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CHAPTER 14

Cognitive Behavioral Treatment of the Juvenile Sex Offender

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Recently, the research and clinical literature has paid a great deal of attention to the treatment of adult sex offenders (Furby, Weinrott, & Blackshaw, 1989; Greer & Stuart, 1983; Laws, 1989; Marshall, Laws, & Barbaree, 1990). At present, the most popular and widely recognized therapy for the adult sex offender is cognitive-behavioral therapy, including relapse prevention. A number of authoritative chapters and articles have detailed the components of this therapy, which seem to be required for it to be effective (e.g., Abel, Becker & Skinner, 1986; Marshall & Barbaree, 1990). Surprisingly, little such attention has been paid to the treatment of the adolescent sex offender. This lack of attention is especially surprising given the fact that (1) adolescent males represent a significant number of those arrested and convicted of sexual crimes (*Uniform Crime Reports*, FBI, 1985), and (2) the majority of adult sex offenders can trace the origins of their sexual deviance to their adolescence (Longo & Groth, 1983).

We have been conducting a cognitive-behavioral treatment program for adolescent sex offenders at the Sexual Behavior Clinic, New York State Psychiatric Institute in New York City for a period of 7 years. The present chapter provides a summary and overview of this program as it has evolved in our setting. We will begin with a discussion of the intake process and assessment of the offender, and then describe the treatment program.

ASSESSMENT

Adolescents seen at our clinic are between the ages of 13–18 ($x = 15.4$) years. The racial composition is 66% black, 23% Hispanic, and 9% Caucasian. The majority of adolescents are from a lower socioeconomic status. Approximately 70% of the adolescents have molested young children, and 30% have committed sexual assaults.

Upon referral to the Sexual Behavior Clinic, each adolescent undergoes a comprehensive evaluation to determine treatment needs. An available parent is included in the assessment process. Approximately 85% of the adolescents are accompanied by a parent or guardian. In the majority of cases (80%) the mother accompanies the child.

Prior to clinical assessment, the following materials are reviewed when available: victim statement, hospital records, police/criminal justice system records, and prior psychological/psychiatric records. Also, both the adolescent and the parent(s) sign a consent form. The consent form outlines the nature of the entire assessment process. Both the adolescent and parent must indicate consent before any evaluation will be conducted. If either or both refuse to consent, the assessment will not be conducted.

The assessment at the Sexual Behavior Clinic consists of three components: a structured clinical interview, psychometric testing, and physiological evaluation.

Psychometric testing involves a number of self-report measures. The Adolescent Sexual Interest Cardsort is a 64-item self-report measure of sexual interest developed at the Sexual Behavior Clinic to determine the presence of deviant sexual interests. An example of an item is, "I've forced a 10-year-old boy to suck my penis. It's getting hard." The adolescent is asked to rate this vignette on a Likert Scale from −2 (really turns me off) to +2 (really turns me on). The Adolescent Cognitions Scale (ACS), is a 32-item true-false test developed at the Sexual Behavior Clinic to determine if the adolescent offender has any distorted cognitions regarding sexual behaviors. A sample item is, "Showing my penis to a stranger in a public place will get me into trouble." To assess the adolescent's sexual knowledge, we administer the Math Tech Sex Test (Kirby, 1984), which is divided into two parts: (1) sexual knowledge and (2) attitudes and values.

Social skills are assessed by the Matson Evaluation of Social Skills in Youngsters (Matson, Esveldt-Dawson, & Kazdin, 1983), which is designed to assess the social and assertive skills of adolescents. It is a 62-item self-report measure that assesses five factors: (1) appropriate social skills, (2) inappropriate assertiveness, (3) impulsive-recalcitrant traits, (4) overconfidence, and (5) jealousy withdrawal.

The Beck Inventory is used to assess depressive symptomatology (Beck, Ward, Mendelson, Mock, & Erbough, 1961). It is conducted to objectively evaluate the sexual interest patterns of these young offenders. It is important to note that, to date, data are not available on a non-sex-offending adolescent population. Reliability and validity on erectile assessment of adolescents have yet to be established. Consequently, risk management and treatment decisions should never be made solely on the basis of physiological assessment.

It is imperative that the adolescent and parent or guardian have the procedure described in detail prior to their signing the consent form. At our clinic, we only conduct this assessment on postpubertal males (they are usually between the ages of 13 and 18 years old). The stimuli consist of 19 audiotaped passages, each lasting 2 minutes, recorded by an adult male. The tapes, which are narrated in the second person, are descriptions of various sexual activities with a variety of targets. Each passage describes the age and sex of the target and an interaction scene. Two of the tapes describe a non-sexual social interaction among a group of adolescents (neutral). Because we have a multi-ethnic population, the use of audiotapes allows the client to imagine the specific characteristics of his victim.

We have found that our adolescent population tolerates this procedure very well. Preliminary research using this assessment technique has found that deviant erectile responding is common among adolescents who have molested young boys, and who have a history of sexual victimization themselves (Becker, Hunter, Stein, & Kaplan, 1989). Although our research is in preliminary stages, we have found that adolescents who admit to their deviant sexual behaviour are more likely to show deviant arousal in the laboratory. We are continuing to document erection profiles for the adolescent sex offender population (Becker & Kaplan, 1988).

TREATMENT PROGRAM

Entry Criteria

In order to be accepted into the program, an adolescent must either admit that he has engaged in deviant sexual behavior, or his sexually deviant behavior must be documented by a victim statement, a court finding, or a reliable valid witness such as a parent.

In addition, at intake the following variables are used to assess treatment needs:

1. Distorted cognitions
2. Self-report of deviant sexual fantasies
3. Significant inappropriate sexual arousal during the psychophysiological assessment

4. Having been found guilty of a sexual offense
5. Lack of remorse regarding inappropriate sexual behavior
6. Failure to accept responsibility for the inappropriate sexual behavior

THE PROGRAM

Our treatment is a multicomponent program utilizing a cognitive behavioral model that was initially developed for, and evaluated on, an adult sex offender population (Abel, Becker et al., 1984). After attempting to utilize this adult model with an adolescent sex offender population, it became apparent that numerous modifications had to be made to make the intervention more appropriate given the level of cognitive, emotional, and social development these adolescents displayed. The following section will describe the components of our therapy program and discuss issues to be considered.

Verbal Satiation

This technique teaches the offender how to utilize deviant thoughts in a repetitive manner to the point of boring or fatiguing themselves with the very stimuli to which they had previously become aroused.

In our earlier work with adults, clients were instructed to complete 20 hours of masturbatory satiation (described in detail in Abel et al., 1984). This technique proved most difficult to utilize with our adolescent sex offenders for the following reasons: (1) The majority of the adolescents seen at our clinic reported that they did not masturbate and that to do so would be in violation of religious or ethical practices. We do not feel that a clinician should require clients to engage in any form of sexual behavior with which they feel uncomfortable; therefore, the masturbation segment of satiation was dropped. (2) The majority of adolescents either share rooms with their siblings or others, or have no privacy in which to conduct the satiation sessions; therefore, these sessions could not be conducted at home. (3) Many of the adolescents seen at our clinic cannot be relied upon to carry out therapeutic homework assignments. (4) The majority of adolescents protested that 1 hour (the time required for adults to complete one satiation tape) was too long for them to focus on a topic.

Given the above issues, we modified the procedure as follows: each adolescent is required to complete a minimum of eight, 30-minute verbal satiation tapes that are conducted at our clinic. The adolescent is presented a slide depicting a naked male or female child or male or female adult, corresponding to the gender and age of his victim. While viewing the slide, the adolescent is requested to repeat, over a period of 30 minutes, a phrase describing the nature of the deviant sexual activity he engaged in with his victim(s). When beginning this procedure, most of the adolescents have been unable or unwilling to

verbalize their deviant sexual fantasies. In these cases, the therapist chooses a particular phrase that is relevant to their offense and which is as close as possible to the adolescent's own colloquial language. In each of the eight sessions, a different phrase and a different slide is used. One fantasy is eliminated at a time. Every effort is made to attempt to elicit any additional deviant thought or fantasies from each adolescent. Examples of phrases typically used in our treatment are:

Target—Young Children (girls or boys)

I'm feeling this girl all over.
I want to be with this girl.
I'm telling this girl to take off her clothes.
I'm telling this girl to sit on my lap.
Me and this girl are going to have some fun.
I'm going to have sex with this girl.
I'm going to rape this girl.
I'm about to touch this girl.
I'm holding this little girl.
This little girl wants me.

Rape—Adult Woman

I'm sneaking up behind this woman.
I'm going to rape her.
I'm holding this lady down.
I'm ripping her clothes off.
I'm telling this woman to take off her clothes.
I'm staring at this woman.
I want to rape this woman.
I'm beating this woman up.
I'm punching this woman.

These are only suggestions. If no violence was involved in the offense, we do not recommend using violent phrases.

While the adolescent is engaged in the satiation procedure, his erectile responding is measured by a penile plethysmograph. Although it has rarely been the case, there have been adolescents who at the end of one 30-minute session have still shown significant arousal (20% or more of a full erection) to the deviant stimuli. When this occurs, the adolescent must continue with the session until all or most deviant arousal has dissipated (as measured by the plethysmograph) before he can end the session.

Preliminary results indicate that arousal to deviant sexual stimuli declines

after eight sessions for those adolescents who have offended against females less than 8 years of age. If erectile responding has not declined after eight sessions, the adolescent is required to complete another eight sessions. In general, a maximum of 16 sessions is sufficient to lower arousal.

GROUP TREATMENT

Upon completion of the satiation sessions, adolescents are entered into a 40-week closed-group treatment led by a male and female cotherapist team. We have found that 7 clients constitute an optimal group; however, due to absences and dropouts, we begin with 12 and typically finish with between 7 to 9 members. Initially, we had designed the groups to be an hour and one-half in length (based on the adult model); however, we found that with the limited attention span of our clients an hour was more optimal. We have observed that it is less threatening for the adolescents to be seated around a table as opposed to having a seat with nothing in front of them.

The first group session begins by group members introducing themselves (first name only). They are then given group rules, which are as follows:

1. Each group member must show respect for everyone else, no put-downs are allowed.
2. Once the group starts, no leaving (for the men's room or any other reason) until the group is over, unless it is an emergency.
3. One person speaks at a time—no interrupting.
4. No shouting or yelling.
5. Everyone must stay seated.
6. Coming in late disrupts the group. If you're continually late you can be dropped from the program.
7. Any physical fighting will result in being dropped from the program.

For adolescents who are court mandated to receive treatment, there are consequences from the Juvenile Justice System if they are dropped from treatment. After the rules have been explained, everyone is informed that all group participants have committed different types of sexual offenses and that no one sexual offense is better or worse than another. For instance, we have observed that the adolescent rapists tend to "put down" the child molesters. Members are cautioned against these kinds of unnecessary criticisms.

Group members are then informed that it is usual for everyone to be wondering what type of sex offense the other members have committed and that it is usual for young men to worry about having to discuss their offenses in the group setting. Each adolescent is then asked to state the age and gender of his victim(s), whether the victim was related to him, and whether the abuse

occurred once or more than once. While adolescents are compliant in presenting this information, they usually do so in a low voice and with their eyes downcast. At the completion of this session, cotherapists emphasize the need for strict confidentiality ("What goes on in here stays in here"). The clients are thanked for engaging in a difficult task.

The next step in the group program is aimed at modifying cognitive distortions and this segment runs for five sessions. Cognitive restructuring involves confronting the adolescent with his maladaptive beliefs about his deviant sexual behaviour. The cotherapists inform participants that for the next 4 weeks the group will talk about "things that you told yourself to make it okay to do what you did." The adolescents are given the following example: "If I speed in a car, I know that it is against the law, because speeding is illegal. So if I feel bad about breaking the law, I tell myself reasons that it is okay for me to do it, so I won't feel bad. One example is that it's no big deal because everyone else speeds." The cotherapists then ask group members what other reasons they would use to make it "okay to speed."

Group members then engage in role-play enactments where one of the therapists plays a child molester who uses typical rationalizations for his behavior. The adolescents take the role of therapists, court personnel, judges, and psychiatrists; they either agree with the "molester's" rationalizations or disagree. At the completion of each role play, the group discusses the rationalizations or distortions that were used and "why they were wrong." For the first few sessions the maladaptive beliefs that the cotherapists role play are taken from the Adolescent Cognition Scale, which was described earlier.

During the course of these sessions, the following topics are role-played: child molestation, incest, date rape, non–date rape, voyeurism, exhibitionism, and frotteurism. For those adolescents who have abused young children, issues of the children's inability to consent to a sexual act are emphasized throughout the group. The adolescents are also informed that people who are high on drugs or alcohol, or are developmentally disabled are legally unable to give informed consent.

At approximately the third session, the clients are asked to write down how they rationalized their sexually deviant behaviors. Examples of typical responses from child molesters are: "What the hell, nobody is here so why not—I can't get laid" (this is an example from someone who molested a female child). "Nobody will see me and I will get away." "Since somebody put me in pain, I might as well put someone else in pain" (this is an example of an adolescent who had been sexually abused and then acted out sexually.) "A young person wouldn't know better so she would do what you asked her to do." The following statements were made by adolescents who raped their peers: "I asked a cute girl, does she want to have sex with me, the girl said 'no because I'm only 13,' but I kept forcing her so she finally said yes." "It was fun." "If I forced a girl to have sex with me, if she didn't fight back it was okay, if she didn't

yell it was no trouble, and if she fought back she didn't like it." The following statements were made by adolescents who had participated in gang rapes. "Friends were doing it and said it was all right." "I'm not responsible because two other guys held her down and one raped her, I only touched her and I thought it might be all right because she wasn't making any noises."

The above statements reflect the following themes: (1) lack of empathy, (2) objectification of females, (3) viewing sex as something that one does to another person for personal gratification as opposed to a shared consensual experience, (4) lack of remorse, and (5) acceptance of violence as part of their lives.

There are numerous ways by which children develop these beliefs, including personal experience of having been neglected or victimized, being exposed to coercive models within their homes and communities; associating with antisocial peers; and societal messages about females and about the acceptance of violence.

In general, we have observed during these sessions that the mixture of different categories of offenses (e.g., child molesters with rapists) facilitates confrontation and changing belief systems. For example, when the therapist role-plays an adolescent who has had sex with a 7-year-old girl, the rapists in the group are horrified in their role as court personnel and immediately insist on that person being sent to jail. The adolescents in the group who have had sex with children listen to the reactions of their peers, and that helps them learn how others view their behavior. By engaging the adolescents in role-playing in these first sessions, a sense of cohesion in the group is facilitated.

The next several sessions (four to five) are spent developing and utilizing covert sensitization scripts. The purpose of covert sensitization is to teach each adolescent to recognize his own thought processes and behaviors that place him at risk to abuse someone, and to interrupt these thought processes and behaviors by substituting negative rather than positive consequences. Several group sessions are spent in which individuals write their own "scripts" of risk factors and negative consequences. We entitle this component of treatment "risk and consequences." An example is: *Risk*: I arrive home; no one is there; I feel lonely. I sit at the kitchen table watching young kids playing in the park—they look so happy. I think I'll go down and play with them. *Switch*—*Consequences*: I'm sitting in jail wondering what the judge will do. I'm really scared. All because I went down to the park to play with young kids.

From these scripts each adolescent makes eight individual tapes at the clinic, apart from time spent in the group. Each tape is 15 minutes in duration. The tapes are reviewed by the therapist with the client, and feedback is given. The tapes are then erased.

The next several sessions (five) focus on developing assertiveness and learning to control anger. Many of these clien

aggression as a means of problem solving. During the early developmental years, many parents help children direct their aggressive impulses in socially appropriate ways. However, some adolescents have not received or been able to integrate parental training or have learned dysfunctional modeling from adults and peers.

Adolescents are given examples from each of three categories of responses (i.e., passive, assertive, and aggressive). For example: "A friend asks to borrow your favorite piece of clothing. You do not want to give it to him." The client is then told that he may respond in one of the following ways: "You say okay or you say you can't find it when you know you can" (nonassertive); "You explain why you do not want to lend it to him" (assertive); or "You yell at your friend for asking" (aggressive).

The next session concentrates on learning to handle emotions. An example of an iceberg is used, in that the largest part of an iceberg is under the water and cannot be seen. Group members are taught that emotions are very similar; when someone "icebergs" or "blows off steam," the only emotion that shows is anger—but there are other feelings that need to be recognized and expressed appropriately. Group members are asked if they have ever been upset about something and then taken it out on someone else. An example would be failing a test and then coming home, tripping on a dog bone, and kicking the dog and taking it out on him.

We explain that many times people abuse others because they are feeling frustrated. An example would be a boy whose dad has remarried and then had an infant girl who gets all the attention. This boy was angry at his father for remarrying, hated his stepmother for getting his father's attention, and was angry at the little girl for being so loved. Subsequently, he sexually abused his half-sister, as a means of expressing his anger.

In one of the sessions, the video, *Rethink Workout for Teens: Learning to Manage Anger* (Silverman, 1988) is used. The main premise of this tape is expressed in the acronym "RETHINK":

Recognize when you are feeling angry; why you are angry.
Empathize; try to see things from the other person's point of view and to step into the other person's shoes.
Think about the situation another way, from another point of view.
Hear what the other person is saying.
Integrate respect and love in what you say even when you are angry.
Notice how your body reacts and how you calm yourself.
Keep you attention on here and now and the problem to be solved.

their own attitudes and feelings concerning sexuality, and clarify their values about sexuality.

In order for adolescents to explore and clarify their attitudes about sexuality, the atmosphere must be one of openness. In each session, we encourage clients to ask questions. We point out that we know it is sometimes difficult for them to ask questions; therefore, 10 minutes before each sex education class ends, all students are asked to write down anonymous questions about sex that they were reluctant to ask in class. Throughout these sex education sessions the following points are made:

All group members should be treated with respect—no put-downs allowed. Some people will know more than others about some things, but not about everything.

Different viewpoints, opinions, and values are expected and encouraged.

It is wrong to force someone to do something sexually or to have sex with anyone who cannot give consent.

A list of 20 sexual myths is made up on index cards. An example of a myth is, "If a boy pulls out before he comes, the girl will not get pregnant." The first student picks an index card from among the deck which is face-down on the table; he reads it aloud, and then says whether he thinks it is true or false. After he answers, the others are encouraged to respond. In one of the sex education sessions a film on anatomy and physiology is shown in order to educate the adolescents about sexual physiology and anatomy.

Another session explores why teens have sex. We break the group into two small groups and make it a contest to see which of the two groups can come up with the longest list of reasons that they can think of for having sex. The therapist then explains that there are many different reasons and many different meanings for sex, and it varies at different times and in different situations. The therapist then writes answers on the board. Some of the typical reasons proffered include to prove masculinity or femininity, to get pleasure physically or give pleasure, to keep up with friends (or show off), to show anger or degrade someone, to show love, to relieve physical tension, curiosity, get acceptance, to keep a boyfriend or make a commitment, to have children, or to have fun. When all the reasons are on the board, we ask the group what they think about each of the reasons and which are positive and valuable.

The remaining sex education sessions concentrate on birth control decisions and methods, sexually transmitted diseases, and values clarification. For values clarification, we explain to students that the following exercise is designed to explore opinions about a variety of sexual issues. We emphasize that there are no right or wrong answers, only opinions. Everyone has a right to take a turn expressing his own opinion, as long as no one is put down for having a

different opinion. Some sample opinions that get frequently expressed are "Homosexuals are sick" and "Most men want to marry a virgin."

Our clinic is located in New York City, which has a high HIV-positive population. Some of the adolescents in our clinic have known HIV-positive people, either relatives, friends, or acquaintances. We recently assessed pre-treatment general knowledge about AIDS in a population of adolescent sex offenders and male runaways. Sex offenders scored significantly lower than runaways in general knowledge about AIDS in an adolescent sex-offender population and male runaway population and were not able to discriminate safer sexual behaviors from those that were less safe (Rotheram-Borus, Becker, Koopman, & Kaplan, 1991). Therefore, we provide four sessions focusing on AIDS prevention.[1]

The content of these sessions review briefly the entire treatment. Each individual writes his own "plan" to avoid relapse. Safety measures that are covered include the following:

1. Avoid unsupervised contact with young children.
2. If you are not sure if someone is too young, ask him or her questions such as what grade he or she is in, what school he or she goes to. If you have to, ask for identification. A good rule to follow is to date someone no more than 4 years younger than you are.
3. Never test yourself (don't stay around kids to see if you get excited; if you want a test, come to the lab).
4. Always remember that children cannot give consent because they do not know the consequences.
5. Be sure that your partner consents to any sexual interaction.
6. Remember the bad consequences of your behavior—for you and the people who are close to you.
7. If you are not sure if your sexual behavior is appropriate, ask someone who is not involved, such as a friend, a parent, or a teacher for an opinion. Be aware of your attitudes about sex; do not fool yourself.
8. Increase contact with kids your own age.
9. Practice social skills.
10. Be assertive by expressing your negative and positive feelings; don't keep them to yourself.
11. Do not use thoughts of children or rape while having sexual intercourse or masturbating.
12. If inappropriate sexual urges return, it is not the end of the world; call

[1]If this is to be included in your program, we suggest you become familiar with M. Quackerbush & P. Sargent, *Teaching AIDS: A Resource Guide on Acquired Immune Deficiency Syndrome* (Santa Cruz, CA: Network Publications, 1986).

us. Do not wait to ask for help. If you are thinking you might need help, call immediately. Always have our telephone number with you.
13. Take care of yourself; you are the only one who can do it.

Following treatment, we assess each individual on four occasions: after treatment and at 3, 6, and 12 months following treatment discharge.

TREATMENT OUTCOME

Becker and Kaplan (1988) reported 1-year posttreatment follow-up data, which indicate that treatment is effective, according to self-reports, rearrests, and plethysmographic data. Of the first 300 adolescents evaluated, 68.3% (205) entered treatment. Although only 27.3% (56) attended 70–100% of the scheduled therapy sessions, recidivism rates at 1-year posttreatment were low. According to self-reports and reports from parents and criminal justice agencies, only 9% had recommitted sexual crimes (Becker, 1990).

CONCLUSION

Although clinical research of adolescent sexual offenders is at an early stage, preliminary results such as described here are promising (Becker, 1990). Further research needs to concentrate on the development of adolescent sex offender typologies and the evaluation of treatments relative to those typologies. Controlled therapy outcome studies are also needed.

Finally, then, the challenge to clinical researchers is to conduct studies that will inform us about the development of sexual interest patterns in children and adolescents, and how individual, familial, and environmental factors interplay.

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