

The Nature of Adolescent Sexual Offending

Part Three: Treating Adolescent Sexual Offenders and their Families.

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Introduction

The aim of this article will be to describe the major approaches for treating Adolescent Sexual Offenders. This is the final article in a three part series on Adolescent Sexual Offenders. In Part One and Two we gave an overview of the problem, described assessment criteria and discussed practical intervention strategies available to the Social Worker when interviewing an Adolescent Sexual Offender and his family on their caseload.

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Treatment Issues

It is well recognised that without treatment Adolescent Offenders are a serious risk to community safety. As described in Part One, approximately half of all adult sexual offenders started their offending during adolescence (McCarthy and Lambie, 1995). The notion that they commit less extensive (often called "serious") offending is widely recognised as a misnomer. (Becker, Cunningham-Rather, and Kaplan, 1986).

Many adolescents and their families need to be mandated to receive treatment because of a lack of awareness about the seriousness of the problem, their minimisation and denial, and the often long term commitment that needs to occur in order to receive effective treatment. The Youth Justice FGC is the most effective place for this process to begin. Here they can be made accountable for their behaviour, face the Victim and/or their family, and be made to pay some reparation to the state and possibly the victim. If such a process occurs the seriousness of what they have done is drawn to their attention. This in combination with appropriate treatment can reduce the likelihood of recidivism. Contrary to some beliefs, more effective treatment can be provided through mandated treatment rather than self-referral (Loss, Ross, and Richardson, 1986; Salter, 1988). In fact Chaffin (1994) reports sexual offenders who had been criminally prosecuted scored higher progress ratings, higher attendance rates and developed greater victim empathy than those not prosecuted.

Given the above, it is clear that treatment should occur in all cases of adolescent sexual offending regardless of the behaviour. However, how long should the treatment phase last? The American National Task Force on Juvenile Sexual Offending (ATFJSO) was set up in 1987 to suggest standards for assessment and treatment of Adolescent Sexual Offenders (AMSO, 1993) and Salter (1995) both recommend that treatment of adolescent sexual offenders requires a minimum of 1 to 2 years. The length of treatment will depend on the needs of the individual with some requiring less than 1 year, and others more than 2 years.

The effectiveness of treatment is enhanced with comprehensive, multi-faceted approaches of individual, family and group therapy. Within this framework a number of different issues need to be addressed. Some of these are common to all adolescent sexual offenders while others are influenced by an individual's offending behaviour (including the length of time involved in offending, the number of victims, offence behaviour), whether they have a personal history of abuse, level of family support, other "non-sexual" offending behaviours, educational level, and their attitude to their offending (e.g., level of minimisation and denial, and degree of empathy for their victim). Treatment also needs to 'fit' with the different theories on the aetiology of sexual offending.

It is widely recognised that a number of different theories have developed explaining sexual offending behaviour (Ryan, 1991). Some of the main theories are described below. Learning theory argues that the behaviour is learnt from three things. Namely, observing and later modelling the behaviour; the pairing of sexual arousal with a deviant behaviour, or that the deviant sexual behaviour is paired with reward or punishment. Developmental theories suggest that a child's experience in their immediate and wider family system has a significant impact on subsequent behaviour. The Addiction theory (Carnes, 1983) proposes that the behaviour exists because of physiological and psychological reinforcement

during the deviant act. This model also argues that the family system is an important place in maintaining patterns of behaviour that occur across generations.

A feminist theory (e.g., Brownmiller, 1975) proposes that males are socialised to control and dominate others. Such behaviour manifests in all areas of life including family and sexual relationships. This domination of women and children is one reason why most of the violence in society is perpetrated by males.

In response to the above theories, a range of treatment approaches have been developed. Some of the areas that should be addressed in treatment include: denial, minimisation and cognitive distortions, healthy sexuality, deviant arousal, pornography use, stereotyped views of men and women's roles in society, patterns of offending, substance abuse, anger management, personal abuse history, social skills training, victim empathy, apology, non-offending "at risk" behaviour and family issues (ANTFJSO, 1993).

Individual Therapy

Individual therapy is commonly the initial contact point with the offender. In this process, care should be taken to establish a good level of rapport with the adolescent and to help minimise the shame and anxiety they often experience in the early stages of treatment. The aim in the early stage is to gain as full a disclosure as possible of their current and past offences. It is useful to enquire about other abusive behaviour that they may not have presented with (e.g., indecent exposure, obscene phone calls, stealing underwear, etc) as it is not uncommon for adolescent offenders to have a range of paedophilic behaviours, for which they have not been caught.

In the early stages of individual therapy it is essential that the therapist makes a thorough assessment of any safety concerns surrounding the adolescent at this time e.g., current contact with children, level of sexual fantasy, and removal of the adolescent from living with other children.

Cognitive distortions commonly occur with adolescent offenders. With a balance of challenging and questioning it is important that over time they accept responsibility for their offending. Group therapy however provides a more effective environment where individuals can be challenged by their peers. It is generally more difficult to achieve this in individual therapy where the therapist may be seen as an authority figure.

Individual therapy also provides an opportunity to address deviant arousal patterns. Some of these techniques include the following:

1. Journals of sexual fantasies where the adolescent is asked to self-monitor their sexual fantasies can be given as homework tasks and later reviewed and discussed in subsequent therapy.
2. Thought-stopping techniques can be taught to control deviant impulses. It is often necessary to ask the adolescent to demonstrate these at subsequent sessions to ensure that they are fully conversant with the method.
3. Verbal satiation can also be taught to treat deviant impulses. This method involves talking for 10 minutes about consenting sexual behaviour with the same aged peer, followed by 50 minutes talking about sexually abusing someone. The latter exercise must be similar in description to their abusive behaviour. Hunter and Goodwin (1992) report greater treatment effectiveness with older adolescents and that such techniques may require from six to nine months for those adolescents who have long histories of offending and may be unresponsive to other therapy.

Individual therapy can also be used to counsel adolescents who have personal histories of abuse, and to address issues not appropriate for group therapy but directly related to the relapse prevention programme (e.g., anxiety, depression, suicidal ideation, etc.).

In some instances it may be appropriate to refer to specialised programmes outside an adolescent sexual offender treatment programme. This might include the treatment of substance abuse, anger management, and social skills training programmes.

Group Therapy

As with adult sexual offenders, group therapy should be a central component of any comprehensive therapy programme for adolescent sexual offenders.

Given that the challenging of one's behaviour is most effective from one's peers as opposed to a therapist, and that, developmentally, adolescence is a time where peer influence is extremely important to one's identifying behaviour, group therapy is an ideal place to address many of the treatment issues.

A variety of approaches have been used including a Pre-adolescent Assessment group and subsequent group therapy for those adolescents assessed in need of this (O'Brien, 1981); an entirely cognitive-behaviour rally based group programme (Becker, 1990); group therapy based around a series of graduating levels (Simmonds & Houlahan, 1991; Smets and Cebula, 1987); Outdoor Wilderness Group Therapy, (Hickling, 1992; Simmonds and Houlahan, 1991); while Ryan and Lane (1991) use the adolescents' understanding of their own sexual assault cycle as a central component in the content of group therapy.

On the SAFE Programme we combine wilderness group therapy and a series of graduating levels originally developed at the Leslie Centre (Hickling, 1992; Simmonds and Houlahan, 1991). This encompasses role training, psycho-educational, cognitive-behavioural, behavioural, psychodrama and social skills.

Wilderness Programmes

A central component of treatment during the SAFE Programme is a ten day outdoor wilderness group therapy experience. The therapeutic value of this cannot be underestimated. We have found that the group process increases significantly over the period of 10 days, with the relationships being enhanced between the adolescents and facilitators. In our experience this enables therapy to occur at a deeper level over a shorter period of time. Another reason for the outdoor component is practical. It is simply easier to provide treatment for adolescents in an intense way when they are a "captive audience" for a set period rather than in weekly groups which are invariably erratically attended because of the large geographical area in which adolescents have to travel from school, home and work.

The other rationale for a wilderness component is therapeutic. Adolescents with a history of failure, as with most adolescent sexual offenders, frequently believe that they are worthless, hopeless, and incapable of succeeding at any task (Babor, et al, 1991, cited by Latta, 1995). Social learning theory (Bandura, 1977) states that an individual must not only know how to achieve a desired outcome, but also must believe they have the ability to succeed in actually achieving it. Accomplishing a series of physical challenges - mountain climbing, rafting, caving - allows the adolescent on the SAFE Programme a sense of achievement which increases their self-esteem and motivation to succeed (Castelano and Soderstrom, 1992). These physical challenges enable the adolescent to believe that he can also succeed in meeting the challenges presented later in therapy.

Experiencing these challenges as a group facilitates group cohesion, thus enabling the adolescent to gain support from peers. A success-oriented, supportive environment is therefore created and can be used to motivate the adolescent in later therapy.

Similarly, Garrett (1985) noted that wilderness programmes reported the greatest effect on recidivism rates. However, Catalano, et al. (1990) caution that positive changes made during a wilderness programme are gradually eroded over time as the adolescent returns to the real world "with their reputations and relationships unchanged."

At SAFE, three procedures guard against this. First, family therapy as will be outlined later is offered throughout the programme in an attempt to support relationship changes. Second, follow-up therapy groups are held approximately monthly for several hours on a weekend for the year following the wilderness component. Third, individual therapy continues alongside both of these in an effort to support the adolescent to maintain changes, and to address individual issues such as their own victimisation, deviant sexual fantasies, substance abuse or anger management. And finally, a 4 day outdoor wilderness intensive group is held towards the end of the relapse prevention programme. This intensive group serves as a "booster" before their eventual exit from the programme.

Group Treatment

In group therapy the areas which are typically addressed include understanding one's offending cycle, sex education and healthy sexuality, assertiveness and social skills training, victim empathy, attitudes about how to treat others, and cognitive distortions.

The areas which therapists cover in group therapy will depend on a number of things including available time and resources. Mix gendered therapy teams are considered optimum and provide modelling to the adolescents about how men treat women with respect and also about how women are able to be strong and be leaders.

In the initial stages of any group treatment programme, it is important that the adolescents disclose to the group their offending behaviour. The therapist may want to preface it by highlighting the difficulty that they face in doing so and the need to be honest. In the SAFE Adolescent Programme (SAP) we highlight that this marks an important step in their removing some of the shame they have experienced as a result of their offending and that the more honest they are, the more useful this will be for them. It is also a time where any sense of isolation they may have been experiencing is removed and they begin to hear other boys' offences. It is not uncommon for some families to express their concern that their son may pick up ideas of other offending behaviours they may act out. In our experience this has not been the case because:

1. The adolescent will already be aware of other offending behaviours they may have not necessarily engaged in.
2. The process is often a time of embarrassment about what has occurred.
3. The therapeutic milieu of the group process is one of stopping offending and changing to more positive behaviour.

Following this stage a variety of areas may be covered.

1. Discussion about what is sexual abuse and who engages in that behaviour and why. This serves as a warm-up to the subsequent therapy. The style of group facilitation will depend upon the personality, style and skill of facilitators. However, we stress that it should not end up being reminiscent of a classroom setting, nor military academy where the facilitators ask questions and dictate orders or are forcefully confrontational. Some answering of questions and structure to the groups is important, but wherever possible the group would ideally progress to a level where it is running often facilitated by the adolescents themselves.
2. Each adolescent can be asked to, in turn, present a genogram depiction of their family and the quality of the adolescent's relationships with other family members. This serves two functions. Firstly, it gives the therapist insight into the adolescent's level of isolation within the family, any issues (e.g., grief, conflict) that need addressing in later family therapy, and give the adolescent an opportunity to disclose any emotionally painful or victim experience they have had within their family. Secondly, it allows the adolescent an opportunity to "warm-up" to thinking about families, family roles and victim experiences which can subsequently be used to facilitate their achieving victim empathy.
3. Previous experiences of the adolescent's own victimisation (e.g., sexual, physical, rejection) can be explored as a further warm-up to victim empathy. Each adolescent in turn may draw a picture of themselves in that experience and present it to the group. They can receive empathetic feedback from the others. This serves as a warm-up to victim empathy for the other boys in the group.
4. Victim empathy may involve education about the effects of sexual abuse, watching videos where victims describe the effects on their lives of being sexually abused and discussing these, and role playing the victim and offender. This latter technique was expanded at the Leslie Centre (see Simmonds and Houlahan, 1991) to using the Psychodramatic method. This has since been adopted and further developed over the years and is now used on both the Adult and Adolescent Programmes at SAFE.
5. The adolescent's offending pattern and the cycle of offending. This involves their gaining an understanding of what led them to offend, what helped continue them offending, what occurred during the actual offence and what they experienced afterwards. On SAP this includes their thoughts, feelings, behaviours and environmental surroundings. The discussion of each offending cycle in the group and the relating of this back to a typical sexual offending cycle often gives the adolescent as well as therapist significant insight as to why they started and why they continued offending. Ryan and Lane (1991) give an excellent and detailed description of the way in which they use the offending cycle in their treatment programme.

6. Each adolescent must generate ways in which they can remove themselves from their offending cycle. Ongoing discussion of both the offending cycle and strategies to prevent their re-entering it are important in individual and family therapy. A high level of self awareness, when combined with good motivation can contribute to the offending cycle being a key component in preventing re-offending.

7. Many adolescent offenders have little knowledge about sexuality as well as having distorted views. Basic sex education (this can include male and female anatomy, sexual arousal, sexually transmitted diseases, contraceptives), as well as the importance of no violence, a consenting same aged peer, respect and love when having sexual relationships are important to educate adolescent offenders about. Often a fruitful discussion can occur about sexual orientation and any confusion or concerns people may have about this. This is often especially relevant for those adolescents who have offended against boys or who have disclosed to the group having been sexually abused by a male.

8. Role training is particularly suited to group therapy. Here, scenarios which might be potentially risky for the adolescent can be acted out. This often involved being faced with meeting children in playgrounds or at family occasions. Other role training exercises can occur around the forming of age appropriate relationships. The boys can have turns and receive feedback from each other as a "fish bowl" approach to this exercise occurs. Those adolescents who find this exercise difficult can have their learning enhanced through the modelling they receive from other adolescents. It is often a fun occasion and one where adolescents can feel a new sense of achievement as the skills are often mastered relatively quickly.

Role training can also be employed to improve assertiveness skills and for anger management. One of the strengths of role training is that, though the primary need may lie with one individual, every adolescent cannot help to benefit by the mere fact of their participation in the group. It is important in role training exercises to include every group member so as not to isolate those individuals in greatest need. This also ensures that the group's cohesion is maintained.

9. All male sexual offenders have attitudes about how to treat women and children which have allowed the abuse to start and continue. Such beliefs are often so dominant that they become installed in their thought patterns over time and develop into entrenched cognitive distortions (e.g., "she liked it", "he asked for it", etc) which enable the offender to justify their actions, move from one victim to another and continue offending despite the victim experiencing obvious signs of distress (e.g., crying, trembling, etc.) during the actual abuse. In group therapy the adolescent's beliefs can be changed through education, challenging, and using the process of victim empathy to allow the adolescent to experience a time in their life when they were made to feel powerless, scared, and humiliated. Such discussions are important to be included throughout the entire course of therapy (e.g., especially when they made the initial disclosure, during victim empathy and sex education). If we are to be successful in our therapy we believe it is important to change those attitudes that perpetuate their thinking that they have a sense of 'entitlement' to others and can treat them as if they were their own property. Such changes in attitudes and behaviour should not be isolated to sexually deviant behaviour but should include both the physical and emotional treatment of others.

10. The apology session is a place where the adolescent apologises for what they have done. This occurs once the major treatment components have been completed. It should include an apology to the victim and their family, as well as the adolescent's own parents/caregivers. It does not need to be long but should include the following:

1. They take full responsibility for their offending.
2. The victim and their family are not to blame.
3. They are sorry for what they did.

It is important that they do not ask for forgiveness and do not state in detail what they are sorry for doing as reading this may re-traumatise the victim and their family. Whether the letter is sent to the victim and their family will depend upon a number of things, including if the victim chooses to have contact with the adolescent via a letter. In many cases they may not. For the therapist it is important to liaise with the victim's social worker or counsellor in order to establish whether it is appropriate that the letters are sent. Should it be established that it is, then the letters must be reviewed and sent by the therapist who is counselling the offender.

The above is only a brief overview of some of the main areas to address in treatment. For more detailed descriptions on the treatment of adolescent sexual offenders please refer to Barbaree, Marshall and Hudson (1993), and Ryan and Lane (1991).

Family Therapy

Family-oriented approaches to therapy with child sex offenders have, in the past, been criticised especially by feminist writers e.g., McLeod and Saraga (1988). Much of this criticism has been directed at approaches which stereotyped dysfunctional families (Mrazek and Bentovim, 1981) and submissive mothers as partially responsible for the abuse.

However justified this criticism, more recent attempts at family therapy with adolescent sex offenders, has focussed on educating, and supporting the family, and assisting them to place responsibility for the offending with the adolescent himself. These approaches have also recognised that the family of an adolescent sex offender is, in many ways, a victim of the abuse, too. Families in which an adolescent sexual offender has been found have been observed passing through a number of stages similar to a grief process (Jones-Smith and Trepper, 1992). Parents, in particular, often blame themselves, and require support to communicate with their son about the offending, and to maintain effective parenting to siblings. Having an adolescent sexual offender in the family is often a time for the family to re-evaluate its beliefs, values, lifestyle and priorities.

Conversely, a family may present with similar cognitive distortions to the offender and be in absolute denial that the allegations could be true.

Family therapy is a key component in the treatment of adolescent sex offenders. Without family therapy there is a risk that any progress made in individual or group therapy will be undermined by the family's lack of understanding of the seriousness of the problem and the adolescent returning to unchanged and dysfunctional family dynamics.

The family is a powerful influence on the motivation of an adolescent offender (Stevenson, Castillo and Sefarbi, 1990). Evidence for this is provided by studies which have indicated a correlation between family organisation and the ability of the offender to admit or deny the abusive behaviour (Sefarbi, 1990).

While family therapy is indicated in the literature as an important element in treating the adolescent offender, it has also been noted that, in incest cases, if family relationships, especially the parental relationship, is strengthened by such therapy, care needs to be taken by the therapist that the victim is not left feeling even more isolated and frustrated (Satagun and Prince, 1989).

The following are issues which the therapist must address in therapy with the family of an adolescent sex offender: family denial and disbelief; safety concerns for others; the need for support for family members especially those who have directly been the victims of the abuse; enlisting their on-going commitment to their son receiving treatment on a long-term basis; assisting them to understand the seriousness of the problem; alerting them to current and future risks; establishing safety rules; and, depending on the family circumstances, facilitating eventual family reunification, if possible and/or appropriate.

Most families know very little about adolescent sex offenders, their thinking patterns, and their secretive behaviours. Most struggle to comprehend how the son they thought they knew well could have deceived and betrayed them. It is completely understandable that a family could not possibly be expected to know how a cognitively distorted offender will think and act. Because of this, one of the main roles of the family therapist is to educate the family about sexual abuse (e.g., the effects of sexual abuse) and adolescent sexual offending. This includes the reasons why their son might have offended, the sexual offending cycle and how their son's offending fits into this, the techniques that their son must use to remove himself from the offending cycle, what treatment involves and the rationale for the length of treatment. Another important phase in the latter stages of family therapy is to ensure the family has a good understanding about relapse prevention and the need for on-going support and monitoring of their son's behaviour.

Families of adolescent sex offenders may be very difficult to engage in therapy. Various reasons exist for this. Practical barriers often present themselves e.g. cost, transport, childcare, time off work and school. Cultural barriers may exist which make the therapy unsafe or inappropriate. Previously

unsuccessful attempts at resolution of family problems can give families a hopeless feeling about further intervention. Families in which generational abuse is a long-kept secret may be resistant to the therapist having access to the adolescent, fearing that he may tell all. The family may not believe that the abuse happened, may minimise it, or may believe that they have already successfully dealt with it. These families are often so disorganised and disengaged that they may be unable to assemble to address the problem at all (the FGC process can be a first step in overcoming this). The family may be so hurt and shocked that they effectively banish the adolescent from the family and disown him, refusing participation in therapy. Lastly, some families' denial is so strong that they want revenge on the victim for disclosing and refuse to allow their son to be "dealt with" unless the victim endures similar treatment.

In family therapy we believe it is important to work in mix-gendered, co-therapy teams. This is because men and women's needs in families are often quite different and therefore may best be met by talking with a person of the same gender. A further reason is that the family dynamics can be more accurately assessed and worked with by having another person in the room.

Relapse Prevention

As discussed earlier in this article, parallels have been drawn between sexual offending and alcohol addiction. From the alcohol field, Pithers, Marques, Gibat, and Marlatt (1983) have developed a model of relapse prevention for working with sexual offenders. This model can be applied to adolescent sexual offenders as well as adult offenders. Its basic premise lies in the fact that sexual offending cannot be "cured" but rather can be "controlled". Part of a relapse prevention programme involves making the adolescent and their family aware about critical points in the developmental life cycle where they are likely to be most vulnerable to re-offend and ensuring that they know the details of their offending cycle. This must include their own high risk behaviours.

Issues for the Therapist or Social Worker

The treatment of adolescent sex offenders is a complex process and often places the therapist or social worker in ethical or practice dilemmas. Several important considerations have been noted in the treatment literature (Ross, 1988; Roundy and Horton, 1990; Conte, 1990).

1. Working as part of a team or, at least with a colleague is a means of obtaining support, critique of one's practice, and peer supervision. This also helps avoid the temptation to become collusive with the adolescent and/or his family in the face of their hostility to the invasion of secrecy that therapy demands. Working with a colleague can also protect the worker from adolescents who are manipulating, threatening, or aggressive.
2. As has been mentioned with regard to family therapy, having a male and female therapy team can also be useful in terms of adolescents being given the opportunity to see appropriate male/ female behaviours and relationships modelled by the therapists. Some adolescents respond better in treatment to a male or a female therapist indicating that, if possible, both should be available.
3. The importance of supervision in this work cannot be overstated. This work is intense, time-consuming, emotionally draining, and sometimes unsuccessful with tragic consequences. Those working with adolescent sex offenders require a supervisor with some knowledge in the field and some experience, if possible, of the ethical dilemmas these clients often pose.
4. Specialised training is also essential. Adolescent sex offenders require particular methods which are similar but also significantly different from other clients, even adult sex offenders. There is evidence to show that treatment effectiveness is enhanced by specific training. Abel, Becker, Cunningham-Rathner and McHugh (1983) found that offenders disclosed 20% more offending to therapists skilled and experienced in this field than they had done when interviewed by therapists not specifically trained and experienced for this work.
5. The limits of confidentiality with adolescent sex offenders will be different to that in therapy with other client groups. There must always be a clear understanding at the outset of treatment that, should the adolescent disclose any information that leads the therapist to have concerns for the safety of any other person, the therapist will not be able to keep that information confidential. Such instances might be: disclosures of current offending; disclosures of historical offending where a child victim's family are unaware of the abuse and where the victim has not had the opportunity for appropriate counselling; and suicidal or homicidal intentions expressed by the adolescent.

6. The therapist or social worker will need to maintain a balance between sympathy for the adolescent's own victimisation and traumatic past and their disgust for the adolescent's abusive behaviour. No adolescent will risk making themselves vulnerable in treatment unless the therapist has both modelled emotional openness and expressed real support for them. However, the worker must also be aware of the manipulative nature of adolescent sex offenders and of the invitations they provide for workers to collude with their beliefs and behaviours.

Adolescent sex offenders may be victims within their own families, but they are also abusers. The therapist's primary task is to stop the abusive behaviour. Primarily focussing on the adolescents own victimisation will not necessarily prevent re-offending and may cause the worker or therapist to lose perspective as to the risk that the adolescent presents to others at that time.

7. Similarly, some therapists or social workers may find themselves working simultaneously with the offender and the victim in family therapy, especially if it is a case involving sibling incest. It is generally recommended that family therapy that includes both the adolescent and victim not begin until: the victim, family, and adolescent have attended their own separate therapy and the victim has expressed a wish to be part of such therapy; when the adolescent has admitted his behaviour, accepted responsibility for it and has explained this to his family; when the adolescent has demonstrated sufficient victim empathy and apologised appropriately; when he has demonstrated an awareness of ways of exiting his offending cycle; and when the family has accepted the on-going risk the adolescent poses, safety rules are in place, and the family has agreed to monitor these.

8. The therapist or social worker may need to stop treatment and return the adolescent to the justice system if therapy is not working or the adolescent is, after some time, not motivated for treatment. Many therapists find this difficult for a variety of reasons - it may be seen as failure on the part of the therapist, or as an action that will punish the adolescent or cause him to dislike the therapist. Such situations require competent supervision.

9. Sex offender, treatment is often viewed by colleagues as a waste of time as offenders cannot/ will not change. Workers in this field who suggest therapy rather than custodial consequences may be accused of being "soft" in their approach. This reinforces the need for effective networking and collegial support for workers in this field, and for wider education of other helping professionals.

10. Some therapists or social workers may find that they need to adopt a new treatment approach to the one they use for other clients. Research over the years has shown that "insight" therapies or Rogerian techniques are not effective with this client group. Specialised training and supervision are again indicated.

Therapists will also need to adopt an explicit value stance with these adolescents. This may necessitate a significant change of style for some therapists or social workers. These adolescents will constantly challenge a worker's values, whether implicitly or explicitly.

11. Working with adolescent sex offenders will test the personal resources of the therapist or social worker. It is an intensely emotional experience listening to adolescents describe extreme sexual violence and their own victimisation, especially in a group setting where many such accounts are related one after the other. Even for those of us who have worked for some years with adult sex offenders, the experience of hearing this information from young people is particularly distressing.

Before entering into this work, a therapist or social worker needs to anticipate the emotional distress it will cause them and take effective preventive measures with regard to burnout. At the same time as feeling horror at the adolescent's behaviour or experiences, the therapist must retain a sense of openness and support toward the adolescent changing, providing the therapist with an emotional "rollercoaster ride".

Some of our colleagues have also described how constantly listening to these experiences has negatively affected their own sexual feelings and functioning. Again, these all indicate the need for effective supervision from, if possible, someone with an awareness of the issues that arise for the worker in this work.

12. Some therapists may find themselves working individually with adolescent sex offenders in isolation from other colleagues. While this may be less than the optimum conditions for treating this client group, there are several things an individual therapist might do to overcome difficulties. Working individually with boys until there are sufficient numbers for a group, undertaking training with an interested col-

league, and liaising with a treatment programme in another town for training or supervision maybe possible. Another option could be to provide some treatment individually and refer to a treatment programme in another town for particular aspects of treatment not suited to individual therapy. While sounding a cautious note in outlining these issues for the therapist or social worker, it should also be stated that there has been considerable success over the years in treating adolescent sex offenders. Such success is, without doubt, what gives therapists the impetus to continue with such challenging work. Quite simply, given the issues above, if it didn't work, we wouldn't do it!

The Role of the Youth Justice System

The importance of this treatment being legally mandated has already been discussed. In New Zealand, under the Youth Justice provisions of the CYP&F Act 1989, adolescent sexual offenders are not well served. The maximum length of sentence for supervision in the Youth Court is six months. It is our casework experience that, in trying to secure longer-term mandated treatment in the present system, social workers and other professionals are not assisted by the law.

It seems that, far from being a straightforward process, the only options that become available for securing mandated treatment over the recommended 18 months to two year period occur by either playing around with, or moving beyond the Youth Justice system. Options which, in our experience, have been used are: that, after a period of FGC's and initial court appearances over a few months, the matters become adjourned for (the maximum) six months in the Youth Court while counselling occurs. Thus, long-term mandated treatment becomes available by default and often due to the slow process of the juvenile justice system. Secondly, a referral may be made to Care and Protection section of CYP&F. Again, this is less than ideal as it fails to convey to the offender (particularly those most at risk), that his actions are serious and illegal, must have real consequences which the victim may help determine, and fails to ensure that some effective leverage is available in case the offender fails to complete treatment. The last option we have seen is where a young person is aged 15 or over, and the Youth Court judge refers matters to the District Court or High Court where longer supervision sentences are available. It is our experience that, when this has occurred, it has caused unnecessary delay and stress on all concerned with no real significant gain. This still leaves unanswered how to effectively provide mandated long-term treatment for those aged under 15 years especially when research shows that a significant number of offenders begin offending before this age.

In addition, the Youth Justice Social Worker must take on initially, what has traditionally been a Care and Protection role. As it is generally recommended that an adolescent sex offender is removed from living with any children for at least the duration of his treatment, it becomes the responsibility of the Youth Justice Social Worker to address these safety concerns. In situations where it is felt that a Care and Protection Social Worker needs to become involved, extremely close liaison and understanding of each other's role must occur.

Conclusion

This article has described the major treatment issues to be addressed with adolescent sexual offenders. This includes individual, family and group therapy. Within each these areas we have given an overview of the treatment issues which need to be covered.

Alongside this we have discussed the Youth Justice System in New Zealand and identified a number of short-comings that we have faced and had to work around in our clinical work. We believe that, to ensure both professional and ethical treatment occurs, these need to be resolved. Without this there exists the potential to provide "bandaids" and "quick fixes" to a serious problem.

In New Zealand the National Association for Adolescent Sexual Offender Services (NAASOS) was set up in 1994. This organisation aims to: establish a network for people working with or interested in knowing more about adolescent sexual offenders; provide information for families and community groups; provide training for those wishing to work in the area; and to advise Government on the needs for service delivery for adolescent sexual offenders (more information regarding NAASOS and its activities can be obtained by writing to PO. Box 138, Auckland).

It is hoped that by increasing the number of comprehensive treatment programmes in New Zealand in a variety of settings, the needs of adolescent sexual offenders and their families will be better served, thereby reducing the number of victims in our communities.

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