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The Historical Development of Treatment for Adolescent Sex Offenders

Anna Grant

The number of adolescents who are sex offenders is unknown. Adolescents who commit sex offences are not always prosecuted, nor necessarily treated. Research has demonstrated that many patterns of sexual offending often begin in adolescence and, in some cases, show a progression to more serious sexual assault as adults.

In November 1999, the Australian Institute of Criminology published a paper demonstrating the cost-effectiveness of intensive "in-prison" sex offender treatment programs (Trends and Issues, no. 134), but much greater savings (in both money and emotional costs) can be achieved through treatment of adolescent sex offenders.

A common reaction to sex offenders is to seek punishment because the pain and trauma for victims is so severe, but early intervention yields greater results. This paper examines approaches to treatment and shows how different approaches can prevent further offending by identified offenders.

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It is now widely documented that the victims of sexual offending suffer long-lasting, long-term damaging effects as a result of their victimisation. Both clinical and research interest in sexual offending has developed significantly.

In addition to issues of reducing the impact of sexual offending on its victims, another challenge to be confronted is the prevention of further offenders. This has led to the development of sexual offender treatment programs.

Perpetrator Profile

For the purposes of this paper, adolescent sexual offenders are defined as young people aged 18 or under who engage in sexually assaultive behaviour (for example, rape or forcible sexual contact). This definition does not include teenage experimentation or non-forcible sexual acts between two (non-related) adolescents of similar ages (Davidson 1987).

Many sexual offenders have in the past escaped both detection and punishment for their actions due to reluctance by the wider communities, particularly in certain cultures, to discuss sexual

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issues, deviant or otherwise. Adolescents are often prevented or assisted in avoiding responsibility for sexually offensive/abusive behaviour through definitions of their behaviour as "exploratory" in nature and believes that it will pass with age (Ryan and Lane 1997). However, recent research on sexual offending and aetiology has highlighted the danger in such assumptions. The research has demonstrated that patterns of sexual offending often begin in adolescence and that many offenders show a progression to more serious sexual assault as adults (Aljazireh 1993). Connolly and Wolf (1995) believe that:

"Underdeveloped public and professional awareness and recognition of sexual abuse generally, together with a tendency to assume that adolescent sexual offending is a normal and experimental aspect of adolescent development, may both have contributed to a lack of critical attention."

The majority of research involving sexually abusive youth has focused on 12 to 18 year olds. However, further research, in addition to clinical practice, has identified that sexually exploitative and aggressive behaviours are also occurring in younger, prepubescent children (Ryan and Lane 1997).

The victims of adolescent sex offenders are more likely than the victims of adult offenders (although this is the most prevalent group for adult offenders as well) to be acquaintances or siblings (Weinrott 1996). These offenders are more likely to have contact as a family member, babysitter, or other substitute caretaker due to consequent opportunities to access the victim (Davidson 1987). This victim selection can be one of the reasons for the dismissal of the possibility of offending behaviour by adolescents as they are often trusted by the victims' families, primarily because of their age, to an even greater extent than adults.

Adolescence, at least in contemporary Western societies, is seen as a time for exploration of issues such as identity, autonomy, social roles, and behaviour with certain social expectations of increased responsibility. Research into "adolescence" has shown that this is a vital time in socialisation and development which is essential for future social, emotional, and occupational functioning (Hoghugh 1997).

Research has also shown that a majority of sexual offenders, adolescent or otherwise, hold certain ideas and beliefs about sexuality and interpersonal relationships that condone the taking of sexual gratification from others (Connolly and Wolf 1995). If such beliefs become ingrained during adolescence, the implications for future non-offending functioning of the individual are ominous.

Treatment—Why is it Important?

The first difficulty in the treatment of sexual offenders is convincing the community (and particularly the victims) that treatment is not only effective but also appropriate. It is not unreasonable for both society and the victims to demand that perpetrators of sexual offences receive punishment for their actions. It is also not unreasonable for victims to question why resources are being devoted to offenders when so many victims continue to suffer without adequate assistance. Nevertheless, it must also be realised that helping victims and helping offenders are not mutually exclusive aims. The long-term interests of both are present and potential victims and offenders are best served by lowering the risk of reoffending (Glaser 1993).

The history of treatment approaches used to help individuals troubled by deviant sexual deviation or variation is notable for the way it has re-

flected the changing attitudes of both society and medicine to such behaviour (Hawton 1994).

In the 1940s, several paediatricians and radiologists began documenting what they believed were isolated cases of physical child abuse. Whilst children were often presented to doctors suffering from sexually transmitted diseases, very little action or investigation was undertaken. It was not until during the 1960s that society and medical practitioners began to investigate the maltreatment of children. As standards for the care of children improved, legislation began to allow greater surveillance and intervention in the rearing of children, which led to the discovery of the alarming incidence of sexual abuse of children.

The changing status of women during this period also affected the perception of sexual violence. By the 1970s, sexual offending has been addressed in both civil and criminal statutes and research on the adult perpetrators began to increase (Ryan and Lane 1991).

This research confirmed the need for earlier identification and intervention with offenders. These studies indicted that over half of the adult offenders had begun sexually abusive behaviours prior to the age of 18. Simultaneously, workers in juvenile corrections and human sexuality programs began to see that many of the juveniles committed, or referred, on lesser complaints had actually committed serious sexual offences.

In the mid-to-late 1970s, these programs, which were attempting to develop treatment specific to the adolescent sex offender, typically functioned in isolation without the benefit of networking to share information or validate experience. Many of the youths involved in these programs were reported to have multiple undetected offences, more than one type of offence and patterns which indicated a progression

from less intrusive to more aggressive behaviours (Ryan and Lane 1991).

Because there were no scientifically-based theories or model programs to guide their development, most of these early programs developed an understanding of the adolescent sex offender and designed treatment approaches through trial and error. Interestingly, there were many similarities in the philosophies and approaches among the programs. As similarities began to arise among the various programs, the basis of current treatment programs began to evolve (Ryan and Lane 1991).

Yet, by 1980, there were still only a few definitive studies on sex offenders and even fewer that could withstand the careful scrutiny of rigorous evaluation. Many of the studies were based upon case studies which did not provide any useful information regarding therapeutic approaches that resulted in a measurable change in behaviour over time. Even fewer of these studies contained quantitative data with adequate samples on the success rates for controlling deviant behaviour over time (Mayer 1988).

However, the clinical work with adolescent sex offenders began to contribute to an understanding of the patterns and cycles of sexual offending and this led to some important changes in therapeutic approaches. Many of the providers of sexual offender treatment programs came to believe that the sexual element of the offending behaviour was secondary to the abusive element, and that developmental and phenomenological problems are the most important factors when assessing risk. Recent research regarding treatment of sexual offenders has articulated a belief by a growing number of theorists and clinicians that a more holistic, developmental treatment approach is the most effective (Ryan and Lane 1997).

There appears to be only two dedicated programs within Australia for adolescent sexual offenders, Male Program for Positive Sexuality (MAPPS) in Victoria and the Adolescent Sexual Offenders Treatment Program (ASOTP) in NSW. Whilst treatment is available in other states, it is generally provided on a more individualised level and generally through individual therapy and counselling rather than a dedicated program (For further information and an excellent review of the current literature see: Department of Human Services 1998, *Literature Review: Male Adolescent Sex Offending and Treatment*, Victorian Government, Melbourne).

Theories of Treatment

The various theories that have received substantial attention in the last century serve as a basis for understanding both the history of the way in which we think about sexual offending and the history of the current approaches to treatment (Ryan and Lane 1997). Theoretical approaches to sexually offending behaviour have progressed from ideas based entirely upon theoretical assumptions to theories based on the findings of research that is driven by data (Holin and Howells 1991).

Psychosis Theories

Truly psychotic sex offenders account for a very small percentage of the total population of perpetrators. While the psychotic offender's behaviour is no less impactful than that of other offenders and the need for effective intervention is not diminished, these offenders are unlikely to benefit from specialised sex offender programs (Ryan and Lane 1991). The majority of these offenders are better served through mental health avenues rather than behavioural programs.

Physiological Theories

Most recently researchers have demonstrated that, for some individuals, the experience of overwhelming trauma may produce permanent changes in the way the brain secretes certain chemicals in response to certain events. This area of study appears to be potentially relevant to the understanding of many dysfunctional responses which have previously defied adequate explanation. Neurological and hormonal factors seem to be the most promising areas for psychological research as it would involve measurable and potentially alterable conditions.

Even so, only a small portion of treatment programs and studies exist and, in most cases, therapies based upon these theories, such as the use of Depo-Provera (chemical castration), are not considered as an exclusive treatment, but one which can aid the offender in controlling their behaviour (it should be noted that no program using such methods is currently operating in Australia with adolescent offenders). The most important consideration in this paper, however, is the ethics involved in using such measures with adolescents. Anti-testosterone therapy involves numerous side effects, the most troublesome of which is interference in growth and maturation (Ryan and Lane 1991).

Family Systems Theories

This set of theories was largely a reaction to early feminist thinking. A survey of literature on incest in 1964 reported that such behaviour was predominantly viewed as a family dysfunction and that the perpetrator's behaviour occurred "independent of general criminal tendencies". It was believed that women would "frustrate their husbands sexually while encouraging father-daughter intimacy" and that the victims "seldom resisted or complained ... and rarely experienced guilt" (Ryan and Lane 1991).

The first shift in family-system thinking in the 1970s removed responsibility from the child victim, although mothers were still thought to play a role. It was not until the 1980s that intra-familial sexual abuse was seen as the responsibility of the offender and that offenders were encouraged to take responsibility for their own behaviour. Current research does note that family dynamics can play a role but family therapy is now part of the specific treatment for perpetrators and protection and therapy for child victims rather than as an explanation for the occurrence of such behaviour (Ryan and Lane 1991).

Learning Theories

Learning theories are based upon the concept that all behaviour and knowledge is learned through experience. The focus of learning theories is in reducing undesirable behaviours, such as sexual offending, by learning more acceptable patterns of conduct.

In terms of adolescent sexual offending, a child's early experiences of sexual arousal may have occurred in the context of an exploitative relationship, including sexual victimisation (Ryan and Lane 1991), which may affect the development of the child in such a way as to support and protect the development of their own sex offending. A number of recent research projects have investigated the link between prior victimisation and subsequent offending.

Developmental Theories

Developmental theories are very similar to learning theories and are often used in conjunction with both learning and cognitive theories. Developmental theories seek to explain sexual offending in terms of early childhood experiences, family, and environment. Thus, factors such as family trauma, physical and sexual abuse, neglect, undefined family roles and boundaries, and expo-

sure to sexually traumatic experiences or explicit materials are believed to contribute to the development of sexual offending behaviour (Ryan and Lane 1991).

Cognitive Theories

One element of sexual offending is the thinking that allows the offender to imagine his behaviour is acceptable, justifiable or harmless. These cognitive distortions or irrational rationalisations are essential to the offender's overcoming the societal taboo against his behaviour (Ryan and Lane 1991).

Cognitive theories examine the internal processes such as the thinking patterns of sexual offenders. As was noted above, research has found that a majority of sex offenders, regardless of age, demonstrate some type of distorted thinking which acts in such a way that supports and excuses their behaviour. In particular, distorted thinking about women, sexuality, rape, and the effects of sexual abuse have been the subject on many studies devoted to describing and analysing the attitudes and thought patterns of sexual offenders (Weinrott 1996).

Cognitive-behavioural treatment techniques aim to address and modify such distortions in a manner that will support behavioural change. Cognitive restruc-

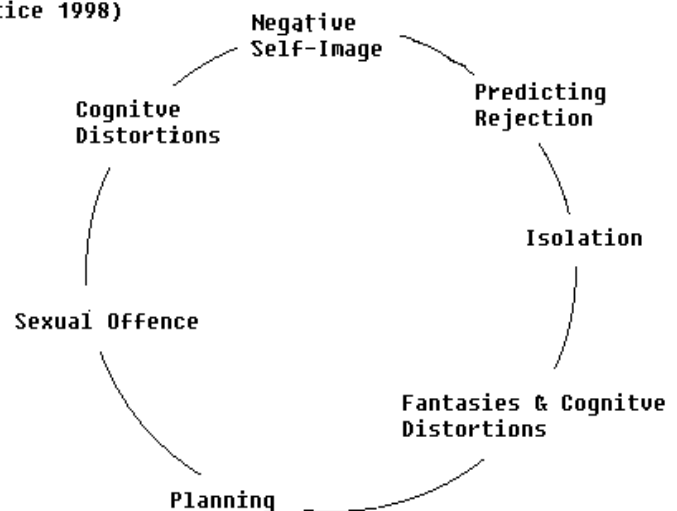
turing often requires a confrontation of the offender's basic belief system (Ryan and Lane 1991). Many of the victims of sexual offenders themselves show signs of distorted thinking regarding the abuse which has occurred (Jenkins 1997) and recent research on prevention of sexual offending has suggested that cognitive behavioural techniques may be important for use with sexual abuse victims as well as offenders.

Sexual Assault Cycle

The sexual abuse cycle is a descriptive process. It is presented as a cycle due to the repetitive nature of the behaviour sequence reported by offenders and the indication that previous offences reinforce subsequent offence patterns.

The concept of the sexual abuse cycle was developed in 1978 at the Closed Adolescent Treatment Centre of the Division of Youth Services, Colorado. Research and practice showed that while each offender had unique perceptions concerning the offence or the victim involved as well as unique motivations and justifications, there was an identifiable pattern common to each of their sexual abuse incidents. There was a common style of thinking and a common type of gratification; even the type of

Sexual Abuse Cycle
(Juvenile Justice 1998)



behaviours involved and the manner of selecting a victim or obtaining victim compliance had common processes amongst different offenders (Ryan and Lane 1991).

The cycle provided a theoretical framework to help both offenders and treatment staff examine sexually abusive behaviours and develop specific individual intervention strategies to prevent further offending. Ryan and Lane (1997) state:

“Because the cycle considers situations, thoughts, feelings and behaviours and because of its versatility and applicability to dysfunctional patterns generally and sexually abusive patterns specifically it has been the ideal framework for understanding eclectic approaches to treatment of sex offenders and is used widely.”

Integrative Theories

One of the main outcomes of integrative theories is the idea of relapse prevention. Relapse prevention was initially developed for the treatment of drug addicts, most well known is the Alcoholics Anonymous program. Research and treatment of such persons showed an identifiable pattern of the decisions and actions which caused them to return to drug abuse after ceasing (Wilmot 1992). Connolly and Wolf (1995) describe the nature of treatment for sexual offenders based upon relapse prevention principles.

“Individual offenders work with the staff (of sex offender programs) to discover, understand, and document their own individual pattern of sexually aggressive arousal and behaviour which leads to their offending. This may include the exploration of the adolescent’s own victimisation issues or other issues which may be contributing to and supporting such behaviour. Offenders also participate in group work. The group often confronts the ideas and thoughts expressed by other offenders whilst supporting and re-enforcing appropriate behaviour.”

Although methodologically problematic, some studies have shown that adolescent sexual offenders are likely to be isolated from their peers and to have “difficulty maintaining close interpersonal relationships” (Hoghugh 1997). Baker and Morgan (1993) identify that the peer support found in such groups (employing the relapse prevention methods) is very important to the offenders and is an excellent tool for cognitive change.

From the brief examination of the theories above, the majority of current research can be seen to be no longer theoretical in a direct sense. Rather, researchers and theoreticians in the area of adolescent sex offenders are beginning to take a more empirical approach. The result is an emphasis on a wide range of variables including development, interpersonal, personality, epidemiological, sociological, cognitive, and situational. The primary expansion in current research and clinical practice is the development of sexual offending behavioural models that are data-driven through program evaluation rather than the traditional theory-driven models (Holin and Howells 1991).

Future Directions

The wide variety of current therapeutic approaches to treating sex offenders increased awareness of such offending, and the limited resources available for treatment create a practical necessity for developing ways to judge program effectiveness (National Institute of Correction (NIC) 1988). In particular, there is an urgent requirement, particularly in Australia, for rigorously controlled empirically strong studies of the adolescent sex offender treatment programs. One such example is the recent evaluation conducted by Victorian Juvenile Justice of the MAPPS program.

Of particular concern is that the length of follow-up has traditionally been either non-existent or relatively short (Hoghugh 1997). Lengthening such follow-ups must be a priority if long-term effectiveness of programs is to be known. Also important is the use of comparable offenders (NIC 1988) in order to provide comparative measures of effectiveness between different programs, between those accessing programs, and between those not having any treatment.

Another criticism of current treatment is cost. Reilly (1997) believes that “It is hardly surprising that many people are reluctant for public money to be spent on the treatment of offenders rather than using it to support or compensate their victims”. However, as the costs involved in imprisoning adolescent offenders are often much higher than those of the average adult prisoner which still costs approximately \$46,000 per year, cost benefit analyses have shown that treatment programs are by comparison approximately 6-7 times less expensive (Donato and Shanahan 1999).

So, whilst all involved agree that such offenders should, and must be, held responsible for their behaviour, it must also be realised that they also have to be helped to change that behaviour if community protection and prevention of further victimisation is our objective. In this sense, court mandated sentences of treatment, either within a secure facility or community based, are also needed.

The majority of offenders treated in correctional and/or juvenile institutions will, at some point, have to generalise the skills learnt in such programs to life in the community. Institutional treatment, no matter how effective, occurs in an artificial environment. The skills learned must be practiced and reinforced in the real world. If the offender is gradually exposed to the community while continuing in treat-

ment, they have an opportunity to practice these skills, learn to deal with high-risk situations and establish relationships with therapists and supervisors in the community (NIC 1988).

Barker and Morgan (1993) also argue that community-based treatment programs are the logical solution to providing post-release supervision as part of community sentences. In addition, community programs may facilitate early intervention with adolescent sex offenders before the behaviour is serious enough to warrant a custodial sentence.

Support or supervision networks are also essential. Unfortunately, in the case of sexual offenders, such support is often difficult to obtain due to the nature of the offence and the view of such behaviour in the general community. There has, however, been some success with the families, in particular parents, of adolescent sex offenders providing such a role. Often, these families come to a better understanding of the behaviour and thoughts behind it, as well as the importance of their own roles in helping to prevent further offending.

Finally, such offender treatment programs do not alleviate the need to address broader societal issues such as the status of women and the role of violence often portrayed in the community, the media, and the entertainment industry as a problem-solving, conflict-resolution method. There remains a need to change attitudes to violence and sexual behaviour in the community (Broadhurst and Maller 1991). In particular, any evidence of early inappropriate, sexualisation and/or sexually aggressive behaviour must be addressed as early as possible to provide future protection.

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