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Intrafamilial adolescent sex offenders: psychological profile and treatment

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Foreword | *Sexual abuse of children by other children or adolescents constitutes approximately 40 to 90 percent of sexual offending against children. This paper examines the nature and causes of adolescent intrafamilial sex offending and which treatment approaches are likely to be successful. Using the results of a four-year study in Western Australia, it provides an overview of intrafamilial adolescent sex offenders (IASOs), what is known about them and how they can be conceptualised. Findings show that IASOs have greater developmental trauma and family dysfunction than adult sex offenders. They also demonstrate greater levels of various behavioural difficulties associated with conduct disorders than do extrafamilial and adult sex offenders and the general population; most commonly ADHD and Post Traumatic Stress Disorder. Adolescent sex offender programs are based on those developed for adult offenders, with cognitive behavioural therapy the dominant model. However, these programs lack appropriate focus on developmental issues and the influence of family on offending patterns. Programs that combine a variety of treatment modalities show more promising outcomes. It is recommended that a need to understand adolescent sex offending as a health issue, rather than a moral one, allows for interventions that have the best possible chance of changing sexually inappropriate behaviour and ending the intergenerational transmission of abuse.*

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While it is well understood that sexual offending against children may detrimentally impact their development, it is still not widely appreciated that much of that offending is actually perpetrated by adolescents and, in particular, brothers of victims. Estimating the size of this proportion is difficult as there has been comparatively little focus on the issue of adolescent sibling incest. However, estimates of the proportion of intrafamilial abuse which occurs between people from the same generation range from 40 to 90 percent (Bentovim, Vizard & Hollows 1991; Cole 1982; Ryan et al. 1996). Although most of these studies rely on limited samples, it is clear that sexual abuse of children by other children or adolescents constitutes a significant proportion of sexual offending against children.

If sexual offending against children is to be effectively addressed, more must be known about the nature and causes of adolescent intrafamilial sex offending and, most importantly, which treatment approaches are likely to be successful. The aim of this paper is to provide an overview of what is known about intrafamilial adolescent sex offenders (IASOs), how different groups of IASOs can be conceptualised and what the best treatment approaches might be. This discussion draws on the results of a four-year investigation into the treatment of IASOs at a community based treatment service in Western Australia, which involved an in-depth study of 38 IASOs before, during and after treatment (Grant et al. 2008; Thornton et al 2008). Briefly, the methodology utilised for results reported in this paper involved a descriptive analysis of the profile of the sample pre-treatment, based on a range of psychometric assessments and interviews with the adolescents and their parents. In particular, results on the Millon Adolescent Clinical Inventory (MACI) were analysed using a cluster analysis.

It is agreed that the term ‘adolescents who engage in sexually inappropriate behaviour’ is preferable to ‘adolescent sex offender’ because of its emphasis on the behaviour rather

than the criminality of the behaviour. However, most researchers use the latter terms and to be congruent with the literature as well as for parsimony, 'adolescent sex offender' will be used.

A profile of intrafamilial adolescent sex offenders

IASOs comprise a mixed group, but differ in some significant ways from adult incest offenders. In particular, they appear to have greater developmental trauma and family dysfunction (Hunter & Becker 1994). The link between prior physical victimisation and sexual offending in adolescence has been established in several studies (Adler & Schutz 1995; Boyd, Hagan & Cho 2000; Gray et al. 1999, Veneziano & Veneziano 2002; Worling 1995b). This physical victimisation can include sexual abuse, physical abuse and exposure to domestic violence. In terms of prior physical abuse, Benoit and Kennedy (1992) found that 40 percent of adolescent sex offenders (ASOs) reported such experiences with family and/or peers.

Although the majority of studies that examine prior victimisation among ASOs fail to differentiate between different types of offenders, several investigations have specifically focused on adolescent sibling incest offenders. For example, O'Brien (1991) compared adolescents who offended sexually against a sibling with other ASOs and found that incest offenders reported a higher rate of sexual and/or physical victimisation compared to the other groups. Worling (1995b) also found that a significantly higher number of sibling incest offenders reported a history of sexual abuse (38%) compared to adolescents who offended outside of the immediate family (16%). In another more recent study, Rayment-McHugh and Nisbet (2003) found significant differences in prior sexual victimisation between sibling incest and extrafamilial ASOs (38% vs 16% respectively). This study corroborated these previous studies. Indeed, almost half (48%) of the IASOs undergoing treatment reported being victims of sexual abuse (Grant et al. 2008; Thornton et al 2008).

Prior victimisation has also been linked with the age of onset of disclosed sexual offending behaviour. For example, Murphy et al. (2001) discovered that ASOs who had been sexually victimised began offending at an earlier age compared to adolescents who had not reported prior victimisation. In addition, a review by Righthand and Welch (2001) suggested that offenders with a history of abuse begin offending at an earlier age than those who were not abused. In this study, 29 percent of the IASOs reported physical abuse or domestic violence (Grant et al. 2008).

ASOs are a diverse group, but often display difficulties such as conduct disorder, attention deficit hyperactivity disorder (ADHD), antisocial behaviour (Prendergast 2004; Shields 1995) and social skills deficits (Awad, Saunders & Levene 1984). Specifically, Hunter et al. (2003) noted that psychosocial deficits were most notable in offenders with younger victims. These deficits included social incompetence, anxiety, depression and pessimism. In the Hunter et al. (2003) study, almost half of the participants met the criteria for intervention for depression and anxiety. Some studies have found that IASOs have higher levels of internalising and externalising behaviours, conduct disorder, behavioural problems, ADHD and poorer social and interpersonal skills than control groups (Hummel et al. 2000; Letourneau, Schoenwald & Sheldow 2004; Sheerin 2004; Taylor 2003; Zolondek, Abel & Northey Jr 2001). These findings support O'Brien's (1991) research which found that sibling incest offenders were more likely to exhibit various behavioural difficulties associated with conduct disorder, compared to extrafamilial ASOs and non-child sex offenders. In this study, half of the study group of IASOs had been diagnosed with a psychological disorder, with the most common diagnoses being ADHD (26%) and Post Traumatic Stress Disorder (10%). In addition, relatively high levels of externalising and internalising difficulties were present (Grant et al. 2008). These results suggest that while psychological problems are not uncommon, and are indeed more likely than those found in the general population, a high proportion of IASOs do not exhibit psychological pathology. Therefore, at both a clinical and policy level, it becomes important not to over-pathologise the problem of ASOs.

Several studies have found, perhaps not surprisingly, that family dysfunction is more evident in families where sibling incest has occurred (Bera 1994; Burton, Nesmith & Badten 1997; Grant et al. 2008; Hardy 2001; O'Brien 1991; Worling 1995a). Within these families there is frequent evidence of chemical dependency, sexual abuse of the IASO by an adult caregiver, physical and emotional abuse and neglect, parental rejection, parental experience of past sexual abuse, single parent homes, multiple partners (parents), step or half siblings and negative family environments. A comprehensive study of 90 ASOs (Worling 1995a) found that incest offenders reported higher levels of family dysfunction than non-sibling offenders. The incest offenders were more likely to report a history of childhood sexual abuse, marital discord, physical abuse, rejection and less satisfaction with their family environment. These features of a disrupted and dysfunctional family background were also found in another study by the authors where only one in five offenders was from an intact family (Thornton et al. 2008). Almost three in every four offenders had either no contact or minimal contact with at least one biological parent.

Typologies of adolescent sex offenders

Although acknowledged as a heterogeneous group, researchers have generally grouped all types of ASOs together and there has been little research into the differences between offenders based on offence characteristics. Further, there have been no studies into the types of offenders who do, or do not, continue to offend into adulthood. The following section outlines some of the typologies that have been previously developed to help focus attention on qualitatively distinct groups of ASOs.

The two major typologies of ASOs that have been suggested are those based on either personality/psychopathology, or those based on the criminological features of the offending behaviour. Typologies in the latter category (eg Burton 2000; Hunter et al. 2003; Langstrom, Grann & Lindblad 2000) are largely based on the age of onset and age of victim and how these link to the severity and nature of the offending behaviour. For example, the Hunter et al. (2003) typology distinguishes ASOs who offend against prepubescent victims and those who offend against pubescent victims. Offenders with prepubescent victims tend to show greater deficits in psychological adjustment but are less aggressive. The study by Burton examined age of onset of offending and found that sex offenders who began offending before the age of 12 years were more at risk of continuing to offend sexually than those that started after the age of 12.

The earliest typologies of sex offenders were those based on clinical features. For example, O'Brien and Bera (1986) provided a descriptive typology comprising seven offender subtypes, grouped mainly according to the level of socialisation and impulsivity displayed by the offender.

Subsequent clinically-based typologies analysed ASO profiles on personality and clinical measures. Smith, Monastersky and Deisher (1987) used commonalities across MMPI profiles. More recently, Worling (2001) generated a typology for ASOs based on patterns of response on the California Psychological Inventory, while Richardson et al. (2004) developed a personality-based taxonomy for ASOs, derived from cluster analytic procedures utilising the MACI. However, these subtypes did not distinguish between different types of offending behaviours, giving further support to the heterogeneity of this group (Richardson et al. 2004). Finally, a study in New Zealand by Oxnam and Vess (2008) used the 12 personality pattern scales on the MACI to categorise ASOs. Table 1 shows a comparison of the published typologies, with the categories and major descriptors.

Although each analysis has produced somewhat different typologies, there appear to be commonalities across the groupings. There is clearest agreement that there is an *antisocial group* (antisocial, impulsive, conduct disordered) and a *narcissistic group* (personality disordered, confident/aggressive, dysthymic/negativistic, passive aggressive). There then appear to be two more broad groupings which are less defined: an *inadequate group* (inadequate, immature, unusual/isolated, submissive) and an *over-controlled group* (socialised delinquents, over-controlled/reserved, dysthymic/inhibited, conforming).

Table 1 Comparison of typologies of ASOs

Smith et al. 1987	Worling 2001	Richardson et al. 2004	Oxnam & Vess 2008
Conduct disordered	**Antisocial/impulsive**	**Antisocial**	**Antisocial**
impulsive, alienated, acting out	externalising behaviour problems	conduct disorder, disregard of social norms, impulsive, self indulgent	unruly, oppositional, impulsive, social insensitivity, family discord
Personality disordered	**Confident/aggressive**	**Dysthymic/negativistic**	**Passive aggressive**
narcissistic, demanding	narcissistic qualities	intimidating, low self-control, dysthymia	oppositional, submissive, depressive affect, family discord
Immature	**Unusual/isolated**	**Submissive**	**Inadequate**
shy, over-controlled, isolated, worried	internalising behaviour problems	high anxiety, excessive dependency	doleful, oppositional, self devaluation, impulsive, family discord
Socialised delinquents	**Over-controlled/reserved**	**Dysthymic/inhibited**	**Conforming**
overregulated, aggressive	avoidant in emotional expression	isolated, depressed affect, low self-confidence	anxious, conforming, sexual discomfort
		Normal	
		only minor personality difficulties	

Table 2 Typology of IASOs

Group	Elevated scores on subscales	% of sample
Antisocial	unruly, oppositional, family discord, delinquent predisposition, impulsive propensity	41
Anxious	anxious feelings, depressive affect, family discord, sexual discomfort	37
Narcissistic	dramatising, egotistic, family discord	22

Source: Grant et al. 2008

None of these previous studies differentiated between intrafamilial and extrafamilial ASOs. In this study group of IASOs, a cluster analysis of the MACI (n=32) yielded a slightly different profile which is shown in Table 2.

The analysis of different types of IASOs is important because each of these groups of IASOs will have different treatment needs and pose different challenges to those offering treatment. For example, those who are high on antisocial characteristics may need a focus which also addresses their propensity for delinquency and aggression, while those who are highly anxious will need strategies to manage their anxiety. Although all will need treatment modules which address their overt offending behaviour, some of the other personality and behavioural issues will also need to be addressed in order to reduce the risk of reoffending. The typology shown in Table 2 provides a solid basis for considering the differing groups and therefore treatment needs of the three major clinically relevant subgroups of IASOs.

Treatment of adolescent sex offenders

In the main, adolescent treatment programs are based on those developed for adult offenders (Eastman 2004). Developmental issues and the influence of family are, unfortunately, not given the focus that is appropriate with this group (Grant et al. 2006). Most treatment programs utilise a combination of group and individual therapies, with family therapy a feature of only a few programs.

Cognitive Behavioural Therapy (CBT) is the most common model of therapeutic

intervention with ASOs and it is widely used in Australia and internationally (Grant et al. 2008; Robson 1999). CBT targets particular areas including deviant sexual arousal, poor sexual impulse control, deficits in victim empathy, social skills, relapse prevention and cognitive distortions (Hunter & Santos 1990; Wood, Grossman & Fichtner 2000).

A handful of studies have indicated positive treatment outcomes, including reduction in arousal to deviant sexual cues (Hunter & Santos 1990; Weinrott, Riggan & Frothingham 1997), reduction in recidivism rates (Worling & Curwen 2000), improved empathy (Eastman 2004) and improvement in social relationships, social problems, competence, sexuality and intimacy (Kelley, Lewis & Sigal 2004).

Individual psychotherapy is designed to target specific individual issues likely to have contributed to the offending behaviour. However, individual interventions do not address the ecological or family factors that may contribute to an abusive environment (Grant et al. 2006; Prendergast 2004; Shaw 1999; Swenson et al. 1988) and therefore are unlikely to be effective as the sole means of treatment for ASOs (Bourke & Donohue 1996; Ertl & McNamara 1997).

Group therapy provides a supportive environment in which specific issues such as cognitive distortions, social skills, victim empathy and sex education can be addressed (Bourke & Donohue 1996). One of the strengths of group therapy is that it makes it difficult for individuals to minimise or deny their offending behaviours to the group (Sciarra 1999; Shaw 1999). It can also foster peer acceptance, reduce isolation and provide opportunities for social skill development (Prendergast 2004). The IASOs in this study reported that although they were anxious about the group therapy component, it was seen as highly significant to their progress, and engendered insight and group acceptance, despite the initial shame (Grant et al. 2008).

Family therapy targets communication patterns and family support networks and provides sex education including how to disrupt the abuse cycle (Sciarra 1999; Shaw 1999). It is particularly useful where there has been intergenerational abuse (Shaw 1999; Thomas 2004). Bremer (1992) found a low recidivism rate in an evaluation of a program including family therapy (6% reconviction and 11% relapse based on self report). In this study, parents reported they had gained valuable insight into the sexual offending cycle, how the family could avoid facilitating an environment where offending behaviours occurred and valuable skills in parenting more effectively (Grant et al. 2008). This view was supported by the adolescents, who rated their family functioning as significantly improved after therapy on a measure of family cohesion and communication.

Multisystemic Therapy (MST) targets characteristics of the ASO, the family, school and peer relationships (Borduin et al. 1990; Swenson et al. 1998). MST engages parents as 'agents of change' for their children (Swenson et al. 1998: 333) and intervenes in the wider system of the adolescent, as well as with the adolescent per se. MST has shown some promising results, with significantly lower recidivism rates compared to a control or comparison group (Borduin et al. 1990; Borduin & Schaeffer 2001). MST is one of the few treatments for ASOs that has been evaluated with randomised control designs and indicates impressive results for a range of outcomes (Letourneau et al. 2004).

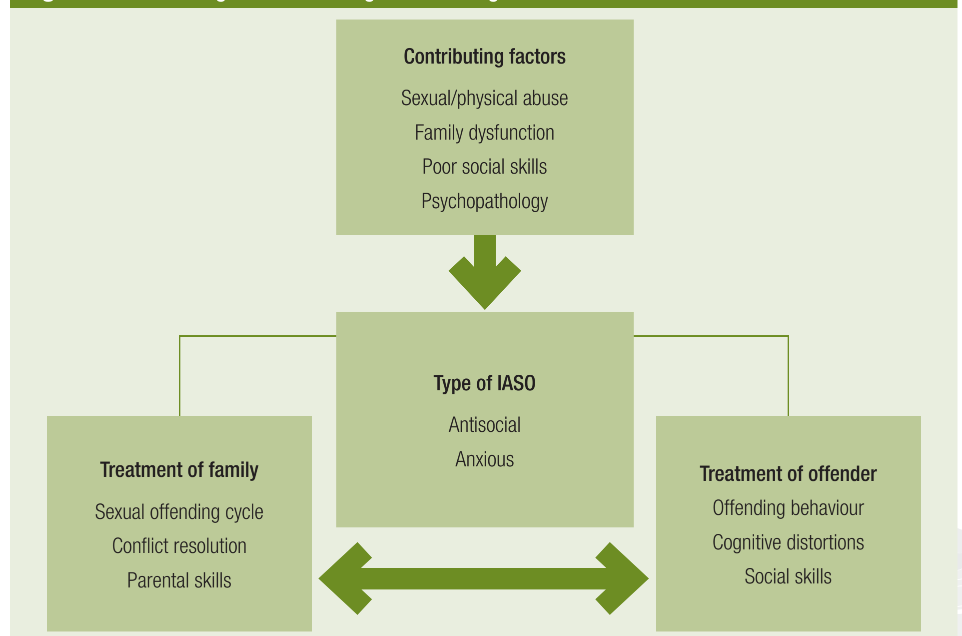
Programs that have combined a variety of treatment modalities addressing the broader context of the offender, their family and wider social system have shown some promising outcomes, including low relapse rates (Mazur & Michael 1992), improved social skills (Graves, Openshaw & Adams 1992), improved family function (Grant et al. 2008), improved sexual knowledge and self concept and fewer cognitive distortions (Eastman 2004). In this study, both IASOs and their parents reported improvements in the IASO's impulsivity, responsibility, family relationships and emotional regulation (Grant et al. 2008) following the treatment program.

Conclusions and policy issues

There are significant developmental, psychological and family issues that substantially contribute to intrafamilial adolescent sex offending. What is needed is a holistic, systemic and developmental treatment approach (Davis & Leitenberg 1987; Grant 2000; Grant et al. 2008). Figure 1 summarises the etiological factors, subgroups and treatment needs of IASOs discussed in this paper. It is suggested that only by addressing the complex range of contributing factors are we likely to provide effective and long-lasting treatment.

The sexual abuse of children is a problem about which the public is becoming increasingly aware and this awareness has already led to some radical policy commitments, mainly in Indigenous communities. Although the true extent

Figure 1 Addressing the interacting contributing factors in treatment of IASOs



of child sexual abuse in our communities remains hidden, there are already some established 'facts' about its nature which emphasise its importance. Perhaps the most compelling is its intergenerational nature. The sexual abuse of a child victimises and potentially damages the child, but in so doing lays down the psychological conditions for this tragedy to spread through the victim's developing relationships with others throughout his or her life.

Because of its intergenerational nature, the sexual abuse of children cannot be viewed as a tragedy that is visited solely upon an individual. Part of the difficulty in seeing the problem in its entirety is that we are unwilling or unable to hold the notion of an individual being both a victim and an offender simultaneously. However, this is exactly the task that is required. It is this dual 'role' that is at the heart of the cycle of abuse. It is now well understood that a propensity for domestic violence is 'transmitted' generation to generation and in academic and policy communities the 'cycle of violence' is readily recognised. However, perhaps because of understandable sensitivities, sexual abuse, particularly that perpetrated by a young person, is yet to be seen in the same light.

Policy, therefore, needs to conceptualise IASOs largely as victims who have become offenders. Identifying and understanding the effects of past sexual, physical and emotional abuse will also allow us to gain a more realistic and holistic picture of the problem and allow for the provision of a range of interventions to help the parents and other family members, the identified victim/offender and other 'at risk' children. It is clear that most IASOs will present with a collection of psychological problems, many of which are associated with dysfunctional family dynamics. Treatment needs to be holistic, varied and flexible if it is to meet the needs of the individual's particular circumstances. Based on the results of this study, treatment programs can provide valuable help for parents of an IASO and this, in turn, can provide a more stable family environment that has greater potential to promote sexually appropriate behaviour and support for relapse prevention.

Responses so far in dealing with intrafamilial adolescent sexual abuse have often been guided by the archaic, simplistic and possibly damaging principles of 'crime and punishment'. Insofar as we refuse to accept that intrafamilial adolescent sex offending is a damaging response from a damaged individual, it is seen as a wanton response from a criminal. This kind of thinking leads to an impoverished conceptualisation of the issues surrounding the behaviour and feeds into the media's sensationalism of adolescent sex abuse. This feeds a politicisation of policy precisely at the point where it does most damage and where a compassionate approach or simply a detached, understanding approach is most needed. When the sexual offender is a child, there is a special opportunity to change our emphasis somewhat and conceptualise the problem primarily as a health issue, rather than primarily as a moral one. This would allow interventions to be designed that have the best possible chance of changing the sexually inappropriate behaviour and ending the intergenerational transmission of abuse.

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