The Nature of Adolescent Sexual Offending:
Part one. An Overview of the Problem and Initial Assessment

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Abstract

The nature and clinical typology of the adolescent sexual offender is reviewed. Areas to cover in a social work assessment are discussed. The importance pf the Family Group Conference as the threshold for intervention is emphasised.

Introduction

0ver the past decade there has been increasing recognition of the effects of sexual abuse (eg., Brown and Finkelhor, 1986; Finkelhor, 1990) and with it identification of the perpetrators who commit the abuse. A growing body of literature has been published in the area which deals with both survivor and offender treatment (e.g., Safter, 1988). Those that perpetrate the abuse were once thought to be the old man in the rain coat or someone psychiatrically disturbed. While some offenders can be classified into each of these groups, it is now widely recognised that the majority of offenders are male and are known to the victim (Anderson, Martin, Mullen, Romans and Herbison, 1993).

Prevalence

Adolescent sexual offenders have historically been ignored in both research and treatment. Their behaviour has been classified as “boys will be boys”, "a man's right and “it is just experimentation". Yet increasingly, studies have identified this group of young people as committing a substantial proportion of extensive (often termed 'serious') sexual offences. Research both from New Zealand and overseas, gives weight to the problem.

In a New Zealand study that interviewed 497 women, nearly one third had reported at least one incident of sexual abuse prior to the age of 16 (Anderson, et al, 1993). The women reported that nearly 50% of the perpetrators were under 25 years of age, while 50% of these were younger than 18. The researchers stated; "teenage offenders were a large and often quite violent group, who carried out one quarter of the offences” (Mullen, Anderson, Roman-Clarkson and Martin, 1991, p.2).

American studies have found high rates of offending among adolescents. Abel, Mittelman and Becker (1985) reported that out of 411 adult sex offenders in a community survey, 58% of the adults had started sexually offending during adolescence. In addition 42% of the sample had deviant sexual arousal patterns by the time they were 15 years old. By the time this group were interviewed they had committed 218,900 offences and the total number of victims was 138,137. On average each offender had 336 victims. Other researchers have also reported that a significant proportion of adult offenders started offending during adolescence (Awad, Saunders and Levine, 1979; Longo andGroth,1983). Becker, Cunningham, Rather and Kaplan (1986) found that from a group of 80 adolescent sexual offenders seen on an outpatient programme, 61 % had sexually abused children. These children were mostly under 8 years old. Longo (1 982) reported that from a group of 17 adolescent offenders, 76% had committed offences under the age of 12 and 8 had molested in their childhood. Finkelhor (1979) in a survey of 796 female college students found that one third of the total women reporting victimisation indicated that it was a male aged between 10 and 19.

This research clearly shows adolescent offenders account for a significant proportion of the sexual offences committed in our communities and that there exists a strong link between adolescent and adult offenders.

Offender Characteristics

Though no New Zealand research has been carried out to categorise adolescent offenders, American studies describe adolescent offenders as heterogeneous, coming from all racial and socioeconomic groups in society. In our experience this description would a!so be true of New Zealand.

While the majority of adolescent sexual offenders are male, females do offend and their offending behaviour is similar to male offenders (Fehrenbach and Monastersky 1988).

Research indicates that between 96 - 98% of all adult offenders are male (Farrelly and Sebastian, 1984; Russell, 1983). It is likely that a similar prevalence exists for adolescent offenders and as awareness of the problem increases, so will the percentage of female offenders. In future studies we estimate that this might be between 5 and 10 per cent of the total adolescent sexual oftenders. We could find only three studies in the literature that discussed female adolescent sexual offenders (Fehrenbach, Smith, Monastersky and Deisher, 1986; Fehrenbach and Monastersky, 1988; Scavo, 1989). This may be due to a number of reasons. Firstly, the research into adolescent sexual offenders is still relatively new compared to adult offenders. Secondly, society ascribes social rules that place men as the aggressors and women in subservient roles. And finally, women do not fit society's view of what constitutes a sexual offender. The issues to be addressed in assessment and treatment are the same regardless of the adolescent’s gender.

Offending Behaviour

Overseas research has shown that adult sex offenders who begin offending as adolescents often start their offending behaviour by committing less extensive often termed "hands oft offending". Longo and McFadin (1981) found from a group of 84 adult rapists and paedophiles, that 45% had engaged in voyeuristic behaviour as an adolescent, while 37% had a history of exhibitionism. Of these two groups, 62% had committed both types of behaviour. In Longo and Groth's 1983 study of 231 adult sexual offenders ' they found that at least 30% had histories of 'hands off offending’ (e.g., voyeurism and exhibitionism) and that such behaviour occurred more often in the histories of child molesters than rapists. Though not documented, from our experience at both the Leslie Centre and the SAFE programme in

Auckland, we have seen a significant number of sex oftenders who started hands off offending (e.g., obscene phone calls) and moved onto more extensive offending (e.g., genital touching) in their adolescent years.

From what has been described in the literature, adolescents may present with one type of behaviour but have often engaged in many different types. The type of offending behaviour can be identified on a continuum. They tend to focus their particular offending behaviour by late adolescence, often starting with behaviour where they are less likely to get caught. As we have seen this may include obscene phone calls, voyeurism, etc., but it often involves molesting young children. The adolescent offender finds these victims easier to control, often easier to access and they see them as less threatening.

Becker (1990) has described a number of possible reasons why they engage in this behaviour. She notes that some are socially withdrawn and have contact with people younger than themselves because of their inability to relate to their age appropriate peers. For others it maybe part of generalised behaviour problems, whilst some adolescent offenders will have deviant arousal patterns, fantasising and masturbating about their offending behaviour. For these adolescents the abusive act is reinforced in the process of fantasy and masturbation and reduces internal defence mechanisms that may inhibit offending. Over time the fantasies become stronger, until the adolescent offends. The fact that adolescents become conditioned to this deviant arousal is thought to be one reason why a significant number of adolescents will continue offending into adulthood unless they receive masturbatory reconditioning treatment

A significant body of research (e.g., Becker, 1988; Freeman-Longo, 1986; Ryan, 1989) has focussed on the victim offender as a causal factor in males who have been sexually abused and later go on to sexually abuse others. Many families and professionals who work in the area believe that most sexual offenders have histories of abuse (e.g., physical, emotional or sexual). Studies (e.g.,Becker, 1988; Longo, 1982; Seghom, Prentky and Boucher, 1987) of male sexual offenders show that between 19 and 57% have been sexually abused. When these rates are compared to the general male population (2.5-8.7% Finkelhor, 1990) they do show higher rates of sexual abuse. However it must be remembered that being sexually abused does not make someone become an abuser and is never an excuse for sexual offending and other abusive behaviour. Hindman (1988) found that adult sexual offenders self-reported much higher rates of their own sexual abuse early in treatment than they did later, following polygraph test.

Therapeutic Assessment

The assessment of adolescent sexual offenders requires one to have an indepth understanding of the behaviour in which they engage. They are likely to deny and minimise their offence and some will have previous offences for which they have not been caught. If adequate assessment and intervention does not take place, the community remains at risk. An assessment should include the following:

1 . The type of offending behaviour including offence details.
2. The duration of offending.
3. The number of offences.
4. The degree of force/physical violence and/or coercion that was used.
5. Their level of honesty and responsibility for their behaviour.
6. Their level of motivation and desire to have counselling.
7. The presence of any other antisocial behaviour.
8. The presence of inappropriate sexual fantasies and pornography in their offending cycle.
9. Past history of sexually abusive behaviour.
9. A personal history of sexual, physical or emotional abuse.
10. Family relationships, their parents beliefs about their son's offending (including the level of responsibility they think their son should accept) and their support for the adolescent.
11. Social skills and the ability of the offender to express their anger appropriately.

Before beginning any assessment of an offender, the social worker must confirm that the behaviour is, in reality, offending behaviour. Particularly with younger offenders (i.e., those less than 12 years old), there will need to be an assessment as to whether this is sexual offending rather than sexually reactive behaviour which requires a quite different treatment approach (Gil and Cavanagh, 1993). The goals in the assessment of an adolescent sex offender are to examine the nature, extent, and severity of the offender's behaviour, to check current safety - the risk to others in the immediate situation, and explore their motivation to attend counselling/therapy. It would be unrealistic to expect that an offender will immediately disclose all of their offending, but it is important to gain some idea as to their historical offending, their present offending, their most extensive offence, and their attitude towards their behaviour (Gil and Johnson, 1993). In addition the social worker needs to assess their motivation for attending counselling and their level (if any) of suicidality The role of the social worker in the initial assessment is not an investigative role. Rather, it is therapeutic. It is the role of those in the legal system to determine whether or not an offender is guilty of offending (McGrath, 1990).

Salter (1988) suggests that engaging sexual offenders in general requires a different set of therapeutic principles, thus the social worker/client relationship is somewhat different from the more traditional "insight" approaches which can be applied to other clients. As previously stated, nearly all sexual offenders deny or at least minimise greatly their offending. In addition, they will often be highly ambivalent about changing their behaviour. Yet, due to the harm that these young people cause to others, the social worker cannot allow their behaviour to go unchallenged.

It is often suggested that adolescent sexual offenders need to be self-motivated in order for treatment to be successful. This is now generally discounted by those in the field (e.g., Garland and Dougher, 1991; Salter, 1988). What is held to be most effective in treatment is the existence of one or more 'behavioural contingencies' (Garland and Dougher, 1991) that will compel the offender to attend and then continue treatment. Among the most useful forms of leverage is pressure from third parties e.g., family, or threats from the legal system. In our experience, the true motivating power of leverage is usually contained in the threat of sanctions, as opposed to the actuality of sanctions.

Adolescent sexual offenders do not usually develop the intrinsic motivation towards treatment until they have learned some other ways of meeting their needs, learned to control the abusive behaviour and have begun to develop some empathy for their victims (Loss and Floss, 1988).

Unlike social work with other clients, the social worker must take an explicit value-stance with adolescent sex offenders. The worker should make it clear to the offender that they believe child sexual abuse is unacceptable as it is harmful to children, that children are more reliable reporters than offenders, and that the social worker has no intention of colluding with the offender in any way (Salter, 1988). In doing this, the worker is both setting clear limits for the offender and is modelling an honest relationship. It is vital that the social worker remains consistent in this approach.

It must be made clear to the adolescent that certain 'unsafe' behaviours are completely unacceptable. A set of safety rules can then be drawn up which must be able to be articulated by every member of the offender's household (Berliner, 1992). The social worker should advise the offender that family and friends will be asked to monitor these rules and report back to the social worker.

Another important limit concerns confidentiality. It is essential that the social worker explain to the offender and their family that, while most of the information shared will be confidential, any information disclosed which leads the social worker to have concerns regarding the safety of any other person will be shared with other people or agencies as necessary. This applies both to current offending and to historical offending.

Trust is traditionally an essential part of the social worker/client relationship. With adolescent sex offenders, this cannot be the case. Due to offenders' strong invitations to be collusive, social workers should be extremely wary of efforts on the part of offenders to convince them that they can be trusted in regard to re-offending (Salter, 1988). While empathy and acceptance are essential in work with sexual offenders, the social worker must strive to be non-collusive at all times (Garland and Dougher, 1991).

It is essential that the social worker has a clear grasp of the offender’s motivation. Garland and Dougher (1991) suggest that practitioners in this field often underestimate the offender's motivation to change by having expectations that are unrealistic. They suggest that no-one should minimise how embarrassing disclosure is for the offender. In addition, an approach which is motivational rather than forcefully confrontational is much preferred (Garland and Dougher, 1991; Salter, 1988).

Few adolescent sex offenders admit that they deliberately set out to harm a child, despite the obviously harmful nature of their behaviour. All sex offenders, including adolescents, operate from a set of distorted beliefs which protect the offender from having to admit the harm they are causing and thus allow the offending behaviour to occur. These cognitive distortions take several forms - denial, minimisation, rationalisation and justification. At the time of the initial interview, these beliefs may lead the offender to deny the need for treatment. The social worker must be aware of these beliefs and take them into account when engaging the offender.

Discussion

There exists a need in New Zealand to provide appropriate and thorough assessment, along with counselling, for adolescent sexual offenders and their families. New Zealand and overseas research indicates that if this is not provided it can have long lasting effects on our society

For those families who come to the attention of the New Zealand Children and Young Persons Service the threshold and nature of intervention with adolescent sexual offenders needs to be set at the Family Group Conference. By using the Family Group Conference as the first stage of intervention (in some cases Court may later be usefully involved), the adolescent offender and their family can receive the message that the offending behaviour is wrong and that the adolescent can start facing the consequences of their behaviour. Although social work assessment also provides an opportunity to ascertain the level of risk and give advice about appropriate intervention. Many clinicians (e.g.; Salter, 1988) emphasise that this requires specialised skills, some of which are different from general counselling. Without this there remains a risk of not changing the adolescent’s abusive behaviour and therefore increasing their risk of re-offending.

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