ADOLESCENT PERPETRATORS

ADOLESCENT SEX OFFENDERS: ASSESSMENT AND TREATMENT

—by Barbara L. Bonner

Treatment for adolescent offenders has received increased attention over the past five years, prompted in part by a number of studies indicating that the onset of deviant sexual arousal and behavior often occurs before the age of 18 (Abel, Mittelman, & Becker, 1985; Longo & Groth, 1983).

The exact incidence of sex crimes committed by adolescents is not known (Becker, 1990). However, crime statistics have shown that approximately 30% of rapes and over 50% of child molestations are committed by offenders under the age of 18 (Fehrenbach, Smith, Monastersky, & Deisher, 1986). Studies of adolescent sex offenders have shown that a significant number commit their first sex offense between the ages of 12 and 15 (Deisher, Wenet, Paperny, Clark, & Fehrenbach, 1982).

A 1986 study of 305 adolescent sex offenders found that adolescents commit an array of sexual offenses, that the offenses typically are not isolated incidents, and that the offenses frequently reflect the boys' more general difficulties in adjustment (Fehrenbach et al., 1986). Another study suggested that deviant sexual behavior in adolescents is not experimental and can lead to repeated sexual offenses (Becker, Rathner, & Kaplan, 1987). These findings underscore the need to identify and treat juvenile sex offenders when the symptoms first appear and before the behavior patterns become ingrained and less responsive to treatment.

The assessment and treatment of adolescent sex offenders is a broad, complex clinical area which lacks empirically verified evaluation or therapy techniques. Several programs have published descriptions of their treatment components (Knopp, 1982), but little data regarding treatment outcome are available. In fact, although guidelines for assessment have been suggested by clinicians working with adolescent offenders, and research projects are being conducted to test the efficacy of certain treatment methods, no accounts of controlled outcome studies assessing the effectiveness of treatment programs for juvenile sex offenders are available (Becker, 1988; Davis & Leitenberg, 1987). In the absence of firm empirical guidance, however, adolescent sex offenders must be identified and given problem-specific treatment. Clinicians have reported that there are considerable differences between the assessment of adolescent sex offenders and those adolescents with more traditional mental health problems (Knopp, 1984; 1985). In general, mental health professionals tend to underestimate significantly the risks involved with sex offenders (Knopp, 1985).

A test battery to evaluate adolescent sex offenders might include the Weschler Intelligence Scale for Children-III, Child Behavior Checklist, Rorschach, Thematic Apperception Test, Jessness Inventory, Millon Adolescent Personality Inventory, or Minnesota Multiphasic Personality Inventory, and the Family Adaptability and Cohesion Evaluation Scales.

Additionally, an assessment should include a thorough and detailed sexual history, including information on the normal or non-deviant sexual activity of the adolescent; the extent of the adolescent's deviant sexual interests, the numbers, ages, and gender of the victims and the relationship between offender and victims; the duration and frequency of the deviant behavior; the use of sexually deviant fantasies; the effects of alcohol, other drugs, or pornographic materials on the adolescent's behavior; the degree of force used by the adolescent; the reported ability of the adolescent to control the deviant behavior; a history of sexual or physical abuse; any progression in the nature and frequency of the deviant behaviors; and the adolescent's general knowledge about sexuality.

The clinician should also evaluate the adolescent's social skills, value system, and cognitive distortions. In some cases, the sexual arousal patterns are measured by penile erection responses. As denial is a common feature found in sex offenders in general, it is recommended that clinicians use all available information to evaluate the adolescent offender, including court records, statements or videotapes of the victim, and previous psychological reports. (For additional reading on assessment, see Bethea-Jackson & Brissett-Chapman, 1989; Blaske, Borduin, Henggeler, & Mann, 1989; McCraw & Pegg-McNab, 1989; Smith, Monastersky, & Deisher, 1987).

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A recent study by Kavoussi, Kaplan, and Becker (1988) assessed the psychiatric characteristics of a group of outpatient male adolescent sex offenders (N=58) and found that 48% of the sample met the criteria for socialized, nonaggressive Conduct Disorder. This suggested to the authors "... that many sex offenses committed by adolescents are part of a pattern of poor impulse control and antisocial behaviors" (p. 243). The Kavoussi et al. study emphasizes that adolescent sex offenders are a heterogeneous group and that a continuum of severity in psychopathology will be found based on the subset (inpatient, outpatient) being evaluated.

Treatment programs for adolescent sex offenders are typically modified versions of adult offender programs. They are being implemented in both community-based and residential settings (Knopp, 1986). Depending on the program and the needs of the adolescent, one or more of the following treatment modalities are generally employed: (a) individual, group, and family therapy; (b) education in human sexuality; and (c) social skills and assertiveness training. Most programs put a strong emphasis on the involvement of the adolescent's family and some other programs will not accept an offender unless the family is involved.

One model for a community-based treatment program for adolescent sex offenders was established at the University of Oklahoma Health Sciences Center in 1986 (Bonner, 1990). The program is designed as a year long, outpatient program for adolescent offenders and their parents. The boys attend weekly, 1.5 hour sessions and parents are required to attend a monthly, one hour session with the boys. Additionally, parents have the option of attending weekly 1.5 hour parent group sessions. The adolescents are referred from the Juvenile Court, the Department of Human Services, inpatient psychiatric treatment facilities, attorneys, and parents. Their offenses include making obscene phone calls, exhibitionism, fondling young children, anal and oral sodomy, and rape.

This program uses a cognitive-behavioral approach and is divided into treatment components that address the following: a) goal setting; b) disclosure of the abuse; c) effects on the victim, adolescent, and both families; d) victim empathy and restitution; e) sex education; f) normal/abnormal and legal/illegal adolescent sexual behavior; g) values clarification; h) assertion skills; i) anger management; j) impulse control; and k) relapse prevention.

An overall goal of treatment is to increase the responsible behavior of the adolescent in all aspects of his life. Depending upon the boy's age, it is expected that he will maintain part-time employment during some period of his group membership, and all boys on probation with the Juvenile Court are required to perform 60 hours of community service.

Several techniques used in the Oklahoma treatment program appear to be particularly helpful in treating adolescent sex offenders. One has been the use of a group leader. As this is an open group with new members being added throughout the year, members of the group are at different stages of treatment. Once every six weeks, the group elects a new leader. The person selected has typically shown responsibility in terms of attendance, behavior in the group, helpfulness to other group members, and verbal participation. This leadership role is frequently the first experience for these boys

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in being acknowledged as a leader by their peers, and appears to be a positive experience for the adolescent.

Another technique useful to both adolescents and therapists is a periodic group review of a boy's progress in the group on behaviors such as attendance, participation, and responsibility. The group members' assessment is often remarkably similar to the evaluation the therapists send to the boys' probation officers prior to each court hearing. One other technique that has been found useful is the use of outside speakers, particularly in the parent sessions. At times, the group is characterized by a high level of denial and anger toward the juvenile justice system by both boys and their parents. This issue has been effectively dealt with by having speakers such as a detective from the Sex Crimes Division, a District Attorney from the Juvenile Division, a defense attorney, or a Juvenile Court Judge attend the meetings to explain the laws and procedures that were used to adjudicate the adolescent.

Other observations about effective clinical approaches with these boys have been that a) the use of paper and pencil exercises with objective ratings, such as the progress evaluation, are effective in focusing the group's attention and documenting progress; b) having new members join the group causes some disruption to the group process but this appears to be offset by the benefits of having more experienced members to act as models; and c) the direct involvement of the parents with the boys in group sessions has decreased parental denial and increased communication in the families.

A community-based program implemented by Becker and her associates was designed as a research project to assess the effectiveness of a structured cognitive-behavioral treatment program with an outpatient adolescent offender population (Becker, Kaplan, & Kavoussi, 1988). Based on a treatment model that was found to be effective with adult offenders, the program components are:

a) eight 30-minute sessions of verbal satiation, a technique that teaches the offender how to use deviant thoughts in a repetitive manner to the point of becoming satiated with the stimuli that he may have used to become aroused; this is followed by a group orientation session.
b) four 75-minute weekly group sessions focusing on cognitive restructuring through role playing;
c) one 75-minute group session explaining covert sensitization, a technique used to disrupt behaviors that precede an offender's coming into contact with his victim; the subjects must complete eight 15-minute covert sensitization audiotapes over the next three weeks;
d) four 75-minute group sessions of social skills training;
e) four 75-minute sessions of anger control training through role playing;
f) sex education and values clarification; and
g) two 75-minute sessions of relapse prevention.

Another community-based group treatment program for adolescent sex offenders has been described by Smets and Cebula (1987). The group program is part of a total treatment approach that includes individual and family treatment. In 1987, the program had operated for two years and treated 21 boys. The average age of the boys wass 14.5 years and approximately 70% of the victims were girls between the ages of 3 and 9 years old.

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This program is structured around a five-step "level" system. This program has a beginning "zero" level with five program steps. The group meets weekly for 1.5 hours and the average duration for the group, i.e., the time required for all the boys to reach level five, has been twelve weeks. Of the 21 boys who have completed the program, 14 have continued in individual and/or family therapy after completing the group. One of the 21 boys has had a reported repeat offense. This adolescent had a history of victimization and had previously been considered for inpatient treatment. For additional information on the treatment of adolescent sex offenders, see Abel et al., 1985; Becker, 1990; Hains, Herrman, Baker, & Graber, 1986; Kahn & Lafond, 1988; Lombardo & DiGiorgio-Miller, 1988; National Adolescent Perpetrator Network, 1988; Ryan, Lane, Davis, & Isaac, 1987.

In summary, programs for adolescent sex offenders tend to address a core of significant issues related to sexual behavior. Clinicians think that many of the techniques currently being implemented are useful. More information, however, is urgently needed. Until more data are available, clinicians will be uncertain which techniques are most effective with which adolescent offenders.

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Barbara L. Bonner, PhD, is Director of Child Abuse Training and Research at the University of Oklahoma School of Medicine, Treasurer of the APSAC Board of Directors, and a national consultant on adolescent sex offenders for the Indian Health Services.