits (Oxnam & Vess, 2008). Miner & Munns (2005) and Ronis & Borduin (2007) found that juvenile sex offenders may have difficulty forming satisfactory interpersonal relationships. It is therefore important that the social adjustment and levels of social competency be assessed in juvenile sex offenders. In some cases, when juveniles have lacked the necessary skills to relate to peers in a functional manner, they have associated with much younger children, and have then sexualized their relationships with those children.

There are a couple of methods by which social skills can be assessed. The first is by asking the juvenile during the clinical interview about the number of friends that he has, and how much time he spends after school and on the weekends with these friends. One must be specific and ask the adolescent for the names of friends and exactly how he spends time with these friends. It is also important to attempt to validate this information by asking the parents as well. Other sources of information, such comments on school records regarding the youth's socialization may be helpful in providing information regarding the youth's social-interpersonal skills.

Legal History

Since many adolescents who have engaged in inappropriate sexual behaviors have also committed other types of crimes, it is important to get a detailed history of their legal and criminal background. Many youth will deny charges brought against them, or downplay their importance and severity.

Mental Status Examination

Finally, it is paramount to conduct a mental status examination as part of every interview.

Special Issues or Problems in Assessing the Adolescent Sex Offender

It is important for clinicians to know that an assessment might not always go as smoothly as one would wish. During the first contact with the adolescent, it is not unusual for him to find it difficult to talk openly. In some cases, the adolescent might even be mute during the attempted initial interview. What underlies this behavior may be their sense of shame, guilt, and embarrassment. Again, it is also important to let the adolescent know that the interviewer understands that it is difficult upon meeting someone for the first time, to discuss difficult and sensitive areas regarding one's life, especially sexual issues.

One has to anticipate that the interviewee may not divulge the full extent of the inappropriate sexual activity during the initial interview. Consequently, it is sometimes necessary and important to continue with subsequent interviews. In doing so, one can continue to question the adolescent about the nature of the offenses over time, continuing to develop rapport and trust. Often, explaining to the adolescent that as he gets to know the clinician better, he might feel more comfortable in talking about these issues.

Adolescents who completely deny the offense(s) may be particularly difficult to interview. There are several approaches that the clinician might use. One is to read to the denier the victim's statement. This may elicit an emotional response, or tap into the adolescent's sense of responsibility. Finally, watching for "slip-ups" and contradictions in

his story can give the evaluator the ability to confront the adolescent with his denial, sometimes helping open up the conversation to what really occurred.

Frequently, adolescent sex offenders have not had positive models for disclosure. They may fear reprisal from their parents if they disclose the abuse, or an attorney might have informed them not to disclose any information regarding the abuse until there has been a disposition on the case. Even after the disposition, adolescents frequently have difficulty talking about the abuse. Being patient and waiting over time can sometimes be the best method.

Family Assessment

It is critical to question the parents about the extent of their knowledge regarding the sex offense committed by their child, as well as their knowledge about what other factors may have contributed to his sexually inappropriate behavior. It is also important to obtain information about the adolescent's developmental history, and any pertinent family life events, such as psychiatric illness or criminal behavior. The parents can often help clarify details the adolescent did not know, or confirm that what he said was correct. This helps pick up distortions about the adolescent's developmental history, other criminal or behavioral problems, and any past family history that the adolescent is unaware of.

Davis & Leitenberg (1987) in their review of the literature on adolescent sex offenders have discussed how family factors may influence the adolescent to commit a sexual crime and point out a number of plausible explanations. They discussed four points. First, when physical aggression and marital violence are tolerated, the adolescent learns that this is acceptable behavior. Second, neglect and abuse may predispose the adolescent

to seek revenge on substitute targets. Third, parental abuse may lower self-esteem and the sexual offense may be a way of restoring self-worth. Finally, parental abuse may impact the adolescent concerning the development of intimate relationships with peers and, consequently, he may socialize and then sexualize relationships with much younger children.

In an attempt to understand the family environment of adolescent sex offenders, (Kaplan, Becker, & Cunningham-Rathner (1988) described the characteristics of parents of adolescent perpetrators. Of those mothers studied, it was found that: 1) parents under-report physical and sexual abuse of their sons as compared with information obtained from the adolescent; 2) there is a high prevalence of sexual abuse in the reports of the parents themselves; 3) there is a high rate of denial of the incestuous behavior committed by their sons; and 4) these parents fail to educate their children about sexuality. Other research has found that the families of juvenile sex offenders, compared to other delinquents, are more likely to be characterized by lying, taboo behaviors, and family myths (Baker, Tabacoff, Tornusciolo, & Eisenstadt, 2001).

In the clinical assessment of family members, there are a number of other issues that are important to consider and evaluate. Many parents are emotionally shocked and embarrassed to learn that their child has committed a sexual offense. Frequently they may evidence similar levels of denial, rationalization, and minimization as their adolescent. Generally, parents are in need of support at this time and they invariably have many questions to which they are seeking answers. Another source of support can be other parents of adolescent offenders who are already in treatment, in a support group for parents or families of sexual offenders.

A particularly difficult situation arises when the offender and victim are siblings. Both children are in need of support and therapeutic interventions at this time, while also making sure the victim is safe.

It is recommended that parents follow local laws and legal recommendations. This usually means that the two children, even though siblings, should likely be separated until both the therapist who is working with the sex offender and the therapist who is working with the victim agree that reunification can take place.

Thomas (1997) has written a comprehensive article entitled, “The Adolescent Sex Offender Family in Treatment.” It is recommended to all clinicians who work with adolescent offenders. In her article, Thomas outlines a five-stage model: 1) the crisis of disclosure; 2) family assessment; 3) family therapy interventions, including goals, planning and treatment issues; 4) reconstruction and reunification of the family; and 5) termination and aftercare. There are also standards that have been established by the Association for the Treatment of Sexual Abusers regarding the issue of reunification (Association for the Treatment of Sexual Abusers, 2005). They should be reviewed and followed when reunification is considered.

The assessment of the family should include the extent of over involvement or enmeshment, isolation of the family from the community, external and internal stress the family may be experiencing, sexual or physical abuse in the histories of other family members, communication styles, parental relationship styles, the extent to which family members’ emotional needs are met, and whether family members abuse power (Thomas, 1997). Other information which is important to obtain include the family members’ perceptions of the youth’s inappropriate/illegal sexual behavior and, if the youth has

disclosed, the family's reaction to the disclosure. Information regarding sexuality histories, psychological data, legal history, and substance usage within the family should also be obtained (Thomas, 1997).

CHAPTER THREE

Sex Offender Specific and Delinquency Assessment Tools

Assessment Tools and Risk Assessment

With the increased sophistication of the assessment process with adolescent sex offenders, the use of psychological checklists, psychological tests, and other forms of testing, including physiological assessment has become increasingly popular.

There are no tests that will determine if an adolescent did or did not commit a specific sexual act. They should not be used to determine guilt or innocence. However, these tests, when carefully selected and used as needed for a specific case, can be helpful in obtaining additional information. It should be stressed that the use of tests should not be considered an alternative for a thorough clinical interview, but should be seen as a supplement to the information gathered through the interviews, review of collateral sources, and other forms of assessment. There are many assessment tools that are available for adolescent sexual offenders and that can be obtained from various sources. Among these sources are the Safer Society Press, the Neri Press and The Association for the Treatment of Sexual Abusers. Among the areas important to assess are the following: Psychiatric history, Psychopathy, General Delinquency, IQ, Learning Disabilities, Social Skills, Sexual Knowledge, and Family Assessment. Two tests developed by one of the authors and colleagues follow.

The Adolescent Sexual Interest Cardsort

Because some adolescents have difficulty stating in a face-to-face interview the nature of their inappropriate sexual fantasies, urges, or behaviors, the Adolescent Sexual Interest Cardsort (ASIC) was developed by Becker & Kaplan (1988), being a revision of one initially developed by Abel in 1979. A copy of it is available in *Assessing Sexual Abuse: A resource guide for practitioners* (Prentky & Edmunds, 1997). This instrument gives the adolescent the opportunity to indicate deviant sexual interest patterns without having to verbally disclose them to the interviewer.

The psychometric properties of this instrument were evaluated (Hunter, Becker, & Kaplan, 1995; Hunter, Becker, Goodwin, and Kaplan, 1995). Although this instrument had high indices of internal consistency and test/retest reliability, in general it did not correlate with phallometric measurements on the same population. This is consistent with findings with adult offenders, suggesting that self-report measures are vulnerable to dissimulation.

The Adolescent Cognition Scale

The Adolescent Cognition Scale (ACS) is a 32-item true-false test developed to determine if the subject has any distorted cognitions or thinking errors regarding inappropriate sexual behaviors. The ACS is the modification of an adult scale devised by Abel, Becker, & Cunningham-Rathner (1984)

The reliability and discriminative utility of a version of this instrument was assessed (Hunter, Becker, Kaplan, & Goodwin, 1991) Results indicated that this scale had only marginal reliability. Furthermore, the test did not discriminate between groups of adolescent sex offenders and adolescents without a history of sexual perpetration. However, it is may be useful for getting additional information that adolescent may not initially disclose. Also, it can be useful for confronting an adolescent in treatment with his

distortions regarding sexual behaviors. This pattern of results may indicate that adolescent offenders have not developed the extent of distorted thinking patterns seen in adult offenders.

For a more detailed description of procedures for conducting the plethysmograph assessment as well as the consent process, please see Becker & Kaplan (1988). The Association for the Treatment of Sexual Abusers (ATSA) has also published guidelines for the use of the penile plethysmograph and for viewing time (ATSA, 2005) and the reader is referred to this for further information.

Polygraphy

Although numerous treatment providers and probation departments are utilizing the polygraph in an attempt to validate sex histories or as a part of supervision, there is a dearth of research to support the validity of its use. To date there is little to no known research regarding its use with adolescents. It is subject to both high rates of false positives and false negatives and is not accepted as evidence in legal proceedings in courts in the United States (Hunter & Lexier, 1998)

Risk Assessment

Frequently, clinicians are asked to make determinations about whether the adolescent who has engaged in an inappropriate sexual act should be treated in the community, a group home, a residential treatment facility, or in a state juvenile correctional facility. The field of risk prediction of adult offenders has grown rapidly. There are now a number of statistically based, empirically derived risk assessment instruments that evaluate

both static and dynamic risk factors regularly being used in the adult sex offender population. Using the adult scales to rate adolescents is inappropriate. Their risk scores might be inflated, given the inclusion of variables like young age and never being married (Harris, Phenix, Hanson, & Thornton, 2003). There are several risk assessment instruments presently available for juvenile sex offenders. The instrument that has been studied the most to date is the Juvenile Sexual Offender Assessment Protocol (Prentky, Harris, Frizzell, & Righthand, 2000; Righthand et al., 2005) Other risk assessments for juveniles are the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR 2.0)(Worling, 2004; Worling & Curwen, 2001; Worling, 2004) and the Juvenile Sexual Offense Recidivism Risk Assessment Tool-II (J-SORRAT-II)(Epperson, Ralston, Fowers, De Witt, & Gore, 2005). Regarding disposition, it is the authors' experience that the majority of adolescents who have been evaluated and determined to need sex offender treatment have turned out to be appropriate candidates for outpatient intervention.

CHAPTER FOUR

Treatment

Research has indicated that juvenile sex offenders are a heterogeneous group. Each adolescent should have an individualized treatment plan and the treatment should be based on the comprehensive assessment conducted. It is important that the therapist review the treatment plan with both the parent/guardian(s) and the adolescent, and obtain parental informed consent.

It is unknown where the future will take us regarding the mode of treatment offered to adolescent sexual offenders. Therapeutic peer groups combined with individual treatment has been considered the preferred method of treatment; to date, There has not been empirical research evaluating the efficacy of individual versus group therapy or controlled treatment outcome studies with large sample sizes and with long-term follow-up that investigate which adolescents respond best to which types of treatment.

Various treatment theories and modalities have been utilized with adolescent sexual offenders. The various models employed are:

1) cognitive-behavioral (Becker & Kaplan, 1993); 2) relapse prevention (Ryan & Lane, 1991); 3) psycho-socio-educational (Barbaree & Cortoni, 1993); 4) psychotherapeutic; 5) family systems; and 6) multisystemic therapy (Borduin, Henggler, Blaske, & Stein, 1990;)

It is important to take a bio-psycho-social approach to understanding the etiology of sexual behavioral problems; therefore it is important to address each of these issues in

treatment. I advocate the use of a multi-modal approach to working with adolescents and their family members. This can include well-established cognitive-behavioral treatment methods, but with the addition of additional interventions when necessary.

The current chapter will present the specific principals that the authors have used to address sexual issues in treatment. Additional treatments for general behavioral problems that are covered in many other texts and sources may need to be added, depending on the adolescent, and will not be covered here.

Cognitive-Behavioral Therapy Overview

Cognitive-behavioral therapy focuses on thought processes of the adolescent. It deals with the present and is practically oriented. This mode of therapy aims to improve an individual's control of his inappropriate sexual thoughts, fantasies, impulses and urges, and helps him decrease any deviant arousal that may occur. These techniques are used with sex offenders to explore how thoughts affect behavior, to identify distorted thought patterns, and to change them to acceptable and healthy thoughts.

Yochelson & Samenow (1977) first described a set of "thinking errors" often seen in sex offenders. These thinking errors are also referred to as justifications, rationalizations, or cognitive distortions. Cognitive-behavioral therapy aims to help the adolescent label and correct these distortions, in order to develop healthy and responsible attitudes of sexuality.

Cognitive approaches to treatment also include training in various areas, such as anger, empathy and psychosocial skills. The adolescent need not always participate in each area of training, as a treatment outline should not be viewed as a "cookbook" that one has to following order to successfully treat the adolescent.

Group Versus Individual Cognitive Behavioral Therapy

Rationales for placing adolescents who have committed sex offenses in group therapy are that the adolescent can obtain support from group members and learn that the problem is not unique to him. They can learn to establish trusting relationships with peers, and can also help each other problem-solve with such things as anger control and social problems. There are some adolescents who benefit from participating in individual therapy, or a combination of both individual and group therapy. The cognitive behavioral model is applicable both in individual as well as group therapy settings. Given that group therapy is the dominant treatment modality, the following will focus on group structure and treatment. Many of the same principles can be adapted for individual therapy.

The foundation of the therapy in a group setting is important. The proper setting makes participants feel comfortable and helps facilitate learning during the program. The leader needs to be aware of a number of factors. Each will be discussed briefly.

Group Dynamics

A number of mechanisms have been identified that make group dynamics work, and in turn help the participants make the wanted changes in their lives. (Yalom, 1983) has developed an empirically based inventory of eleven therapeutic factors that contribute to effective group therapy. These include: 1) instillation of hope, 2) universality, 3) imparting of information, 4) altruism, 5) development of socializing techniques, 6) imitative behavior, 7) catharsis, 8) corrective recapitulation of the primary family group, 9) existential factors, 10) group cohesiveness, and 11) interpersonal learning. Although these mechanisms were

realized from more psychodynamic groups, they seem to apply well to the type of groups used with adolescents who have abused others sexually.

Homogenous Versus Heterogeneous Cognitive Behavioral Treatment Groups

In group therapy, therapists should consider whether group composition should be homogeneous or heterogeneous. Heterogeneous groups present other advantages, in that there are not similar rationalizations and distortions to reinforce one another in a negative manner. When the group is heterogeneous in nature, adolescents with differing rationalizations and distortions may dispute one another's views. Another reason for heterogeneous groups is that it allows increased empathy and support for other group members, and the realization that although there are different types of offenses, all types have a negative impact on the victims.

Although heterogeneous groups have advantages, diversity in the age of group members is not appropriate. Groups should be set up according to age, maturity and development. At times, it is necessary to review the group rules, which should include confidentiality and being respectful.

Orientation Sessions

During the first session, the therapists introduce themselves and have the adolescents give their first names. One should stress the importance of respecting confidentiality and not disclosing either the identity of any other group members, or information from the group to any peers outside of the group. The adolescents should then be informed that everyone is there because they have each engaged in a behavior that is

considered norm violating, inappropriate, and/or illegal. They are informed that what they have each done has hurt other people, and that no sexual offense or inappropriate behavior is “better” or “worse” than another.

The therapist should point out that the group members have committed a variety of types of offense against a variety of victims. In later sessions, the therapist can then ask each group member to provide some general information regarding their offense without giving any victim’s name(s). Such information would include gender of victim, age of victim, relationship to victim, and number of times the offense occurred. By doing so in this order, each member initially sees that they are not alone in the type of behavior in which they have engaged. Each is then likely to be more willing to give a more detailed description of the event(s) when they are asked to do so. It is essential to lead off with an adolescent who is an “admitter,” and who is willing to disclose that he, indeed, engaged in a sexually inappropriate act. He then will serve as a model for disclosure for the other adolescents. It is important to pay attention to which members deny, in part or in whole, their offenses or behavior so that it can be addressed later in future sessions.

It is essential that group cohesiveness be built by fostering mutual understanding and acceptance of group members. Only in conditions of acceptance and understanding will individuals risk expressing and exploring themselves. It is critical that the youth label their behavior but not themselves.

Group Building Exercises

There are a number of activities or exercises that can be used to break the ice, and start to develop cohesion in the group. These activities can help the members feel more

comfortable with one another. It is suggested that at the beginning of the formation of each new group, exercises of this type be employed to foster cohesiveness.

Self-Awareness and Monitoring

It is useful to have the adolescents reflect on their lives in an effort to increase self-awareness. One way this can be accomplished is by writing an autobiographic description of their lives and continuing to record and monitor their behaviors. Thus adolescents can learn to recognize their patterns of behavior and reactions to them. One possible way to start is by writing “events” on one side of the page, and “reactions” to those events on the other.

CHAPTER FIVE

Specific Treatment Modalities

There are different pathways that can lead to an adolescent committing to a sexual offense. One should not assume that sexual motivation underlies every inappropriate sexual act in which an adolescent engages. The majority of adolescents who have engaged in inappropriate sexual behavior do not have paraphilias; thus it is essential that an attempt be made to identify the underlying motivation for the behavior.

The therapist needs to determine whether the behavior is related to an unresolved trauma that the adolescent experienced earlier in his life. Also, it is important to assess whether the adolescent had the intellectual capacity to form the intent to engage in sexual activity that is considered norm violating. Whether anger or frustration is underlying the behavior is also important to evaluate. Once the underlying causes of the behavior can be hypothesized or determined, the different components of treatment can be chosen to help the adolescent change or modify his behavior in the future.

Cognitive Restructuring

In most cases in which adolescents have engaged in norm-violating sexual behaviors, they have developed beliefs that allow him to engage in the norm-violating behavior. Cognitive restructuring is a process of altering these distortions.

During the first cognitive restructuring session, group members are told that they have all said something to themselves that has allowed them to engage in an inappropriate

sexual act. These are rationalizations or cognitive distortions. In order for their behaviors to change, they must also change their attitudes and beliefs about those behaviors. For example, some people drive too fast, even though society has set speed limits. The speeder, however, has beliefs that justify speeding. Group leaders explore how the speeder may justify his actions by saying, “Everyone else is doing it”, “There aren’t any police around right now”, “I probably won’t get caught”, or “I must get to where I’m going in a hurry.”

When the group understands the concept of rationalizations, group leaders ask each adolescent to anonymously write down what he said to himself to allow him to commit his sex offense. The papers are collected, shuffled, and read aloud by group members without identifying the authors.

Informing an adolescent that his cognitions are faulty does not change the cognitions. Adolescents need to understand *why* their cognitions are faulty. Therapists should use the remaining sessions in this section of treatment to confront the group members’ cognitive distortions through role reversal. The therapist should take the role of the sex offender who uses the various cognitive distortions to excuse his behavior. This approach allows the adolescent to articulate another point of view, which increases the likelihood that they will alter their cognitions. It also allows the offender to experience what other people think, without having to be confronted directly. In these sessions, the therapist can role-play a wide range of cognitive distortions. It is best to start with the least threatening distortions, such as those associated with exhibitionism and voyeurism, and work up to specific offenses group members have committed. Usually, adolescents are very critical of distortions other than their own. This helps other group members with that distortion realize the errors in his thinking.

The following are some common cognitive distortions and suggestions for correcting them:

1. If a young child doesn't tell others about having sex with me, it means they really like it and want to keep doing it.

Correction: Children may not resist your sexual advances because they fear you or because they have been taught to obey people older than themselves.

2. If I have sex with a child, the only way I could hurt them is if I used force.

Correction: Adults who were child victims have talked about the resultant emotional problems they have had in later life. The therapist may wish to ask adolescents who were molested as children to describe how they felt when they were victims and what impact that has had on their lives. Typical comments from abuse survivors are:

- a. They didn't fight back because the abuser was older and stronger.
 - b. They didn't tell about the abuse because they thought no one would believe them.
 - c. They didn't tell about the abuse because of fear of further retaliation.
3. If a girl says "no" to my sexual advances, it usually means "yes".

Correction: If a person says "no" to your sexual advances, accept the "no" and don't interpret it to mean "yes". The only consensual sexual behavior is when two peers mutually agree to engage in the behavior.

Managing Inappropriate Urges and Behaviors

Covert Sensitization

Covert sensitization is a cognitive-behavioral technique that is utilized to disrupt the feelings and behaviors, which often precede sexual behavior before engaging in the sexual abuse. It involves teaching the adolescent to associate real life consequences of the inappropriate sexual behavior with the preceding events. This technique is described to adolescents as “Risks and Consequences”.

The major goal of this technique is for the adolescents to be able to identify the precursors to their inappropriate behavior and associate “real life” negative consequences with these precursors. By doing so, whenever they experience a precursor in the future, they will hopefully remember and automatically consider the consequences of their behavior. Therefore the precursors become associated in the adolescent’s mind with the potential negative consequences rather than any previous positive reinforcement. Group members are told that the inappropriate sexual behavior is the final link in a long chain of events, not just an isolated incident that “just happened.” By writing down a chain of events and the feelings accompanying those events, the adolescent can begin to identify the early elements of the inappropriate or illegal sexual act before he gets out of control. The first group session is used to help group members begin construct a covert cycle (starting with the preceding chain of events as described) and to understand why this procedure is important.

The cycle is put together with three separate parts, referred to as part A (the risks), part B (the consequences), and part C (the healthy goal). The adolescent is then taught how to put the three parts together in a cycle and how to rehearse them in a way that helps them tie the inappropriate sexual behavior with the consequences in their own mind. By rehearsing this correctly and repeatedly, the adolescent begins to automatically attach these

different parts in their own mind so that they can take control of and decrease future inappropriate sexual behaviors by pairing consequences with events that lead up to inappropriate behaviors before they even occur.

The therapist can explain the first part (part A) of the procedure to the group in the following way:

“Prior to committing the sexual crime for which you are here, each one of you had thoughts or fantasies about your victim or about engaging in the wrongful act that you did. In other words, in all probability the wrongful sexual behavior (or crime) did not ‘just happen ’as many of you say it did. In reality, we usually think about everything we do before we do it, even if it is only a few minutes before. What we are going to do now is to try to determine for each of you what you were doing and feeling before you committed the act, because in the future, those behaviors and feelings may be a signal to you that you are at risk to commit another offense.”

The therapist can then help the adolescents construct the chain of events and have him write them down on paper in the order that they can or did happen. This chain of events represents the risky situations that occur before the inappropriate sexual act happens. When these situations reoccur, the adolescent is in danger of the chain proceeding once again to the end, leading to recidivism.

The therapist then explains the second part (part B) of the procedure to the group as follows:

“We want you to think about and list the consequences of committing the inappropriate sexual act. For each of you, this will be different. For some of you, the worst consequence may not have actually happened, but might be feared (such

as juvenile detention). It is important to list things that happened, as well as things that might happen if you continue to engage in this behavior.”

Before going on, the therapist should make sure that each group member has a clear picture of what parts A and B comprise. The therapist then tells group that the homework relative to these sessions involves making audiotapes each week at home or in the therapist’s office in a private room. Each tape should be approximately 15 minutes long and consist of the following:

1. Part A (the risks or chain of events) is read out loud onto the audiotape, usually lasting one to two minutes long.
2. Part B (the consequences) proceeds with the adolescent choosing one of the listed consequences and reading it out aloud onto the tape. This may last less than a minute, although more detailed and well-developed consequences are recommended and may take longer.
3. Group members are then instructed to alternate between parts A and B for 15 minutes total. (For some youth, 15 minutes is too long and a lesser amount of time needs to be assigned.) Each time they get to part B, they should chose a different consequence that is on their list, giving variability and helping them realize that there are multiple consequences to the act in which they engaged.

At this point, the therapist should play a sample tape to the group to show them how the procedure is conducted. Then each subject should write down the scenes he is going to use for the first homework session and the therapist should check each. An example first tape might read:

Part A (risks)

“I get home from school and my mother is not there. No one is home. I feel lonely and unloved. I’m bored. I don’t know what to do with myself. I decide to go outside. I leave my house and walk to the park. I see a young boy alone like me and say hello to him. I ask him if he’d like to walk with me. He says okay and we walk towards the bushes...”

“SWITCH”

Part B (consequence)

“I’m at home having dinner with my mom and there is a knock on the door. I hear a policeman saying to her, ‘Your son molested a young boy and we have to bring him down to the police station for questioning.’ I hear her saying: ‘Not my son.’ He’s a good boy.’ I feel humiliated, embarrassed, ashamed, and scared. The neighbors are opening their doors. My mother is crying and saying to me, ‘You didn’t do this, did you? The policeman is putting handcuffs on me...’”

“SWITCH”

The cycle continues switching back and forth between part A and part B. This should continue for about 15 minutes; the cycle should always end with a consequence, not the risk. When the therapist is sure that each group member understands the procedure, he or she then instructs the group to add part C, the healthy goal, to the end of the tape.

The healthy goal is when the adolescent is asked to spend about one minute talking about something pleasant that makes him feel good about his own future, because he will not get into trouble again. In other words, they are asked to describe where they visualize themselves in the future, and how they would feel about themselves and their life situation if they never again engaged in an inappropriate sexual behavior. For example, an

adolescent might say, “I am on a date with my girlfriend. I’m so happy I can be with her because I’ve changed my behavior. I’m continuing to work on my problem and exercising control.” The healthy goal serves to remove the aversive consequences, and acquires reinforcing properties of appropriate social interactions. The group members should take their written scripts with them and record a 15-minute tape during the time allotted for this during the week. . The tape(s) can then be returned to the therapist the next week and spot-checked to make sure they were completed appropriately.

If a client does not read or write he should remember what to say on the tape. If not, the therapist should be present when he makes his first tape individually in order to insure that he makes the tape correctly. What if the adolescent says he had no thought before the crime- it just happened? This is common with adolescents. In this case, the therapist tells him to recount all of the events, including feelings, on the entire day of the crime.

For example, he may have gotten yelled at in school, been rejected by a peer, and so on.

In subsequent sessions, each boy’s tape should be played during the group. The therapist and the group then critique them and feedback is given to each subject. A few hints that will make it work the best are as follow:

1. It is best to describe all scenes in the present tense as if they are happening “right now.” This helps reduce denial and also helps the adolescent get in touch with his feelings.
2. None of the “risk” scenes should involve actual sexual fantasy or sexual behavior. That is too late in the chain, for if the adolescent waits until the sexual behavior occurs, it will be too late to stop it.

3. If adolescents do not do the homework assignments, determine what the impediments are and remind them what their goals are.
4. If there are various consequence scenes, all should be used. However, the most aversive should be used first.

Satiation Therapy

Historically, another treatment technique that has been used with adults and which the authors have applied to adolescents is termed satiation. This approach attempts to modify an individual's inappropriate sexual arousal pattern. For adolescents who have engaged in an inappropriate sex act, it needs to be determined if they have developed an inappropriate or even paraphilic pattern of arousal. For those who have not, certain parts of treatment may not be necessary. However, for those who have, specific cognitive and behavioral techniques have been shown to be helpful in changing or at least controlling the arousal pattern (J. Hunter, J.A. & Goodwin, 1992). Satiation therapy is one such technique that can be used to help the adolescent alter deviant patterns of arousal.

Satiation therapy is a technique that basically "floods" the offender with his own atypical or inappropriate fantasies, with the aim of reducing the fantasies. (W. Marshall, 1979) concluded that the concept of boredom, when associated with deviant arousal, has a significant impact in reducing the participant's atypical sexual interests. Marshall also noted that repeated exposure to deviant stimuli might result in the exhaustion of the participant's response. In other words, if the youngster becomes bored with the fantasies that are precursor to the abusive or inappropriate behavior, perhaps it will lower the chance that they will actually engage in the behavior.

This therapeutic technique teaches the adolescent how to use norm-violating (inappropriate) fantasies in a repetitive manner to the point of satiating or boring himself with the very same fantasies to which he previously became aroused. Thus, it makes the inappropriate fantasy that is presently arousing become boring and aversive. Satiation therapy can be conducted in a clinical laboratory setting.

The satiation procedure, as described in the literature, has been used with adults with a masturbatory component. The adult is asked to masturbate to orgasm as quickly as possible in the privacy of his own home, fantasizing about age appropriate consensual sexual fantasies. He is then asked to continue masturbating post-climax to inappropriate or deviant sexual thoughts to the point that these inappropriate fantasies become boring or no longer appealing. Doing so while masturbating takes advantage of pairing appropriate sexual thoughts with sexual excitement and orgasm, and pairing inappropriate sexual thoughts with the post-climax refractory period. This can lead to decreased inappropriate sexual arousal.

This procedure has also been used with adolescents. However, the authors have found that many adolescents report that they do not masturbate or that it may be against their personal, family, or religious beliefs. (M.S Kaplan, Morales, & Becker, 1993) modified this technique for use with an adolescent population utilizing only the verbal component. It appeared to be successful in many cases. Only if this verbal-only form of satiation is not successful and an adolescent appears to be an appropriate candidate for masturbatory satiation treatment, might a clinician suggest this treatment. Verbal satiation is recommended for some adolescents who have difficulty in decreasing a pattern of inappropriate sexual fantasies or behaviors, but many youth do not necessarily need this

component of treatment. These cases should be carefully selected based on their individual treatment plan.

First, clients are instructed in exactly how to implement the treatment. It has been the authors' experience that the majority of adolescents referred for treatment do evidence arousal to age appropriate peers. Only a small percentage has reported no arousal to individuals their own age. The goal is to reinforce arousal to age appropriate peers, and to explain that it is the atypical arousal patterns that they are learning to control.

There are two parts to each session, appropriate fantasy and inappropriate fantasy. The adolescent is instructed to imagine himself for a period of two minutes being with an appropriate person within two years of his own age whom he finds attractive and would like to get to know (the appropriate fantasy portion). It is important that the adolescent describe someone who potentially is available to him as a partner. The adolescent is to imagine a pleasant social exchange, and not to objectify the person or to imagine any aggressive or coercive action, sexually or physically. The adolescent should then fantasize about talking to that person and gradually becoming more intimate. The fantasy should also include the partner caring about the adolescent. Also, each time the exercise is done, the consensual, age-appropriate fantasy should be varied so that it does not become boring.

After two minutes of verbalizing the appropriate fantasy, the adolescent is instructed to interrupt the prior thought and to begin repeating, over and over, the nature of his inappropriate fantasy or the inappropriate sexual behavior in which he has engaged (the second part). This should be done out loud, because in repeating the same fantasy or act silently to oneself one could get distracted. The item to be repeated is not long, and summarizes the essence of the sexual act, honing in on the inappropriate part of the act. To

be effective, the adolescent should stick with one simple phrase. For example, a 17-year-old boy who molested a young girl who was not related to him is told to repeat over and over again, "I am touching the genitals of a little girl, I am touching the genitals of a little girl," and so forth continuing to repeat the same simple phrase. The same phrase is repeated for up to 28 minutes, making the exercise take a full half-hour each time it is attempted. Some adolescents may find that the phrase takes on a very negative feel, or may become boring to them in less time, but the longer it is repeated, the more likely it is to be effective. This exercise is then repeated many times during the following weeks, until the scenario loses its sexual excitement.

The adolescent should not be given statements that are strongly sexually suggestive, and should not be allowed to verbalize behaviors in which he has not already engaged. When this is done in the clinic setting for the first time, the therapist should listen to the entire procedure. This assures that they are doing it correctly. If he stops verbalizing, he is told to continue repeating the fantasy over and over again. If he gets bored, he can be praised, since becoming bored means that the treatment is working. In the end, it is recommended that the adolescent complete a minimum of eight sessions. If the adolescent is showing a considerable amount of arousal at the end of eight half-hour satiation sessions, he needs to continue sessions until that arousal decreases.

Once the participant has demonstrated the technique correctly in front of the therapist, he can continue the exercise at home until he achieves adequate boredom, or for the eight minimum sessions. In order to assure that he is doing the assignment, he should audiotape the sessions so that they can be spot-checked later on by the therapist. It is important that the therapist erase the tapes or digital recording so that the person does not

just keep turning in the same tape, attempting to fool the clinician. In one situation, an adolescent brought in a tape, but the staff members were busy and failed to erase it. The adolescent took it home and made five copies of that one tape, and brought it in for the remainder of his sessions. Luckily, it was recognized!

Each adolescent completes a rating form at the end of each session. This helps the adolescent and the therapist get feedback about the session and about how treatment is progressing. He is asked to rate his fantasies (both appropriate and inappropriate) separately on a 10-point scale, where zero is not sexually arousing and ten is extremely sexually arousing. He also rates his fantasies as to the extent of its boredom using the same scales. This insures that the therapist is identifying those who are experiencing difficulty so that they can be given extra attention.

In private practice, if an adolescent is not motivated and does not comply with homework tapes, the therapist can have the adolescent do the very same procedure while he is seated in the therapist's office and can have the adolescent speak into a tape recorder. The therapist can remain in the room or leave the room. The therapist can then spot-check the tape later on as listening to the full session can be tedious, and one's time is more valuable doing other things.

In general, what is to be satiated is each one of the inappropriate sexual behaviors in which the adolescent has engaged, as well as each deviant fantasy that he has had. Eight half-hour sessions are needed for each inappropriate behavior and/or each deviant fantasy. It is important that each be satiated one at a time. The reason for this is that if he changes fantasies during the session, for example from voyeurism to inappropriate contact with children, and then back to voyeurism, it will not become boring and the exercise will not

work. In other words, the inappropriate fantasy will be maintained. Therefore, the adolescent should spend eight sessions on the voyeurism fantasy phrase only, and then, once it has become boring, spend eight new sessions on the inappropriate contact with children phrase.

Below are examples of satiation statements that the authors have used for adolescents who have committed molestation or rape. In order to choose the phrase for a particular adolescent to use, every effort should be made to elicit from the adolescent any inappropriate sexual thoughts he may have. Because some adolescents deny fantasy, the therapist in those cases must supply the phrase for them. One way to get ideas for phrases is to look up how the adolescent described the deviant act during his intake interview.

Sample phrases for satiation

In targeting situations of child molestation, sample phrased include:

1. I'm forcing this little girl to touch me.
2. I'm about to touch this little girl.
3. I'm telling this little girl to take off her clothes.

In targeting situations of rape, sample phrases include:

1. I'm holding this woman down.
2. I'm telling this woman to take off her clothes.
3. I want to rape this woman.

These are merely suggestions. Whenever possible, the adolescent's own language or thoughts used during the offense should be used.

The author and colleagues (Kaplan, et al., 1993) evaluated the impact of verbal satiation by comparing pre- and post- physiologic assessments. Ten adolescent males were

selected who had completed eight individual 30-minute verbal satiation sessions within a time frame of no more than 13 weeks. Each of the subjects had admitted their offense. The study's findings indicated that there was an overall decrease in the response to offense-related sexual stimuli in 9 out of the 10 subjects assessed. However, only 4 out of 10 subjects showed phallometric response to the deviant stimuli that were below the established criteria of 20% of full arousal upon completion of the initial treatment component. One subject demonstrated an increase in arousal to deviant stimuli. The two youngest adolescents appeared to be less responsive to this treatment approach than older adolescents.

Given these and other preliminary findings, several points need to be addressed. First, subjects who are younger may be more difficult to satiate. Second, it may be more difficult to decrease arousal to deviant stimuli when the victim and the offender are close in age, particularly because the subject must discriminate that violence (not the age) is inappropriate. Third, it appears from these preliminary data that verbal satiation is effective in reducing inappropriate arousal with some adolescent offenders; eight sessions may be sufficient for some, but not for others.

One should keep in mind that some see the technique of satiation, even when just done verbally, to be controversial in adolescent populations (Hunter and Goodwin, 1992). We therapists should feel comfortable with the techniques that they choose to use with their clients. It is recommended that this procedure only be used with those youth who have been identified as having a paraphilic arousal pattern.

Anger Control

The purpose of this module is to assist adolescents in dealing with negative emotions in ways that will be socially acceptable and constructive. Many adolescents have learned from family, community, peers, and media that aggressive and angry responses are a means of problem solving. Many adolescents feel that when they are angry, the only choice they have is to react in an aggressive manner. It is explained that the more in control of one's feelings an individual is, the more powerful he is.

In the first session, the therapist reviews the definitions of being passive, assertive and aggressive. *Assertive Behavior* is thinking first of oneself while taking others into account when expressing feelings and opinions. This is a form of positive behavior that values others while demonstrating respect for oneself. *Passive behavior* is putting others before oneself. This leads to denying oneself and one's own personal feelings. *Aggressive Behavior* is thinking only of oneself and hurting others. The therapist ascertains the words group members use for these in their lives.

The clinician should emphasize that having more control does not mean that the adolescents are "wimps." In fact, by having control over their reactions to others, they increase their personal power.

The therapist can ask, "Have any of you been upset about something and then taken it out on someone else?" An example might be failing a test at school, coming home, and then kicking the dog. It should be explained that many times people abuse others because they are feeling frustrated. The group should brainstorm what other feelings might come out as anger. Examples that can be used include being made fun of or getting yelled at. The group members then discuss the underlying emotions, such as sadness or humiliation.

Situations can next be presented where the “other guy” is trying to make the adolescent react and set him up, because he feels like fighting. He is trying to control the adolescent by making him angry enough so that he becomes aggressive. They are then asked to think about how else they can react – what can they do? One may have to give suggestions. If they say, “fight,” as an answer, have them think about who is in control of the situation. The first trigger is the other person setting the adolescent up. The second trigger is what one tells himself.

The group members are taught to deal with these situations in a more appropriate way. They could tell themselves, “He’d like me to get really angry and punch him – well, I’m not going to do what he wants.” Clients should be encouraged to come up with these statements on their own, and the therapist can give a few examples if needed. The following are some positive self-disclosure statements:

1. Stay calm and relax.
2. I’m in control of this situation.
3. I don’t need to prove anything to him.
4. It’s not worth it to get angry.

In one of the sessions, various anger control techniques are taught to reduce anger. The therapist lets group members practice them in role-plays of real life situations. The concept of “anger reducers” can be taught. The group members are asked to discuss ways to reduce anger.

The therapist should next discuss the consequences of these anger reducers. For example, violence or abuse toward others may decrease anger in the short term, but may

not work in the long term. It is important to talk about why it is necessary to find ways to reduce anger so that one feels better, and does not hurt himself and others.

The group can be taught the technique of thought stopping, which is inhibiting a negative thought by saying, “stop”, and then immediately substituting a thought that contradicts the negative thought. An example is when a guy comes up and makes an obscene gesture. The person’s first thought may be, “I’m going to punch that guy.” However, they need to, instead, say something like “Slow down,” “Chill out,” “Take it easy,” “Take a deep breath,” or “Ignore it.”

It is suggested that other anger reduction techniques that should be used along with thought stoppers include:

1. Deep breathing, taking a few slow, deep breaths to reduce tension
2. Counting backwards silently from 15 to 1
3. Imagining peaceful scenes
4. Thinking of consequences

Adolescents should be encouraged to use self-talk such as, “If I do this now, what will happen to me later?” It is important to then discuss short-term versus long-term consequences. The short-term consequences may not be serious, but the long-term consequences may be quite severe (i.e. getting arrested and going to jail).

The clinician can have group members practice anger control skills by role-playing real life situations. A conflict situation is described to the group. The main actor should use one or more anger control techniques. The scene should never end with aggression. After the scene, the group can ask the main actor to describe the anger technique he used, and the group then discusses the effectiveness of that technique and offers suggestions for other

useful techniques. Each group member should have a chance to be the main actor. It is important to use real life situations that group members are currently facing.

One should let the group members know that the purpose of these sessions is to give them the skills to avoid aggression and feel good about themselves. Although it is not always possible to avoid fighting, they now have alternatives if they so choose. Remind them that there are some situations in which a person may elect to be aggressive to protect themselves or others. What matters is for group members to think about the consequences of their own actions, to know their options, and to choose what response they are going to give to a situation. People cannot always choose the situation. Their power is in choosing their response.

The same approach as described above should be used with any other feeling (e.g., loneliness, depression, etc.) the adolescent has difficulty managing and which may serve as a precursor to him engaging in norm-violating behaviors.

Psychosocial Skills

Some adolescent sex offenders have few skills in establishing and maintaining close friendships. Because of their deficits in the requisite skills to relate to peers, some adolescent sex offenders will socialize with younger children and sexualize that relationship. Consequently, it is important that adolescents learn age-appropriate social-interactive skills. There are four essential methods to teaching social skills: 1) modeling, 2) role-playing, 3) feedback, and 4) reinforcement. These will be discussed here.

Modeling is most effectively done in a group setting so that group members can imitate the therapist. The therapist takes one skill at a time and demonstrates that skill.

Specific skills will be described below. When modeling, the therapist should pretend he or she is the same age, the same sex, and has the same characteristics as the group members. Modeling should also reflect the social situations which group members would be likely to encounter in their daily lives.

Role-playing is practice for future real life situations. After the therapist models a skill, each group member should have a chance to role play the skill being displayed. Therapists can help pick the situations that can be either present or future oriented. There is usually a main actor and a co-actor for each role-play. The main purpose of role-play is to enact the skill being taught and to practice it.

Feedback is a crucial process to social skill learning. Feedback is information given to the role-player(s) immediately following their scene, to help them find out if they correctly enacted the skill being practiced. Everyone in the group should participate, and then the therapist should comment. Feedback should be positive and encouraging.

Reinforcement is also very important when giving feedback. When a group member is using a skill correctly, he should always be reinforced. The co-actor should also be reinforced for being helpful. Reinforcement can be praise of particular aspects of the role-play. There should not be negative comments if a skill is not enacted correctly. The group members should give positive comments and suggestions. The atmosphere should always be kept positive and encouraging.

Group leaders need to remind the adolescents about guidelines for good listening. In order to do so, they should:

1. Maintain eye contact.
2. Avoid thinking of a reply while the other person is still talking.

3. Avoid jumping to conclusions.
4. Clarify thoughts and feelings for the other person.
5. Pay attention to what the other person is saying.
6. Do not interrupt.
7. Nod, say, “uh-huh,” or say “go on,” to encourage the other person to continue.

Conversational skills that can be taught using the above strategies include:

1. Introducing oneself
2. Starting a conversation
3. Keeping a conversation going (listening, acknowledging what someone is saying)
4. Talking about oneself
5. Finding out about others
6. Joining in a group discussion
7. Enjoying a conversation and reading signals

Next, the therapist can work on non-verbal communication. Non-verbal behavior communicates a great deal. This is, of course, communicated through expressions on one’s face and movements of one’s body. Cultural factors are very important in using non-verbal communication, because different cultures have different norms. For example, in some cultures, too much eye contact can be an aggressive act. There are also many individual variations that are to be taken into account. One can at least discuss general guidelines as outlined:

1. Facial expression. The first exercises have to do with facial expressions. Group members are told to portray a different emotion facially, and the group must identify the expression.
2. Eye contact. Group members role-play making appropriate eye contact, as well as aggressive and dominant (staring) or passive (looking down) eye contact, while others identify the emotion being shown by the role player.
3. Proximity/personal distance. It is important to teach group members about “personal space,” because no matter what conversation is taking place, if an adolescent is standing too close, the other person will feel uncomfortable. An exercise that can be used to practice appropriate proximity is as follows. Divide the group into pairs. One partner stands still, while the other advances and stops a comfortable distance away. He then checks out with his partner whether the distance is too near, too far, or just right and makes adjustments as necessary. Reverse roles and repeat.
4. Affect/tone. The emotional tone seen in one’s body movements is a very important signal to the other person. This can be expressed by posture, where hands are kept, or how we walk and sit. Hand gestures such as shaking a fist, scratching parts of the body, or other habits may also communicate things to people.

Next, one can work on such things as expressing feelings, expressing embarrassment, apologizing, dealing with teasing, being left out, and dealing with peer pressure. During these sessions, group members role-play situations where they must pay close attention to the key social skill variables. In order to facilitate role-playing, it is

suggested that the following method be used. First, anonymous statements are to be put on index cards by the group members. They are then asked to select a card, one at a time, and role-play the situation. Later, other group members can join in the discussion and voice opinions. This gives each member an opportunity to speak and voice an opinion. It is important that they learn from each other's role-play. Group leaders can solicit suggestions of situations the adolescents have experienced and incorporate them in future group sessions. Examples of social skills cards are:

1. I'm a 15-year-old boy. I met a 14-year-old girl at a party and we talked for five minutes. I couldn't tell if she liked me. How could I have known?
2. Tony and his friends are at a party. A girl asks him to dance and lets him know he could come to her house and have sex with her. His friends think he should definitely do it. What should he do?
3. During a free period at school, I introduced myself to a 14-year-old girl I've seen around. While talking, I noticed she stepped back from me. Does this mean she doesn't like me?
4. What would you do if your good friend, who is a boy, tried to kiss you?

It is recommended to show a film about date rape. After the film, hold a discussion with the group on how more effective communication could have helped to prevent the situation. The group should be encouraged to express their feelings about this issue and could discuss cognitive distortions, issue of anger, or social skill problems that could lead to date rape.

Healthy Sexuality and Values Clarification

Results of one study (Kaplan, Becker, & Tenke, 1991) suggest that sexual attitudes and sexual knowledge can be improved in a short (i.e. four sessions) course. The purpose of this component of therapy is to help adolescents who commit sex offenses better understand themselves by focusing on social, sexual, and health issues currently facing them. The sessions are designed to address a number of goals. These include: 1) increasing their knowledge about adolescent sexual development and sexual anatomy and physiology; 2) dispelling sexual myths; 3) learning ways to prevent unwanted pregnancy and sexually transmitted diseases; 4) learning about AIDS and non-curable forms of hepatitis; 5) becoming more aware of their own attitudes and feelings concerning sexuality; and 6) clarifying their own values about sexuality.

In order for adolescents to explore and clarify their attitudes about sexuality, the atmosphere must be one of openness. In each session, group members should be encouraged to ask questions throughout by writing down anonymous questions about sexuality. They should be encouraged to write any questions, comments, or feelings they may want the therapist and group to address. It should be made clear that there is no such thing as a dumb question. Some adolescents with pressing questions may feel uncomfortable if others appear to have no questions; therefore each group member must write something down. Group leaders may want to consult with another clinician or research the answers to questions they do not know, and then provide that information to the group in the following session.

Sexual Myths: One approach to addressing sexual myths involves having each group member select an index card, which has either a sexual myth or a sexual truth on it. He reads it aloud and then says whether he thinks it is a myth or a truth. After he answers,

others can also respond. Everyone gets a turn responding to a card. Allowing a few minutes for discussion of each myth is important. If someone's response is made fun of, remind the class to be sensitive.

The following is a list of myths and facts that can be used. It is suggested that the therapist use myths that have been mentioned in prior group sessions, or ones that are heard locally.

1. Once a boy gets an erection, he must ejaculate or he will get sick.
2. Girls can't get pregnant while they are menstruating (having their period).
3. Boys enjoy sex more than girls do.

Anatomy and Physiology: Many pamphlets and videos on this subject are available from local health agencies.

Birth Control, Pregnancy Prevention, and Parenthood: *A pregnancy prevention* section is of paramount importance. An icebreaker exercise can be used in any section. For example, this area of treatment can begin with a discussion of "why do teens have sex?" The group can be divided into small groups, and make it a contest to see which of the two groups can come up with the longest list of reasons for having sex. The therapist then explains that there are many different reasons and many different meanings for sex, and it varies at different times and in different situations. The therapist then writes answers on the board. Suggestions may be:

1. to show love
2. to give or receive physical pleasure
3. to keep a boy/girlfriend or make a commitment
4. to have children

When all the reasons are on the board, a discussion should be held on values about sex.

The therapist can then go on to a discussion of *becoming a parent*.

Some teenage fathers do not accept responsibility for their involvement. Talking about each parent's responsibilities and discussing both teenagers' roles is important.

Adolescents also need to understand that there are social service, religious, medical, educational, psychological, and psychiatric help for these situations. Encouraging parental involvement as soon as possible in these situations is important.

Birth control methods are important to discuss. Various birth control methods and factors affecting personal choice of a contraceptive should be discussed. Resources from local agencies can be used to teach this section.

Personal values and beliefs regarding the use of birth control and protection from sexually transmitted diseases should also be discussed. The therapist can explain that they will read several statements which group members should think about and then vote with thumbs up if they agree, thumbs down if they disagree, and arms folded if they are not sure. Ask volunteers to explain their reasons for their opinions. Sample statements include:

1. The boy should be responsible for birth control.
2. A girl who uses birth control is more likely to have sex with different boys.

Group leaders should pay attention to the other issues that may have come up in prior discussions that address values and decisions, and add them to the list. Discussion should be encouraged and distortions challenged.

Sexually Transmitted Diseases: A discussion on *sexually transmitted diseases* is the next logical section. It can be presented in lecture format, with handouts and use of

instructional videos, if possible. Topics usually covered are symptoms, diagnosis, treatment and prevention of sexually transmitted diseases.

Values Clarification: *Values clarification* is an important topic that needs to be addressed throughout treatment. However, it is important to spend several sessions solely on this topic. This area can be difficult since each person, including the therapist, has his or her own personal views and beliefs. It is important to accept diverse opinions, but only when the individual's expressed opinion is not consistent with the law or accepted by society in general should group members be challenged and redirected. The following are examples of how one can examine values.

1. Each of the following (and others as deemed appropriate) should be examined for a few minutes or so by the group:
 - a. What are the most important things in a relationship?
 - b. How do you decide whether or not to have sex?
 - c. Do you want to marry a virgin? What makes a girl a slut? If your best friend told you he was gay, how would you react?
2. Although the issue of homosexuality has likely been addressed in some of the prior discussions, it is recommended to spend at least one session addressing *homophobia*. The group members should do the following:
 - a. explore their feelings about homosexuality
 - b. gain new insights and understanding about the concerns of gay people
 - c. understand a viewpoint other than their own
 - d. identify stereotyped attitudes toward homosexuals

Homosexuality is usually difficult to discuss, particularly in regard to one's own feelings. Structured role-playing allows adolescents to act out feelings without having them identified as such. The authors have used an exercise adapted by (Morrison & PRICE, 1974), p. 162). Group leaders should explain to students that the following exercise is designed to explore *opinions* about a variety of sexual issues. Explain that it involves volunteers who will be asked to agree or disagree with various statements. Emphasize that there are no right or wrong answers, only opinions. Everyone has the right to take a turn expressing his own opinion, as long as no one is put down for having a different opinion.

Sample statements are as follows:

- a. A boy who has not had sex by the time he is 17 is weird.
- e. It is all right for boys to have multiple sexual partners.
- f. If a girl gets pregnant, it is her problem to deal with.

Healthy Sexuality

Throughout all of the sessions, it is recommended that the group discuss the topic of *healthy sexuality and sexual attitudes* within responsible consensual relationships. During these specific sessions,

The therapists should make up scenes and place them on cards lying face down on the table. If any of the group members want to write down situations to be discussed during the session, they can do so and give them to the therapist beforehand. The format used is "case studies" of imaginary individuals who have sexual concerns. Each of the group members is asked to pick a card and then one at a time they are asked to read it aloud, think about it, and tell the group any advice that they would give to the persons described on the

card. After they have given their advice, the entire group is at liberty to discuss what they feel would be the best advice for this person. An example would be:

You live in a group home with several other guys. In a recent late-night conversation, the topic was sexual experience. Everyone else spoke of his or her various experiences indicating non-virginity. You are still a virgin and so could contribute nothing to the talk. Later, your roommate begins to tease you about this. You really feel out of it now. What would you say to him?

Relationships and Communicating Feelings

Another healthy sexuality session could deal with *relationships and communicating feelings*. There are a few exercises that are recommended. The first exercise examines the ideal relationship. One can ask each group member to take out a sheet of paper and write a description of his ideal romantic relationship. It should include details such as what the person would be like, how they would spend their time, and how they would treat each other. It is important to remind the group members that this is supposed to be a description of what they would like, not necessarily what they think is realistic. Discussion points could include:

1. What qualities in a relationship were mentioned most often? Why?
2. In order to have the ideal fantasy relationship, what would they be willing to compromise?

Next, one can have the group members rate the following qualities in a partner in order of importance: appearance, access to money, moral values (drugs, sex), his or her

friends, religion, race, family background, intelligence, reputation (sports, crime), sense of humor, fun-loving, education, sensitivity.

The therapist should also lead a discussion that has to do with *defining what love is*. During adolescence and adulthood, people usually look for someone to love.

Understanding what constitutes love, however, is a difficult task. The therapist explains to the group that three types of relationships will be discussed: 1) friendship, 2) infatuation, and 3) love. One can then write the three words on the board. The therapist can have the group members create definitions for each word. This continues with exploring the differences between “infatuation” or “falling in love,” and the hard work of being in love (deciding on things you want to do together and establishing common goals, values, and friends). Discussion points include:

1. How do group members know whether they are interested in someone as a friend or as a romantic partner?
2. How can one tell if they are really in love?
3. Can two people love each other without having sex?

Empathy Enhancement

The goal of this component of therapy is to help adolescents gain a true understanding of the negative impact that their abusive behavior has had on their victims. The goal is a difficult one to achieve for several reasons. First, the development of the ability to empathize with others is a lengthy process that usually begins in childhood and cannot be fully achieved in a short period of time. However, feeling empathy is a skill that

can be gained slowly by learning to put oneself inside another person's situation, and sharing the world that she or he sees and feels.

Group leaders must be aware of encouraging empathy throughout the entire therapy process regardless of which module is being conducted. Group members can learn empathy by watching group leaders interact in a respectful and empathic manner, thereby modeling responding with sensitivity. The group format itself encourages empathy in that each individual is expected to understand and help other group members, and to show concern for others. All this aids in developing empathy. .

The victim empathy component consists of several steps. It is recommended to start with *learning what empathy means*. The authors define the word "empathy" as understanding how another person feels, and seeing the world from another person's point of view. One should explain why it is important to be empathic in order to have a good relationship with others and resolve conflicts.

1. *Writing letters to victims* is a frequently used exercise to help the adolescent gain and demonstrate empathy. These letters are not mailed, but rather are read aloud in the group. Group members are encouraged to express their true feelings in the letter. One can choose to have the letters identified by the author so the other group members can give comment, challenge or praise. Another way to handle the situation is to not identify the author, reading them anonymously. Usually, approximately half of the group members express remorse and some empathy for their victims. The other members' letters typically express anger at or love for their victims.

When all the letters have been read, the therapist can begin talking about which letters expressed empathy for what the victim experienced. “I will get upset.”

These letters can be used diagnostically to determine how a particular adolescent is progressing in therapy. Sometimes, a letter may be written earlier in the treatment process and then another letter written later on, showing improvement and progress. The goals should be to have the adolescent do the following:

1. acknowledge responsibility for his behavior
2. apologize for the impact his behavior has had on the victim and his or her family
3. acknowledge the feelings of the victim; for example, state how the victim may have felt at the time of the abuse

Therapists should review the letters with the adolescent individually. These letters are not meant to be sent to victims, but to give insight to the therapists regarding the adolescent’s progress as to whether they are remorseful, angry, or inappropriate.

It is recommended that the group *watch a film or video about sexual abuse*, to help the group members understand sexual abuse from the victim’s point of view. The goal is to help group members learn what victims experience, identify the feelings of victims, and to help them recognize the consequences to the victims of sex abuse. Often there are television programs that deal with the issue of sexual abuse that can be assigned or purchased from a local television station. One might contact the Safer Society Program, as they have good suggestions for these types of materials.

During this component of treatment, those youth who have been crime victims or victims of physical, emotional, or sexual trauma can be invited to discuss the impact that

such trauma had on them. The therapist should not identify youth with trauma histories, but only invite youth who feel comfortable sharing to self-identify. One can then discuss their feelings of powerlessness and how they coped with these feelings. Because of painful feelings that these sessions bring up, the authors usually suggest individual sessions in addition to group for adolescents who need to work on victimization issues. If there are no staff who have expertise in this area, referral to a victim therapist is recommended.

Trauma Issues

As previously mentioned, given that many of youth will present with histories of maltreatment including neglect, emotional, physical, and sexual abuse, trauma issues should be addressed in either individual therapy or a separate trauma group.

Relapse Prevention

It is important for the adolescent to realize that in order for him to have a better future and for the community to be safe, he needs to learn to manage his behavior and to be aware of certain situations, which might present a risk to him and the community. The adolescent is asked to develop a list of goals for the future and positive behaviors he wishes to engage in. Such a list might include finishing school, having girlfriends/boyfriends, returning to family members, and being off probation. Youth are asked to develop a list of situations that may serve as an impediment to their attaining their goals, such as using drugs or alcohol, engaging in fantasies that could lead to illegal behavior, placing himself in situations that have led to sexually inappropriate behavior in the past.

Therapists should encourage each adolescent to try to remember what kind of troubles and what kind of feelings he was having in his life when he did what brought him into treatment. This is called “stress,” and when an individual is under stress and does not realize it, he may do things that will get him into trouble. If he is in this kind of risk situation, he can remember that he does not have to handle it alone. Rather, he should call his therapist, talk to his parents, or seek out another qualified counselor.

Somewhere in this module, the therapist can discuss alternative actions when in a risky situation. This session(s) explores distractions from urges and fantasies. Group members should each make a list of these alternative actions. One example is using a thought stopping technique. In fact, they can be taught to immediately say the word “Stop” out loud (if alone) or mentally (if with others), when an inappropriate sexual urge develops. The adolescent can also generate and always carry a list of competing positive responses. Examples would include: call a friend, clean his room, house, etc., listening to music, talking to a trusted adult, or calling his therapist.

Family Therapy

During the assessment of a juvenile offender, there is very often denial and minimization by the family members. They are often in crisis and need intervention.

Parental involvement is important for support for the juveniles’ treatment and change, and can help maintain treatment gains rather than sabotage them. Family members can help reduce risky situations for the juvenile. Adolescent’s families’ participation may need to be mandated by the criminal justice system, and consequently, therapists should expect to meet with resistance.

Parents may feel ashamed, guilty and embarrassed that their son has committed a sexual crime. They may blame themselves, or have the expectation that the therapist will blame them. Parents should be informed that. The major emphasis is to ensure that he does not act out sexually again, and that the therapists need the assistance of the parents to ensure that therapy gains are maintained. Readers are referred to (Thomas, 1991) for an in-depth description of the components of family therapy and to Stop It Now! (Henry & Tabachnick, 2002; Rice, 2009; "Stop it now!" 2011) for additional information on the issue of children with sexual behavior problems.

CHAPTER SIX

Summary & Conclusions

In general, sex offenders do not initiate treatment, are not highly motivated to change, and evidence minimization, denial, resistance and non-compliance. In working with this population, the clinician must keep in mind that there are two important goals: helping the client control his behavior and the safety of the community. Overcoming these challenges can be frustrating for some, but satisfying and even rewarding for others. Therefore, it is important that the clinician have an understanding of the adolescent's lack of motivation and the resistance. (Blanchard, 1995) discusses such issues in his book *The Difficult Connection: The Therapeutic Relationship in sex Offender Treatment*.

It is recommended that mental health professionals who work with juvenile sex offenders partner with victim organizations with their community and with legal authorities in the criminal justice system to insure that treatment resources are know and that juvenile offenders are compliant with treatment.

A survey conducted by one of the authors of juveniles seen at an inner-city clinic revealed that only 1% of participants were self-motivated to receive treatment, but the majority were motivated by their probation officers or other members of the juvenile justice system. It was observed that by being involved a probation officer demonstrates to the adolescent that the community takes his behavior very seriously.

Undeniably, this work can be frustrating at times. However, there are rewards to working with this population. Among them is the knowledge that this work will protect

potential victims from experiencing future sexual molestation or abuse by our clients.

Additionally, helping adolescent offenders change their maladaptive sexual behaviors, as well as helping them learn more pro-social ways of relating and becoming more functional members of society can be extremely rewarding.

Our society, especially parents and educators, needs to become more comfortable in discussing sexuality with children and adolescents, not only for problematic behavior, but also to encourage healthy sexual development. We need to encourage discussion of problems in a safe environment before problematic behavior begins.

Future research needs to be conducted on:

1. Etiological factors in the development of typical and atypical sexual interest patterns in children and adolescents
2. Effective treatment of adolescent sex offenders with a critical need for prospective, controlled studies with clear outcome measures
3. As risk factors and treatment methods are identified and proven, programs of prevention to help children and adolescents at higher risk for sexual offending.

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