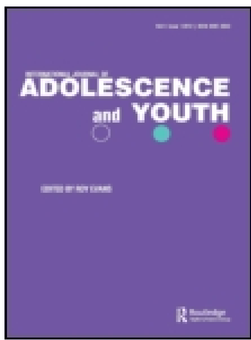

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The Profile and Treatment of Male Adolescent Sex Offenders

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ABSTRACT

This article outlines the most prominent characteristics of male adolescent sex offenders including family and school histories, sexual attitudes, social skills and relationships, other delinquent behaviors, psychiatric diagnoses, and most importantly, cognitive distortions based on mythical beliefs and misinformation. Treatment mandates accountability and correcting of thinking errors while building a foundation of morality, remorse and empathy for victims, knowledge about sexuality, basic interpersonal skills, and effective self-interventions against relapse and reoffending.

The rising incidence of sexual crimes by children against children is no longer America's best kept family secret. Treatment centers for youthful sex offenders mushroomed from 20 nationally in 1982 to about 650 now (inpatient and outpatient), according to Gail Ryan, director of the National Adolescent Perpetrators Network, affiliated with the University of Colorado, (Lakey, 1993). Further, Groth, Longo and McFadin (1982) (cited in Blaske, Borduin, Charles, Henggeler and Mann, 1989) established that a significantly high number of adult sex offenders began their criminal offenses during adolescence. Given these two alarming facts, both lay persons and professionals need to become familiar with a heretofore 'forbidden' subject that is gaining increased media notice and public outcry.

This paper presents an overview of the profile and treatment of male adolescent sex offenders. As defined by the National

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Adolescent Perpetrator Network (Scavo and Buchanan, 1989, p. 60), an adolescent sex offender is a 'youth ranging from puberty to the age of legal majority who commits any sexual interaction with a person of any age against the victim's will, without consent, or in an aggressive, exploitive, or threatening manner'.

Empirical research on male adolescent sex offenders with control groups of 'normal' agemates is rare (Davis and Leitenberg, 1987). Therefore a profile may be ambiguous because he (the majority are males) is a combination of what experts have traditionally perceived to be 'normal' plus abnormal behavior patterns.

A normal adolescent boy is frequently self-absorbed, but an offender is obsessively so, totally bent on satisfying his own needs with no thought of others. The question becomes: Where does normal end and abnormal begin? As puberty approaches, a normal adolescent boy usually begins to show interest in the opposite sex. This is also true of an offender. He may even be attracted to both sexes, but his interest is neither casual nor respectful; it is opportunistic and manipulative, laden with inappropriate sexual fantasies which he may scheme to fulfill.

Normal adolescents usually seek the company of agemates, and though an offender may sincerely wish for pleasurable peer relationships, he possesses few social skills which enable him to initiate or maintain such associations. Thoughts of building up to a sexual relationship are nonexistent; immediate sexual gratification is the goal. Normal adolescents may rebel, but the rebellion is usually manifested in legitimate ways (e.g., long hair, messy rooms), while the sex offender thrills to doing the forbidden (Berenson, 1988).

Fehrenbach, Smith, Monastersky and Deisher (1986) referred to a study that described several qualities that seemed to set offenders apart from their normally developing peers. 'Typically they are lonely and socially isolated from peers; they prefer the company of younger children; they are naive and lack suitable sex education; and they frequently experience disturbed family relations' (p. 226). Kahn and Lafond (1988) concurred.

Bengis (1989) suggested that juvenile sex offenders have a wide range of mental and emotional problems which do not fit a standardized mold. The continuum spreads from naive experimenters to sadistic rapists and somewhere in between. They may be very intelligent or so low in functioning that they are considered retarded. They rarely feel remorse or empathy for their victims, and they deny offenses or minimize the acts and the damage they inflict.

Several factors of etiological importance were noted by Davis and Leitenberg (1987), including 'feelings of male inadequacy; low self-esteem; fear of rejection and anger toward women; atypical erotic fantasies; poor social skills; having been sexually abused; and exposure to adult models of aggression, dominance, and intimidation' (p. 420). The authors pointed out that empirical research regarding these characteristics was either rare or flawed. However, Saunders and Awad (1988) challenged that position with a number of references to respected authors who generally confirmed such characteristics.

Further, Lafond (cited in Knopp, 1985), offered a global approach to the profile of an adolescent sex offender. She said that because of exposure to confused sexual values and neglect or even lack of bonding, these youngsters learned to trust no one. In addition: 'They are exposed to sexual behavior and values that victimize others, and often they live in very transient families where men and women come and go continuously with mother and dad. This lack of stability and consistency, confusion about one's own sexual identity, and a real sense of powerlessness in the family combine to cause real problems. They are not sure what is right and acceptable' (p. 96).

In school these boys are frequently disruptive and unmotivated. Many have learning problems, including attention deficit disorder. Fehrenbach et al. (1986) cited a study of 286 male adolescent sex offenders in which only 55% were on schedule in grade placement; 53% of the subjects had had problems in school or were having them at the time of the study.

In a study of the psychiatric characteristics of 58 outpatient male adolescent sex offenders, Kavoussi, Kaplan and Becker (1988) found that the most prevalent diagnosis was Conduct Disorder, a total of 48% of the sample. The authors speculated that this could be part of a pattern of 'poor impulse control and antisocial behavior' (p. 243). McManus, Alessi, Grapentime and Brickman (cited in Kavoussi et al., 1988) also found a high incidence of Conduct Disorders in 40 incarcerated offenders, as well as substance abuse, alcoholism, and affective and personality disorders (especially borderline).

Scavo and Buchanan (1989) summed up the profile of an adolescent sex offender succinctly when they suggested histories of emotional, family and social instabilities, isolation and sexual victimization, and 'an inability to master age-appropriate behavior in the home, school, and community' (p. 60). It should be emphasized, however, that not all adolescent sex offenders have been sexually abused (Berenson, 1988). They also commit

other crimes such as vandalism, stealing, and firesetting, often engaging in illicit behavior because they are easily bored.

In addition to these characteristics, by far the most important element in the profile of an adolescent sex offender is that of cognitive distortion. This is manifested by 'an undercurrent of misinformation and strange beliefs and attitudes' which form the foundation of 'decisions based on faulty perceptions or "thinking errors" ' (Lakey, 1992).

Yochelson and Samenow (1976), who originated the thinking error theory, insisted that criminality is by choice. The criminal mind does not burn with the quest for information unless facts are needed to commit a criminal act. Adolescent sex offenders get an idea, form an opinion on what they wish to happen, and act as though it will happen, with little or no feasibility research or consideration for morality or reality.

From their tower of superiority and uniqueness, they think of themselves as being immune to pedestrian rules the rest of society must follow. They set their own guidelines, ignoring those of society, taking what they want, believing they already 'own' it anyway, and always assuming they will not be caught. A minor act of good will wipes out all previous evil behavior (Breer, 1987). This modus operandi, which dominates their lifestyle, legitimizes their outrageous disrespect for the rights and feelings of others. Their thinking error of 'I believe what I want to be true, therefore it is true' distorts all responses.

Treatment

The major thrust of treatment is to prevent reoffending. This begins with breaking through denial and processing individual motivations, warning signals leading to offending, emotional responses, and offense patterns. The adolescent perpetrator must assume responsibility for his own behavior (Kahn and Lafond, 1988) and its consequences and understand that he has consciously chosen to act antisocially, regardless of any negative background elements (i.e., victimization, poverty, ignorance of the law, low intelligence) (Yochelson and Samenow, 1976; Berenson, 1988). Thinking errors must be identified while nurturing the desire and motivation to correct them. Therapy must delicately distinguish between the offender and the offense so the offender recognizes and acknowledges his human potential to change.

Other important treatment issues involve changing deviant

sexual fantasies and masturbatory practices; the development of conscience and feelings of empathy and remorse toward victims, with an inherent restructuring of the value system; elimination of the need for revenge; anger, impulse, and stress management, and acquiring adequate social skills (Kahn and Lafond, 1988). If a perpetrator has been sexually violated, his treatment must also include victim issues.

The offender must understand the connection between events, his thoughts, and his feelings, all of which triggered his offending behavior. He must be taught to fantasize about age-appropriate partners who knowingly and willingly consent to sexual intimacy (Davis and Leitenberg, 1987; Kahn and Lafond, 1988). The offender must experience feelings of guilt and enough self-disgust (Berenson, 1988) that he recognizes and stays away from high-risk situations because he has no wish to cause harm to others, nor even victimize himself again. He must design moral alternatives to the inappropriate behavior he has traditionally expressed. He must learn to substitute legitimate leisure-time activities (Kahn and Lafond, 1988; Berenson, 1988) for highly exciting flights from boredom, such as setting fires or being chased by police.

He must learn to slow down his reactions (Berenson, 1988), giving himself time to monitor his impulsiveness and control his anger through self talk, thought stopping, and the ability to distract himself into other activities which will defuse rage and frustration. An offender must learn that assertiveness may be expressed without anger. He must gain insight by extrapolating from his own experience and that of others.

He must learn to respond in a respectful way as easily as he has lashed out in fits of explosive anger, hatred, and revenge. He must abandon the objectification of people, particularly sex partners, and learn the social skills that will lead to attracting someone in a loving and committed relationship. In short, he must learn to feel good about being moral.

If it seems as though treatment is an overwhelming task, it is. David Berenson (1988, p. 74), Clinical Director of the Ohio Department of Youth Services, powerfully expressed the demanding dimensions of treatment: 'The best way I can suggest to come in touch with it is to think in your mind what it would take for you to commit sex offenses.'

Treatment takes many forms—lectures, discussions, exercises, instructional videos, movies, written and oral treatment plan assignments, role playing and keeping daily journals. Adolescent sex offenders themselves are a rich source of experiences which

offer lessons in resolving moral conflicts. Role model therapists and other staff members may occasionally share personal anecdotes while teaching the basics of responsibility, morality, sexuality, emotionality, social skills and communication, and relapse prevention. Current news items and television programs offer rich sources for discussions of moral interpretations and judgments, with constant references to good vs. evil.

Didactic experiences can be enhanced by written and oral treatment plan assignments customized to individual needs. Role playing, particularly a specific perpetration, is a powerful therapeutic tool for breaking denial and beginning disclosure. Hearing and reading testimonials from victims of crime, especially sexual assaults, discussing lifelong pain and damage to them and their families, reviewing the continuing anguish of both perpetrators' and victims' families—all are intended to arouse sensitivity to the expression of feelings and to ignite empathy and remorse.

The acquisition of communication skills (interpreting and responding appropriately to verbal and body language messages) and social competency (personal hygiene, dating, manners), lend themselves particularly well to role playing.

There is a general consensus that group therapy is 'the treatment of choice' for adolescent sex offenders (Breer, 1987, p. 105; Davis and Leitenberg, 1987; Margolin, cited in Scavo and Buchanan, 1989). The rationale for this is that a group mobilizes peer pressure as a powerful agent of change in pressing for disclosure and conformation. Weekly individual counseling usually accompanies group therapy in both inpatient and outpatient settings.

Drug therapy to reduce sexual appetite and the use of the plethysmograph to monitor erectile response to sexual stimuli are generally unacceptable treatment options for adolescent sex offenders. In some states, these techniques might be considered abusive. Drugs for hyperactivity and learning disabilities are used for those students who need them to establish and maintain focus.

CONCLUSIONS

This overview of the profile and treatment of the male adolescent sex offender emphasizes the need for increased public awareness of the potential for this crime to occur. It also strongly suggests the need for comparative research with normal male adolescent

control groups. Our present 'state of the art' therapy does not guarantee a cure. Is there any treatment that would? Various therapy programs need to be compared and many more longitudinal follow-up studies of treated adolescent offenders need to be undertaken. Prevention programs are currently growing in popularity, and perhaps their validity also needs to be tested.

Finally, treatment for adolescent sex offenders does not come cheaply, and usually it is at the expense of the taxpayer. Should not the victim have equal access to treatment? The perpetration of sexual offenses by children on children can no longer be hidden or ignored; awareness, perpetrator treatment, and victim advocacy is everyone's responsibility.

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