Juvenile Sex Offenders

CALEB WHITE is a 15-year-old sex offender. He began molesting when he was 12. One of his confirmed victims is his younger half brother. When his mother, Deborah Butler, discovered the offenses in 1988, she had Caleb arrested. After serving a sentence, he was released. Caleb committed another offense in 1989 and was charged with the rape and attempted rape of two young girls.

Washington state placed Caleb in a group home where he received no treatment or schooling for five months. Caleb's mother, insisting that he needed treatment specifically for sex offenders, sent her son into hiding nine months ago. She says she will not reveal Caleb's whereabouts until Washington state agrees to provide appropriate treatment. Mrs. Butler rejected the state's offer to place Caleb in a work camp planting trees with two hours of counseling a week. Caleb's mother says he has beaten his victims and threatened his brother with a knife held at his neck. She is worried that, without proper counseling, he could escalate into murdering his victims. Caleb, interviewed on ABC's television show 20/20, agreed with his mother. A Washington state official commented, "She (Butler) has certainly blown out of proportion the degree of danger that her son presents to the community" (20/20, ABC, July 11, 1991).

Historically, juvenile sex offenses have been minimized or ignored. Children and adolescents generally have not been held accountable for the impact on the victim or the criminal nature of their acts. Even behaviors that were clearly exploitative and criminal have frequently been dismissed as "adjustment problems," "experimentation" or one-time access.

The current interest in juvenile offenders has grown due to experience with adult offenders. Studies of adults who commit sex offenses show that as many as 50 to 80 percent report offending as adolescents (Abel, 1986; Freeman-Long, 1983; Gough, Longo & McFall, 1981).

Furthermore, "inculpate" sexual offenses, such as obscene phone calls, voyeurism, exhibitionism or stealing underwear are not necessarily harmless juvenile pranks. Those working with adult offenders are increasingly documenting a progression of offenses starting with "hands-off" crimes which can give way to more serious "hands-on" offenses such as fondling or rape (Longo & Gough, 1982; Longo & McFall, 1981, both cited in Knopp, 1985).

Incidence

An examination of data from the National Crime Survey and the Uniform Crime Reports (FBI) reveals that rape is a young man's crime (Knopp, 1982). Approximately 75 percent of known rape offenders are under age 30, of those 30 to 40 percent are under age 18. The rate of victimization per 100,000 populations by rapists under age 18 is estimated as nine in inner-cities, seven in suburbs and six in rural areas.

In Vermont, in 1985 there were 1.6 sex offenses per 1,000 juveniles (ages 5 to 17). In Oregon, in 1985 there were 2.0 offenses per thousand juveniles. Washington state shows a rate of 4.9 per thousand juveniles (ages 10 to 19) for 1985-87 (Ryan & Lueb, 1991).

A national probability study (Agnew, cited in Knopp, 1985) collected data from 1971 to 1980. Agnew estimates that 450,000 adolescents (2 percent of the national youth population) committed a sexual assault in 1976, and for 1977 and 1978 estimates that 1 percent committed a sexual crime. There is also growing recognition that a significant portion of molestations of young children is due to adolescents. For instance, 56 percent of child molestation cases seen at Children's Hospital in Washington, D.C., involved an offender under age 18 (Abel, Mirtelman & Becker, 1985; Gough & Lottman, 1985; Ryan and Lueb, 1991), using data from a survey of studies, estimate that over 50 percent of boy victims and 20 percent of girl victims are attributable to juvenile perpetrators. Ryan and Lueb estimate that 8 percent of all males (70,000/year) and 5 to 7 percent of all females (80,000 to 100,000/
Juvenile Sex Offenders

by lan B. Knoepf (1983) concludes, "Adolescent sex offense behavior is widespread and serious" (p. 19).

Characteristics

Byron and Lane (1951) describe the average juvenile offender. The vast majority (91 to 93 percent) are male, with an average age of 14. He is likely to be white (juveniles of all ethnic, racial and religious groups are perpetrators, in approximate proportion to the numbers in the general population). He is probably living with two parents at the time of the offense. However, there is a 50 percent chance that he has had parental loss due to divorce, illness, death or separation due to placement. He probably has no prior arrests for sexual assaults, although he likely has other offenses. There is one chance in three that he has a prior arrest record for non-sexual offenses. Other researchers cite even higher rates of non-sexual offenses, ranging from 41 to 50 percent (Becker, et al., 1986; Fehrenbach, et al., 1986; O'Brien, 1989; Pierce & Pierce, 1987).

The typical offender involves a 10- to 18-year-old child who is not a relative. The assault is unwanted, involves genital touching and often penetration and sufficient force is used to overcome the child's resistance (Ryan & Lane, 1989).

A popular idea is that adolescent offenders have been subject to prior victimization. While many offenders reveal no history of child sexual abuse, rates of abuse for offenders are much higher than for non-offenders. Finkelhor (1980) reported an incidence rate of 30 percent in a sample of New England college men. Incidence rates among adolescent offenders are much higher, ranging from 30 to 40 percent (Becker, et al., 1986; Gomes-Schwarz, 1986; Fehrenbach, et al., 1986; Longo, 1982; O'Brien, 1989; Pierce & Pierce, 1987; Smith, 1988; Wener, cited in Knopp, 1982). Exposure to pornography has also been cited as a predisposing factor (Coleman, 1988).

Another belief is that social inadequacy plays a role in determining sexual offending. Deficits in social skills prevent some offenders from establishing meaningful peer relationships. Being blocked in meeting social and sexual needs compels the adolescent to look to sex with younger children as an alternative. A number of clinical studies provide some support for this idea as teen offenders routinely show serious deficits in social skills (Coleman, 1988; Fagan & Wexler, 1988; Gilby, et al., 1989; Goff, 1977; O'Brien, 1989; Ross & Fabiano, 1988; Smith, 1988; West, cited in Knopp, 1982).

Physical abuse has been cited as a predisposing factor (Coleman, 1988; Fagan & Wexler, 1988; Hunter, et al., 1990; Lewis, et al., 1981; Wener, cited in Knopp, 1982) along with exposure to parental and peer violence (Awdal, et al., 1984; Fagan & Wexler, 1988; Lewis, et al., 1981; Pierce & Pierce, 1987) found 62 percent of their sample had been physically abused; 70 percent had been neglected. Other clinicians cite similar findings (Van Nieuw, 1984; 41 percent; Awdal, et al., 1984, 33 percent; Smith, 1988, 65 to 80 percent).

Family dysfunction is a frequent finding (Awdal, et al., 1984; Coleman, 1988; Isaac, 1986; Ryan & Lane, 1991; Smith & Israel, 1987). Common characteristics are emotional impoverishment, disruptions in care and family, lack of psychological development, lax or rigid sexual climates. The role of the family in the offending is debated, yet most clinicians agree that getting the family involved in the therapy is essential. Many adolescent offenders show delays in learning and cognitive development, as well as problems with impulse control (Coleman, 1988; Davis & Longstreth, 1988; Gilby, et al., 1989; Pierce & Pierce, 1987). It is difficult to ascertain how these organic problems are causative factors or simply predispose the teenager to sexual acting out.

There is also a suggestion that adolescents who offend hold stereotyped perceptions about the roles of men and women, overestimating women as sexual objects. They believe men get power by obtaining sex and women try to control men by withholding sex (Coleman, 1988).

Compared to violent delinquents, juvenile sex offenders have fewer alcohol and drug problems, are less often gang members, and their families are less likely to have been involved with the justice system. Sex offenders also have fewer non-violent offenses, and thus are a "hidden" population that resembles normative youth more than delinquent youth (Fagan & Wexler, 1988).

There is a rationale for subgrouping adolescent offenders. O'Brien (1989) compared three offender subtypes: (a) child molesters, (b) adolescent offenders, adolescents who molest children outside their family (child molesters) and non-child adolescent offenders.

Sibling incest offenders were described as having more severely dysfunctional families characterized by high rates of physical, sexual and drug/alcohol abuse. The sibling offenders were also more likely to have been sexually victimized when younger. Sibling offenders had more severe deficits in socialization, more conduct-disordered and were more likely to have had psychotherapy. Sibling incest offenders had significantly longer histories of offenses (4.3 percent offenses for over three years compared to 5.3 percent for child molesters and 7.9 percent for non-child offenders), and their offenses were significantly more intrusive (i.e., penetration) than the non-familial child molesters or those offending against peers or adults.

Breer (1985) subdivides adolescent sex offenders into two groups, those who molest females only and those who molest males. Breer feels those who molest boys are most likely to have been victims themselves, as well as at higher risk to become an adult pedophile. He suggests that these subgroups be seen in separate treatment groups, as their needs differ.

While he does not suggest a typology, Smith (1988) found differences between adolescent sexual offenders according to their own history of victimization. Those who had been physically or sexually abused or who were from a violent family were significantly more likely to commit serious, "hands-on" offenses than offenders with no abuse history. Becker, et al. (1989), using a physiologic measure, found adolescent male offenders with a history of sexual abuse who had molested boys had significantly greater erection responses to deviant stimuli than
did non-abused adolescent offenders. This finding offers support to both Breer and Smith’s formulations.

Ryan and Lane (1991) offer a typology based on victim characteristics rather than family selection. They note that children who meet their own needs. These children fail to develop an internal view of self-worth. Nurturance has a price and needs are met through manipulation. Rigidity/dimensional families are secretive and isolated, with members co-dependent and symbiotic. The offense may be an attempt to create distance in the mother-son relationship. Chaotic/Disorganized families experience chronic dysfuction, and perpetual crisis. Parent model acting out and relationships are chaotic. The "Perpetrator Family," puts forth a good image hiding an intense level of family breakdown. Previously Adequate families are blended families, through marriage or adoption. Acting on this information and Lane, family dynamics can be causative, supportive or reactive.

Early Treatment Efforts

Specialized services for adolescent sex offenders are recent. In 1982 Knopp identified only 22 programs in the United States. Half were located in four states, Oregon, Washington, California and Minnesota. Within two years, 70 times as many programs were identified. By 1986, Knopp was aware of 410 programs and in 1988 he listed 645 (Knopp & Stevenson, 1989).

Nicholas Groth and his colleagues were prominent in the recognition of the importance of adolescent sexual offending. It was through critical thinking that Groth discovered that the adult offending began in adolescence (Groth, 1977). Groth and others began to suggest the development of specialized assessment and treatment strategies for adolescents, hoping that earlier intervention might prevent later offending (Groth & Loreda, 1981; Groth, et al., 1981).

In the fall of 1975, New specialized services to adolescent sex offenders started at the University of Washington’s School of Medicine’s Adolescent Clinic. Diagnostic work began in 1975, but the community-based treatment component was delayed due to funding difficulties until 1978. Early programs proceeded in a trial and error fashion. The models utilized for adults were tried, but staff often were not satisfied with the results.

Gradually, it has become clear that a key difference between treating adults and adolescents appears to be the role of the family. Not only is the family a major source of learning and modeling, but the family also is the basic support for the teen. If the family is not enthusiastic about treatment, the adolescent might not even attend much less progress. Not only must the adolescent change, the family system must change as well.

Keeping families involved can be a struggle. Courts have jurisdiction only over the child’s treatment, thus leverage for keeping the family in treatment are minimal.

So as mentioned earlier, courts have been resistant to viewing the adolescent sexual offender as a serious threat to the community (Hammert, 1994). Instead, courts have interpreted adolescent offenses as “experimentation” and have been reluctant to scrutinize the youngsters by adjudicating a sexual offense.

Assessment

“The process of interviewing an adolescents sex offender is bound to be uncontrollable” (Ross & Loss, 1987, p. 3). Rather than put the offender at ease, Jonathan Ross and Peter Loss suggest using the offender’s anxiety to facilitate disclosure. They reject the idea that clients must be self-motivated for accurate assessment. The initial motivation of an assessment is almost always external.

Specified assessment has several goals. First, the clinician needs to ascertain the likelihood of recidivism and the degree of threat to the community, the victim and other potential victims. Second, assessment attempts to determine the nature, extent and seriousness of the sexual behavior problem.

The clinician needs to evaluate to what extent the sexual behavior is compounded by other serious psychological problems such as retardation, mental illness, substance abuse and organic factors. At least one study (Karras, Kaplan & Becker, 1988) found that over 90 percent of a sample of 58 adolescent offenders qualified for a DSM III diagnosis in addition to the sexual disorders. Third, an evaluation of specific social, family, environmental and behavioral treatment needs of the adolescent. What the task is determining to what extent the sexual behavior is situationally determined and to what degree it is symptomatic and characterological (Groth & Loreda, 1981; Knopp, 1982). Finally, recommendations for treatment are formulated, with the ideal course of treatment stated even if such services are not readily available.

Assessment begins by collecting all available information relevant to the first interview. This includes victim statements in police and/or protective service records. Ross and Loss (1987) suggest talking to the investigator to obtain any information not in the official report as well as contacting the victim’s therapist. Other important sources of information are presentence reports, past mental health records, criminal records and school records.

Parents are included in the assessment, but most phases of the assessment will remain adolescent from parent. Ross and Loss (1987) suggest that the interviewer maintain firm control of the assessment. They suggest that the evaluation start with approximately 20 minutes of education and exploration by the interviewer. In this section of the interview, the examiner deals with confidentiality policies, discusses the seriousness of sexually abusive behavior and explains the process of denial and minimization. The need for honesty is stressed.

In the course of the initial interview, the adolescent and the parents are interrogated separately. Admitting to sexually abusive behavior is very difficult for the adolescent and admission is unlikely if a parent is present. Ross and Loss (1987) suggest that the clinician always assume a history of progression of behavior. Ask “when did you first…” rather than “did you ever…” A very detailed history of sexual and sexually aggressive behavior is crucial. Coleman (1988) suggests using very specific and very graphic language in this phase. “Tell us, as professionals, we want to maintain our professional demeanor, and we need to using words that nobody can misunderstand” (p. 21).
The Sexual Abuse Cycle in the Treatment of Adolescent Sexual Abusers (Advanced Training) by Cornie Isaac and Sandy Lane, 1990, 90 mins, $75 plus shipping

This video begins with thoughtful remarks by Fay HoneyKnopp. Then Isaac and Lane present information about the adolescent sexual-abuse cycle and how to modify it. Based on their work with over 2,000 adolescent sexual offenders, the presenters believe that there is an identifiable progression of thoughts, feelings, and behaviors that occur prior to a sexual assault.

The video will help you to see the cycle as it unfolds. The authors point out that the cycle includes a male, female, and adolescent. The model is used to highlight the potential of the male, female, and adolescent to sexually abuse. The video concludes with the presentation of a sample treatment plan.

Remedial Intervention in Adolescent Sex Offenders: Nine Program Descriptions, by Fay HoneyKnopp, 1982, 196 pages, $75.00

The book provides a comprehensive overview of the current state of knowledge and practice in the field of adolescent sex offender treatment. It includes nine program descriptions, each with a detailed description of the program's goals, methods, and outcomes. The book is a valuable resource for anyone working with adolescent sex offenders.


This manual details a treatment program that was successfully implemented at the Henderson County Home School. The program focuses on the development of social and emotional skills in male adolescent sex offenders. The manual includes a comprehensive overview of the program's goals, methods, and outcomes. It is a valuable resource for anyone working with adolescent sex offenders.

A Comprehensive Service-Delivery System with a Continuum of Care for Adolescent Sexual Offenders by Steven B. Benson, E.D.D., 1986, 34 pages, $7.50 (includes postage)

This manual provides a comprehensive overview of the current state of knowledge and practice in the field of adolescent sex offender treatment. It includes a detailed description of the program's goals, methods, and outcomes. The manual is a valuable resource for anyone working with adolescent sex offenders.

When Children Molested: Children's Group Treatment Strategies for Young Sexual Abusers by Caslity Cunningham and Kiev treatment program includes a developmental approach, an individualized treatment plan, and a focus on building self-esteem and self-esteem. The manual is a valuable resource for anyone working with sexual offenders.
Juvenile Sex Offenders  
Continued from page 3

Essential information includes the frequency and duration of offenses, the length, nature, and progression of offenses, the number of victims and victim selection characteristics. Access to victims and potential victims is examined. Precipitating factors to the offenses are explored. The presence of other abusive or addictive behaviors is probed. Non-offending sexual history is gathered with specific emphasis on any past victimization.

Some clinicians use specific tools or tests to assist in data gathering. One instrument, with sexual variations currently being used, is a sexual interest card sort. A sexual interest sort typically consists of 5-by-5 cards on which short descriptions of sexual scenes are printed. Offenders are asked to rate each card according to how arousing they find it. The card sort can assist in identifying an offender’s interest in a number of sexual behaviors which are difficult to elicit in a clinical interview.

There are problems with card sorts, however. No version has been validated with an adolescent population. Also, the graphic language may trigger deviant thoughts (Kahn, 1987).

Another tool for assessment is the phalloscopy. A phalloscopy is an instrument that records penile erection response. The phalloscope is presented a series of slides and/or audio tapes depicting various sexual stimuli. Varying degrees of response are shown with scenes describing sex with young children, youths, and adults, both male and female. The rater then records the response. Discomfort about the test, and the adolescent also self-reports on his degree of arousal.

After gathering sexual history, a more general assessment is undertaken. Family dynamics and functioning is assessed with particular attention to the family’s support or lack of support for treatment. The social and peer relationships of the adolescent are examined. School and employment history are obtained along with past delinquent or criminal activity.

While gathering this information, the clinician also assesses less concrete variables. How cooperative is the adolescent? How honest? What degree of personal responsibility is claimed for the behavior? What are the internal and external motivations for treatment? What is the response to confrontation?

Ross and Loss suggest interrupting attempts at denial and returning to presenting educational material if necessary. They suggest repeating and rephrasing questions and confronting dishonesty or denial of material. If the offender persists in denial or is argumentative or uncooperative, the interview can be terminated, either for a "time-out" or rescheduled.

Face-saving measures can be utilized. These include discussing hypothetical situations or suggesting that the adolescent will have memory improvements and recall a good deal more by the next interview. The offender is told there is hope for controlling the behaviors.

Ross and Loss provide a risk-assessment scale where each factor is rated individually. Scores are then profiled and examined. Another instrument for estimating clinical risk criteria is Wenst and Clerk’s (1983) 37-point checklist (also see Knopp, 1982). This instrument is not validated through research, but is useful as a guide.

Predicting re-offense is an uncertain undertaking. One study of 112 male juvenile sex offenders (Smith & Menensky, 1986) examined re-offense variables. None of the clinician rated low-risk adolescents re-offended during the 17-month follow-up time. However, there were a substantial number of "false positives" (offenders rated high-risk with no documented re-offense). The study was limited to the 17-month follow-up time, individually may have re-offended if the study had continued longer. Re-offense behavior is very low, possibly because re-offense was defined as a referral to the legal system for a sexual offense.

Treatment

Sexual offending is "a very complex behavior" (Ross, 1988, p. 31). Thus, it is not surprising that sexual offenders fail to respond to traditional one-on-one psychotherapy. Of the adult clients referred to Ross and Loss for sex-offender treatment, over 60 percent had been through traditional psychotherapy without success. An interdisciplinary team is needed to support the treatment process.

Due to the varying needs of individual clients, a continuum of services is also necessary. The continuum should include more intensive specific treatment in locked, secure programs, community and residential facilities, specialized foster care and outpatient groups (Bengt, 1987).

For the juvenile sex offender, treatment requires accountability. The concept starts with the legal intervention, which, ideally, should stress that the sexual acts were criminal and serious. A sexual message about accountability is given by waving of confidentiality, in act which requires the juvenile to relinquish the secrecy surrounding his offending.

Many programs have a formal treatment contract. Ross and Loss use a nine-page contract (Ross, 1989). Both the juvenile and the parent must sign the contract.

During treatment, accountability is stressed by requiring participation, self-disclosure and self-monitoring. Techniques for monitoring behavior include journal keeping, behavioral observation, verification with collateral sources, contracts and polygraph monitoring.

The juvenile is encouraged to accept responsibility for his acts without minimization or externalizing blame. Confrontation is one treatment technique that can be used strategically to counter denial or minimization. Confrontation should be firm but supportive, not undecisive, derogatory or condescending. Polygraph statements and specific statements can be useful in confronting denial. High-risk behaviors can also be confronted. Education appears to be a major component of most treatment approaches. One of the Five concepts taught is the sexual assault cycle (Lane & Zamar, 1984). "Adolescent sex offenders usually completely misunderstand and are embarrassed by their behavior. They initially do not have any idea what needs are being satisfied by the sexually aggressive behavior" (Ross & Loss, 1987, p. 3).

Briefly, the sexual assault cycle is as follows:

• An event occurs that raises a negative emotional response
• The youth attempts to compensate and regain control
• This attempt fails and the juvenile feels anger and rage
• These feelings generate thoughts of retaliation and fantasies of overpowering another
• A victim is selected
• A sexual offense occurs
• The youth at first feels empowered, but later feels depressed and guilty

Typically, the adolescent shows a pattern of gradually escalating offenses. Often, "hands-off" offenses such as exhibitionism, voyeurism and obscene telephone calls give way to "hands-on" offenses. The adolescent is asked to make an audio tape to share with the group describing the particular events which lead to the offenses. Each week two 15-minute tapes are required. The adolescent must describe his
In order to examine services available in the Commonwealth of Virginia, clinicians currently treating juvenile sex offenders were surveyed in spring 1991. Therapists and programs listed in the Directory of Sex Offender Treatment Providers in Virginia (1990) were invited by telephone.

Most of the juvenile offenders seen by Virginia clinicians have been male (97 to 100 percent). Female sex offenders have been identified rarely in rural areas. Richmond clinicians report seeing one or two female adolescents in the course of several years of service.

The number of juveniles identified in the last year is small. One program (Pines Residential Treatment Center, Portsmouth, VA) reported seeing one or two female adolescents in the course of several years of service. The number is small because the rate of juvenile sex offending in Virginia is relatively low.

The majority of adolescent offenders identified to date in Virginia are 13 to 15 years old. About 22 percent of the sample are age 16; 60 percent are age 15; 15 percent are age 14; and 3 percent are age 13. Approximately 36 percent of the sample are Black, 40 percent are White, 17 percent are Hispanic, and 6 percent are Native American.

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Multimodal approaches involving cognitive, behavioral, and social learning techniques are the most common theoretical orientations, in all settings. Cognitive and behavioral techniques are used to teach the thinking patterns and offending cycle. Relapse prevention is a core component of treatment. Only a few clinicians report using any form of the psychoanalytic approach in conjunction with the cognitive-behavioral model. All therapists report an educational component to therapy. Social skills development, assertiveness training, anger management, self-education and appropriate expression of feelings are most often included. Victim empathy, reality testing and inner-child work are also common. Most clinicians use a variety of materials, many self-developed. The Palmatys workbook series by Timothy J. Kuhn (1990) is often used by the clinicians.

Exit criteria are generally set by the individual counselors in conjunction with the client. Common criteria for treatment termination include: appropriate expression of feelings, genuine victim empathy, a knowledge and understanding of thinking patterns and offending cycles, a detailed plan for avoiding recidivism and a knowledge of appropriate sexual activity. Lamman requires an extensive therapeutic letter of apology written to the victim. This letter is not sent to the client but is presented to the group. The adolescent also completes a project detailing the benefits of treatment. The project may include a video tape for the group or a letter to the judge.

The average length of treatment for juvenile sex offenders is 14 to 15 months. However, treatment ranges from four months to three or more years.

Some clinicians use pretest/post-test evaluation, phototherapy, the MSI or other methods to assess change. Some clinicians contact the offender at periodic intervals following treatment—from every several weeks to every several months for about a year. Unfortunately, 56 percent of workers or counselors do not attempt to evaluate their work at all.

Juveniles pose a variety of unique problems for treatment. The clinicians surveyed. Lack of family involvement and commitment was cited by 75 percent of clinicians. Since the offender is a juvenile, clinicians feel at the mercy of the offender's parents. Often, the family denial is as strong as the denial of the offender, and therefore the family is not cooperative with the treatment plan. If the juvenile depends on his parents for a ride to treatment, and his parent decides not to take him, the juvenile offender receives no treatment. Related to this are other forms of family sabotage. Parents can "bad-mouth" the court system or the
Spotlight on Virginia
Hanover Learning Center
The Ellen Allen Residential
Sex Offender Treatment Program

Two years of planning culminated on Jan.
14, 1990, at the opening of Virginia's first
residential treatment program for juvenile sex
offenders. The program serves males 14 to 17
who have been incarcerated for sexual offenses.

Frank MacHovec, Ph.D., is chairperson
of the treatment committee that oversees
the program. "We are proud of this program," he
declares. "It was carefully researched, it
reflects the state-of-the-art in treatment and
it works well."

Prior to designing the program, a thorough
literature review was undertaken. Staff
visited programs in Colorado and Minnesota.

Psychologist Edward Wiczkowski, M.A.,
was hired in Nov. 1989 to implement the
program. "The biggest problem was the
appropriate length of stay at Hanover, which
is about five months," notes Wiczkowski.

"Some time is necessary to treat sex
offenders. Luckily, we gained support from
the administration. The length of stay in our
program is 10 to 15 months."

The main treatment modality is group
work. A typical week includes two group
psychotherapy sessions, two psycho-
educational groups on sex education and
two on social skills, and a community meeting.

Family therapy is also available.

Students in the program must individually
earn privileges, including release from
the facility. Release is secured by the
Hanover Learning Center for all those
incarcerated, program youth must also
complete the treatment objectives of the sex
offender program. Five objectives are needed
for eligibility for an off-campus visit, 10 for
a home visit and at least 15 to be considered
for release. Earning credit for objectives
requires considerable effort and culminates
in the student presenting each treatment
objective during a group therapy session.

A sample of the treatment objectives
includes: autobiography, to examine life
history; cycle of offending, to identify,
analyse and chart the offense cycle;
disclosure of offenses, to identify and report
sexual offenses and deviant sexual behavior;
victim empathy, to examine the effects of the
offense on the victim, personal victimization,
to identify and study his own sexual victimi-
ization; if any, fantasy and arousal, to examine
the role of these issues in the sexual offense.

Family therapy is conducted by Brenda
Hamilton, C.S.W. She also coordinates with
the victim's therapist if the victim was a
sibling or a relative. If feasible, sessions
between victim and offender are arranged.

To successfully complete the program,
students must articulate what they have
learned and how it has been demonstrated
behaviorally in campus life. The treatment
team monitors student progress in biweekly
team meetings.

Wiczkowski emphasizes the importance of
a multidisciplinary team approach. The
Hanover team consists of a psychologist, a
clinical social worker, a counselor, a cottage
manager and four line staff. "Line staff can
make or break a program," states Wiczkowski,
"it is essential that everyone work as a team."

The program can serve 14 students at a
time. In its first year, 43 students referred
to the program 16 were judged appropriate.
Four students have successfully completed
the program to date, and two of those originally
admitted were released early. One student was
terminated for refusal to participate.

A follow-up system has been established
to monitor student progress after release.
Telephone contacts are made at intervals
of one, three, six, nine, 24 and 24 months
with the aftercare counselor, the student,
and the parent or guardian. The four
students who completed the program and
the student who completed two-thirds of
the program are required to make one
adjustment to the community.

The success of Hanover's program has
been recognized by Virginia's Department
of Youth and Family Services. The
department will open a similar sex offender
unit at the Beaumont Learning Centre this fall
that will serve 15 youth. An intensive program
for intellectually low-functioning juvenile
sex offenders will open at Oak Ridge by Sep,
1, 1992. "These programs should satisfy the
need of our population system wide," states Dr.
MacHovec.

More information is available from:
Treatment of Adolescent Sex Offenders
Committee, Hanover Learning Center,
P.O. Box 507, Hanover, VA 23069-0507,
(804) 799-6219.
Juvenile Sex Offending: Causes, Consequences and Correction, edited by Gail D. Ryan and Sandy L. Lane. 1991. 435 pages. $42.50 posted.
Available from: Kampf Center
1275 Oneida St.
Denver, CO 80220
(303) 297-4020

If you can read only one book about juvenile sex offenders, this is the one to choose. Ryan and Lane have assembled a very comprehensive, very readable volume.

Part One discusses the problem of juvenile sex offenders — who is included in the definition, frequency of the problem, the historical response to the juvenile offender, and the history of recent program development. Part Two looks at theoretical perspectives. An unusual inclusion is a chapter on normal sexual development in infancy and early childhood. Also included are chapters on ecology, the sexual abuse cycle, and family characteristics. A third section reviews consequences of sexual abuse, both for the offender and for the victim. The remainder of the volume deals with intervention, treatment and prevention. Included is an excellent chapter by Rosa and a loss about assessment. Special populations (the child perpetrator, the preadolescent perpetrator, the intellectually-disabled offender and the female offender) are discussed. The role of the family in the treatment process is explored. The book concludes with a chapter covering the impact on the therapist of working with sexual abusers.

Ryan and Lane have assembled contributions from major experts in the field such as Faye Honey Knipp, Steven Boga, Brandi F. Stolle and William Greer. The result is a state-of-the-art book.

1275 Oneida St.
Denver, CO 80220
(303) 297-1965

Interchange is published twice per year. It contains articles, conference announcements, book reviews and updates on the work of the national task force. A subscription is an ideal method of remaining updated on the latest developments in research and treatment of adolescent offenders.

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Spotlight on Virginia: Arlington

Juvenile Sex Offender Specific Treatment Program

Audrey Chase, Mary Jean Evans, Jeannine Beck

Concerned about the increasing number of juvenile sex offenders referred for treatment, Adult/Child Bureau Chief, Audrey Chase, Mary Jean Evans, L.C.S.W., and Jeannine Beck, M.A.W., therapists at the Arlington County Mental Health Clinic, applied for a federal grant from the Juvenile Justice Department. Therein was the only new direct service grant awarded to a Virginia agency.

“Our interest is to develop an outpatient treatment model that is replicable,” explains Evans, the program coordinator. “We will focus first on adolescents, but we also hope to start specialized services for younger children who are acting out sexually due to prior abuse.”

The clinic is currently conducting a search for a consultant who specializes in specific sex offender treatment. Evans comments, “We feel we need a great deal of training and intensive supervision throughout this year. Traditional therapy is not effective with sexual offenders.”

The program will serve only youth who have been adjudicated by the Arlington Juvenile Court and who are court-ordered to receive treatment. Parents of the youth will be required to participate as well, both in the evaluation and treatment process. “We will gather a detailed sexual history and do a risk assessment prior to acceptance into the program,” notes Evans.

The program will start with a six-week educational component that will focus on sex education, relationship issues and the sexual assault cycle. The education group will meet once per week for three hours. The therapy group will start after the education group and will meet twice per week. “The group will be very confidential,” states Evans. “There will be careful monitoring of behavior in and out of the treatment sessions.”

Groups will be limited to eight adolescents. As referrals are received, new treatment groups will be formed. Evans anticipates at least two groups during the first year.

Evans expects that treatment will take a year or more for most adolescents. “It is not a short process,” he comments. There will be an aftercare program, but that is still in the planning process.

The program is managed by an advisory board composed of interagency personnel. The board will attend training with the staff,” states Evans, “so we all should be operating with the same principles in mind.”

The grant is funding two half-time staff members, supplies, travel and training. Fees for the treatment are assessed on a sliding scale the same as for any clinic of the clinic. “The grant is renewable for three years and we can ask for half the amount for a fourth year,” says Evans. “Evaluation data will be gathered so we will have an idea of what works and what doesn’t. We can then modify the program to better meet client needs.”

More information is available from: Mary Jean Evans, Arlington County Mental Health Clinic, 1725 N. George Mason Drive, Arlington, VA 22205, (703) 528-5150.
Started in 1989, CBSI has been successfully providing home-based services to children, youth, and families at risk. Over the years, specialized programs have been developed for teenage mothers, foster families who need relief, families at risk for child removal and chemically dependent teens. Since September 1989, a program has been offered to adolescent sex offenders.

Sally Wilklow, regional director with the program, described the program’s beginnings. “We were convinced that the only option for juvenile sexual offenders was a residential program at the Pines Residential Treatment Center in Portsmouth, Va.” Wilklow. “We did a great deal of research and sent staff to Bill Seals in Minnesota for training as well as to transfers.”

The current program combines intensive, in-home services with group treatment. “We spend 10 hours a week in the homes,” states Wilklow, “and the group meets weekly for 1.5 hours. Some adolescents also attend individual therapy sessions.”

The program accepts cases only if the court order treatment. Initial interview assessment, but not psychological testing, is performed. “We try to understand the emotional and situational factors,” states Wilklow. “Ours is a psychodynamic approach to treatment. We use the Pines’ workbook, also. We view the sexual assault as symptomatic of family dysfunction. The whole family is treated.”

To date, the program has served 15 adolescents. There are currently two groups, one for those 12 to 14 years, another for 15 to 16-year-olds.

CBSI may be a unique program in the nation. By combining intensive, in-home service with specialized juvenile offender groups, family involvement is assured. Many programs use the lack of family involvement as a primary roadblock to treatment. Thus, CBSI has found a solution that may deserve replication. “Having all the service coordinated by the same treatment team is important,” states Wilklow. “Continuity is very necessary for this population.”

More information is available from Sally Wilklow, Regional Director, Community Based Services Inc., 1952 Williamsburg Court, Fairfax, VA 22033. (703) 991-2877.

The Behavioral Studies Program at the Pines Treatment Center

The Behavioral Studies Program is an innovative, comprehensive, residential treatment approach for youth ages 10 to 19 who have sexually offended. Residents come from all over the United States and even from other countries.

The program was conceptualized by John Hunter, Ph.D., who is still the program director. Dr. Hunter came to the Pines in 1983, having completed his training under Judith Becker and Gene Abt. Dr. Hunter also worked for over three years with a multidisciplinary child abuse and neglect evaluation program at the University of Tennessee’s College of Medicine.

The Behavioral Studies Program opened in 1986 with eight beds. It now serves 92 youth and has expanded to include female adolescents. A recently opened group home houses eight additional youth.

Prospective residents are screened prior to acceptance into the program. “To be accepted, the adolescent needs to show some acceptance of responsibility for his behavior,” explains Dr. Hunter. “We review the background information carefully and talk with the referral source. Treatment is a privilege we want to extend to any youth who will take full advantage of it.”

The treatment team is multidisciplinary and the treatment approach is comprehensive. "Remediation of sexual deviation is a sophisticated process," says Dr. Hunter. "A therapy that is based on insight alone or re-polarization will generally not be effective."

Dr. Hunter believes that deviant sexual behavior is often learned through modeling and is often linked to prior victimization. He and his staff use a cognitive-behavioral model of treatment. Specific techniques such as assertion and anger management are employed to directly change sexual responses (for a description of these techniques, see main article). There is an emphasis on providing appropriate ways to handle feelings such as through anger management techniques and assertiveness training. Development of empathy is stressed. Family therapy is control, where possible.

Believing that all treatment should be equally based and modified, Dr. Hunter and his staff gather data throughout the treatment process. This thorough is supported through a research grant from the and Neglect.

Length of treatment varies from 12 to 36 months, with the average stay approximately 16 months. The program has over 25 graduates. Only two are known to have re-offended.

More information is available from John Hunter, Ph.D., Behavioral Studies Program, The Pines Residential Treatment Center, 725 Crawford Parkway, Pearsall, TX 77536 or (274) 357-1794.

Control Group

Subject's 1990 survey. The director has 37 Link! Link providers who offer services to sex offenders. Of the providers, 24 offer services to juvenile delinquents. Information about services and healthcare facilities is provided.

For more information, you may call John Hunter, Ph.D., Behavioral Studies Program, The Pines Residential Treatment Center, 725 Crawford Parkway, Pearsall, TX 77536 or (274) 357-1794.
Education also means dealing with skill deficits. Many juvenile sex offenders lack basic social skills, such as dating skills, appropriate relationships with peers and basic communication. The young offender may not even be able to identify and label feelings. Other skill deficits can include anger management, stress management, values clarification and inadequate academic skills. Because of the psychological and physiological reinforcement attached to sexual behaviors, sexually offending behaviors can “take on a life of their own” over time. The cycle of sexual offending also considers the issue of compulsive or addictive sexual behaviors. Some treatment programs adopt a 12-step approach modeled after substance abuse treatment.

Education alone, no matter how thorough, is not considered sufficient to prevent offending. Issues in the adolescent’s past are also important. Family dysfunction can either trigger or support sexual offending. Confused role boundaries, power imbalances, peer or distorted communications and resistance to acknowledging the offender’s behavior can all contribute to a high-risk environment for development and maintenance of sexually abusive behaviors.

The sex offender’s own psychosocial and behavioral history will hold important clues to current functioning. If development was impaired by physical or sexual abuse or if there was trauma of other sorts, rejection or loss, then part of therapy will be dealing with the adolescent’s own victimization or loss.

Self-esteem issues must be addressed. Changes in self-concept also require developing a positive sexual identity. This is a complex issue that may include dealing with homosexuality. Education is needed on all aspects of sexuality, including sexually-transmitted diseases.

Part of relapse prevention is the development of victim empathy. Personalization of victims is addressed in many ways including calling the victim by name, role playing the victim’s experience, describing the victim’s perspective, having victims come to group sessions and learning about subtle sex stereotyping that can contribute to objectification. Developing empathy assists in understanding the consequences of offending — to the victim, to others and to himself. Often victim empathy cannot occur until the offender deals with his own sexual, physical or emotional victimization.

Most programs insist on family involvement. Whether direct, distant, functional or dysfunctional, family issues must be addressed” (Thomas, 1984, p. 333).

The team member working with the family may need to assume various roles, including director, clinical manager, teacher, guide, advocate and resource person, as well as supportive and confrontive therapist (Thomas, 1991). A comprehensive treatment approach is recommended, rather than the more traditional family therapy model.

Families appear to work through stages. Thomas proposes a five-stage model. First is the crisis of disclosure, and it is crucial that therapy begin during this time in order to engage the family in the healing process. During this stage, the therapist offers support, information and guidance. The second stage is family assessment, discussed earlier. Stage three is therapy interventions. Goals and format are based on the needs identified during assessment. Support groups can be offered as well as individual or dyad therapy. General goals are to address maladaptive patterns of projection of blame, to enhance victim empathy, and to empower the parent to take responsibility for their child.

One may also need to deal with rigid defensive and projection of blame, to enhance victim empathy, and to empower the parent to take responsibility for their child.

Current Status and Future Directions

Much progress has occurred in the last few years in understanding and treating adult sex offenders. Major new ideas include the need for a continuum of care, risk criteria, reintegration of the sexual abuse cycle and relapse prevention strategies. Networking is occurring through the National Association of Rape Treatment Network at the Kempe Center in Denver (see separate review on “Incesticide”) and through the Safer Society Program (see resource review). Program development has advanced from “treatment” to specialized populations such as mentally retarded offenders, female offenders and younger child overlap.

Efforts such as The Preliminary Report from the National Task Force on Juvenile
Virginia’s Task Force on Sexual Assault

The Lieutenant Governor’s newly formed Task Force on Intervention to Reduce the Incidence of Sexual Assault is examining methods for the early identification and intervention of young adult victims and offenders. This task force has set goals of breaking the cyclical pattern of abuse and reducing the incidence of sexual assault.

The task force has divided itself into six subcommittees. These will focus on offender treatment, victim services, law enforcement, coordination of services, education and research.

The task force began meeting in June and will achieve a Final Draft Report by the end of October. More information is available from Judy Denton, Office of the Lieutenant Governor, Supreme Court Building—Suite 104, 10 N. Eagan St., Richmond, VA 23219.

Virginia’s Picture

the time a juvenile sex offender gets to court the problem is serious and usually fully developed. The judiciary is not cognizant of the developmental history of the adult offender, which usually begins in preadolescence. We have the most success with adults who are mandated into treatment for at least 20 years. We rarely have this support from the juvenile court which tends to take charges “under advisement” for one year.”

Increasing the availability of residential facilities was cited as one measure that would increase the court’s and clinicians’ flexibility. Other needs included an inagency protocol for assessment and expansion of outpatient group treatment. Training for all those involved with the juvenile offender was frequently mentioned.