
The Role Healthy Sexuality Plays in Modifying Abusive Behaviours of Adolescent Sex Offenders: Practical Considerations for Professionals

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Abstract

This paper highlights an approach that guides adolescents who have committed sexual offences to learn healthy/prosocial ways to meet their sexual needs. This paper is divided into an overview of literature, review of the sex education component of an intervention program for adolescent sex offenders, and a discussion on the practical considerations for professionals working with adolescent sex offenders. The information has a direct applicability to professionals working with adolescent sex offenders or with non-offending youths. Themes of healthy lifestyle and healthy choices are stressed.

Résumé

Cet article a pour sujet une approche guidant des adolescents ayant commis des infractions sexuelles vers une pratique de comportements sains et prosociaux pour satisfaire leurs besoins sexuels. L'article est divisé en trois sections : survol de la littérature, révision de la composante constituée par l'éducation sexuelle dans un programme d'intervention destiné aux délinquants sexuels adolescents, ainsi qu'une discussion sur les considérations pratiques auxquelles doivent faire face les professionnels travaillant avec ces adolescents. Les informations concernent directement les professionnels travaillant avec des délinquants sexuels adolescents ou avec des jeunes non-délinquants. Une place particulière est accordée aux thèmes d'un style de vie et de choix sains.

Gilbert-Evans and Redditt (1994), National Task Force Report on Juvenile Sexual Offending (National Task Force) (1993), Perry and Orchard (1992, 1989), Perry, Dimnik, Ohm and Wilks (1998) and other authors have stressed that professionals and paraprofessionals working with adolescents who have committed sexual offenses (adolescent sex offenders) need to provide services that will assist these youth in altering behaviours that are destructive to others and themselves. Treatment needs to focus on a number of areas (e.g., criminal history, empathy, responsibility, crime cycle, relapse prevention) and all interventions need to work towards helping the youth while ensuring the safety of the community (Perry & Orchard, 1989, 1992).

A number of authors have stressed that one important treatment goal for both adolescent and adult sex offenders is for them to learn to replace sexually intrusive behaviours with a healthy/prosocial lifestyle that allows them to meet their needs in socially acceptable ways (Gilbert-Evans & Redditt, 1994; National Task Force Report, 1993; Perry & Orchard, 1992; Association for the Treatment of Sexual Abusers, 1997). The writers

believe that one aspect of developing a healthy/prosocial lifestyle is for adolescent sex offenders to learn prosocial methods of meeting their sexual needs.

We utilize a cognitive behavioural perspective which focuses not only on identifying behaviours to extinguish (i.e. sexually intrusive behaviours) but on identifying and developing their positive counterparts (e.g., meeting sexual needs in consensual prosocial ways). As yet, our approach has not been validated through controlled empirical studies. However, it is based on sound cognitive behavioural treatment methods and research (Daleiden, Kaufman, Hilliker, & O'Neil, 1998; Laws & Marshall, 1991; Marshall, 1996; National Task Force Report, 1993; Perry & Orchard, 1992; Prochaska, Norcross & DiClemente, 1994; Reiss, 1986).

The purpose of this paper is to discuss sex education for adolescents who have committed sexual offenses and to provide practical suggestions to professionals who work with adolescent sex offenders. The paper is divided into three sections: overview of the literature; review of sex education component of an intervention program; and practical considerations for professionals working with adolescent sex offenders.

The concept of "healthy sexuality" for adolescents is a controversial one in our society because of the diversity of cultural groups with varying perspectives on the role sexuality should play in a youth's life and concerns about the spread of diseases or unwanted pregnancies. Carrera (1981) highlighted that "all people have the right to express their sexuality as a dignified, positive source of personal enrichment and happiness" (pp. 9). Brown, Carney, Cortis, Metz, and Petrie (1994) suggested that sexuality defines a part of self-image and self-esteem and relates to who the person is and what he/she can become. Reiss (1986) has defined "human sexuality as consisting of those cultural scripts aimed at erotic arousal that produce genital responses" (pp.234). The writers have defined healthy sexuality as:

The ability to appreciate one's own sexual feelings and act on them through a variety of channels (e.g. abstention, masturbation, fantasies, consenting sexual relationships) without impinging on their own or others right to privacy, mastery and enjoyment/satisfaction. Sexuality, while it may be part of a relationship with another person, is neither the sole reason for the relationship nor does it take the place of meeting other relationship needs.

SECTION ONE: OVERVIEW OF THE LITERATURE

Concerns about sexually transmitted diseases, unwanted pregnancies, abusive behaviours and moral questions have raised questions about healthy sexuality and has promoted the development of a range of sex education programs for youth and adolescent sex offenders (Erhardt, 1996; Kaplan, Becker, & Tenke, 1991; Mazur & Michael, 1992; National Task Force Report, 1993; Peterson, Leffert, & Graham, 1995; Reiss, 1981, 1986; Reiss & Leik, 1989; White & DeBlassie, 1992).

Erhardt (1996) stressed that acceptance of teenage sexual behaviour as a positive component of human development should be the basis for comprehensive sex education. Erhardt (1996) maintains that an exclusive focus on risky adolescent sexual behaviour prevents the development of effective, comprehensive sex education programs for teenagers.

Reiss (1986) proposed that people's abilities to express their sexuality is not "natural," that people need to learn how to express their sexual needs and that this learning needs to occur in a societal context. People have to learn how to express sexuality just as they need to learn how to socialize and make friends. He emphasized the need for programming to assist people to develop healthy ways to meet sexual needs. In another article Reiss defines the morality of sexual acts as the degree of honesty, equality and responsibility present (Reiss, 1993). To prevent sexually related problems Reiss advocates increasing social options for consensual sexual activities.

White and DeBlassie (1992) report that "just say no" approaches may be too rigid to be effective with many adolescents. They suggest that education programs can continue to encourage abstinence but also offer alternatives for youths who are already sexually active or who choose to become so.

Peterson, Leffert, and Graham, (1995) discuss the different demands of early, middle, and late adolescence. Erikson's identity theory and research on gender intensification are presented as a framework for understanding adolescent sexual development. These authors note that adolescents require social/emotional supports in order to develop in a healthy manner. Healthy sexuality is an important part of developing a healthy lifestyle. They suggest that for youths who are dealing with more than one challenging developmental issue at a time (e.g., sexual orientation, family dysfunction), postponing partnered sexual activity into at least middle adolescence is advisable. Youths need to be supported in developing healthy lifestyles through the development of appropriate activities and supportive relationships with adults and peers.

Rotheram-Borus and Fernandez (1995) emphasize that youths with homosexual orientation face distinct challenges in attempting to find ways to meet their sexual needs in healthy ways. They are continually confronted with social pressures to deny their feelings, their sexual preference, and for finding prosocial ways to meet their sexual needs. They highlight that the "coming out process" for youths should involve the following: recognizing oneself as homosexual, exploring one's sexual orientation through community support agencies (e.g., gay and lesbian community), disclosing one's sexual orientation to others, and becoming comfortable with their sexual orientation.

Olson and King (1995) have also discussed issues related to youths who are homosexual. They state that gay and lesbian youths have different

challenges to cope with than heterosexual youths. A primary issue for both homosexual and heterosexual youths is when to become sexually active. For gay and lesbian youths, partner selection may be limited due to societal pressures for youths not to disclose their sexual orientation. This limits choices and may lead to poor choices. The authors suggest a number of areas where there is a need for change and research (e.g., use of mass media to educate the community).

The National Task Force Report (1993) highlights a range of sex offender specific interventions. Focal areas related to healthy sexuality include: positive sexual development/identity; self-responsibility in sexual fantasies and actions; dating and relationship skills; sexual identity issues (e.g., homosexuality/homophobia) and sexually transmitted diseases. This report recommends sex education and sexual identity training which is based on the premise that once a youth develops prosocial relationships and realistic sexual expectations his/her tendency to return to abusive behaviours is significantly decreased. It also stresses that "specialized offense-specific treatment should consider the needs of the whole person and utilize existing resources to enhance the overall prosocial functioning and developmental competence of the individual" (p. 44).

In their review of the research, Becker, Harris and Sales (1993) report that sexually offending youth generally lack social and assertive skills, are often socially isolated and depressed, and that many of their families do not provide proper sex education. They report that after comprehensive cognitive-behavioural sex offender treatment which included sex education and value clarification training, subjects demonstrated a significant decrease in sexual arousal to inappropriate stimuli. A multisystemic treatment program for sexual offenders that addressed cognitive processes, family and peer relations and school performance, produced a 12.5% sexual recidivism rate. This compared with a 75% sexual recidivism rate for offenders treated with individual therapy. This article also indicates that awareness of unhealthy attitudes regarding sexuality is a factor in preventing sexual recidivism.

Daleiden et al. (1998) compared data collected from self-reported sexual histories and fantasies of four groups: incarcerated adolescent sexual offenders 10-15 years of age, incarcerated adolescent sexual offenders 16-20 years of age, incarcerated youth without a history of sexual offending and 135 non-incarcerated male undergraduates. All the incarcerated sex-offenders reported fewer consenting sexual experiences and more involvement in non-consenting and paraphiliac behaviours than the other groups involved in the study. These authors note that the majority of illicit sexual behaviours engaged in by sexual offenders was similar in topography to the normative sexual behaviour of the other groups, but was engaged in with non-consenting partners (e.g., kissing,

petting and vaginal intercourse). They also noted the lack of any sexual offending specific patterns of fantasy. Offenders did not demonstrate elevated levels of deviant fantasizing. Rather, all incarcerated groups reported decreased levels of nondeviant fantasies. This leads the authors to speculate that: “. . . contrary to clinical lore, criminal activity may be associated with suppressed levels of non-deviant fantasy rather than elevated levels of deviant fantasy” (pp. 195).

Kaplan et al. (1991) describes a treatment program for adolescent sex offenders which includes four 40-minute modules to develop healthy sexuality. Subject areas include general information on puberty, anatomy and physiology, birth control, sexually transmitted diseases, communication skills, relationships and value clarification. Kaplan et al. (1991) found that youth who participated in the program benefited (e.g., expanded understanding of human sexuality) but the training needed to be longer and trainers needed to address individual differences amongst the youths.

The writers' approach to providing information on healthy sexuality to adolescent sex offenders is based on the premise that if the youths are meeting their needs in healthy ways they are less likely to reoffend. In other words adolescents not only have to learn how not to reoffend (e.g., develop a relapse prevention plan) but they must find ways of meeting needs in healthy ways. Our program focuses on assisting the youth to develop a healthy lifestyle, with healthy sexuality being one component.

Central to the writers' approach is the integration of healthy sexuality as defined above, with programming for adolescent sex offenders (Perry & Orchard, 1992) within a developmental context crossing a range of cultural and age groups.

One such developmental model that crosses cultural boundaries and age groups has been highlighted by Jones (1980). He identifies three fundamental variables that are important for adolescents to develop into healthy adults: significance, competence and power/potency:

Significance refers to the belief that people are liked by, and important to, someone who is important to them.

Competence is defined as being successful at some task that has value and is reinforced within the environment.

Power/potency refers to people's ability to control important parts of their environment. (Jones, 1980, pp. 3)

The writers believe that a fourth variable needs to be added to Jones' (1980) list which is: *enjoyment/satisfaction* from the activities they are involved in. Program developers must not only look at providing information on healthy sexuality to youths but convey that information in a manner that encourages and fosters growth in significance, competence, and power, and that is enjoyable.

Most adolescents in our area have been introduced to some form of "sex education" within the schools and have been introduced to a value orientation which encourages abstinence while limiting information on how to develop a healthy sexual lifestyle. The primary aim of our intervention is to foster informed youth who are able to assume responsibility, investigating their own sexuality in safe, enjoyable, and non-harmful ways. A central aspect in assisting adolescents who have committed sexual offences is to have them take responsibility for their past and future behaviours (Perry & Orchard, 1992, 1989). This responsibility model stresses that youths develop ways of meeting their needs (e.g., sexuality) in prosocial ways.

SECTION TWO: INTERVENTIONS FOR ADOLESCENT SEX OFFENDERS

At our clinic, the first group that adolescent sex offenders participate in is the Psychoeducation Group (Psychoed).¹ This group is designed to prepare the youth for participation in other group interventions and is a combination of an educational and process group (Perry et al., 1998). Psychoed groups are composed of four to six youths with two facilitators (male and female).² Group sessions are two hours long and are held once a week for 15 weeks. Two sessions are aimed at exploring healthy sexuality and are the focus of this section.

Information on healthy sexuality has been drawn from a number of sources (Blanchard, 1995; Brown, Carney, Cortis, Metz & Petrie, 1994; Carrera, 1981; Denny & Quadongno, 1992; Marshall, 1996; Ross & Loss, 1988; Westheimer, 1994; Younger, 1992). A curriculum of human sexual functioning is presented from the perspective that healthy sexual behaviour is more enjoyable than unhealthy sexual behaviour. The facilitators emphasize that expression of one's sexuality is a necessary and good part of human experience and also that this expression can and must occur in ways that do not harm oneself or others.

One important goal of our intervention is to teach the youths the distinctions between coercion, compliance, cooperation and consent. Ross and Loss (1987) have developed a functional and practical model for teaching youths about consenting and appropriate relationships in the following five steps:

1. *Equality*—one does not overpower someone else;
2. *Affection*—both individuals like each other, as well as being sexually attracted;
3. *Loyalty*—neither person spreads rumours or violates the privacy of the other;
4. *Agreement*—both verbally agree about having sex;
5. *Children*—do not have the knowledge and skills to give consent or understand the consequences of sex.

The first session begins with the youths completing a questionnaire designed by treatment staff that explores group members' knowledge of sexuality. This sets the precedent for questioning and exploring personal

sexuality throughout the program. After completing the questionnaire, the group discusses the concept of healthy sexuality. The youths read excerpts from literature encouraging the broadest interpretation of human sexuality and are invited to peruse a number of resources brought to the group by the facilitators.³

Discussions about published materials teach group members how to differentiate between erotica, pornography, and obscene material. The following distinctions are used: erotica is any sexually arousing material which is not degrading to women, men or children; pornography is sexually arousing literature, art, photography or films which involves nudity and/or explicit sexual acts; and obscene materials are offensive according to accepted standards of decency, for example, sexually violent or paedophilic acts (Brown et al., 1994). The facilitators spend time with the youths discussing the distinctions and potential overlaps of these categories.

The youths also view excerpts from two educational videos on human anatomy. After viewing these videos, facilitators lead a discussion about the role of healthy sexuality. Youths and facilitators explore myths surrounding masturbation, fantasy, consenting sexual activities, and the use of contraception—in particular, condoms. We have condoms available and youths are encouraged to take them.

The second session on healthy sexuality begins with a discussion about the information shared the week before and the impact of this information on the youths' perception of healthy sexuality. Youths are then asked to review notions of "normal" in human sexual behaviour by reflecting on their own introductions to sexuality. As they discuss their introduction to sexuality they explore the values and knowledge imparted by family, friends, and media.

The group then discusses the adolescents' struggles with puberty, sexuality, and sexual orientation. This process allows youths to explore myths associated with human sexuality (e.g., myths surrounding homosexuality). A number of gay youth have attended our programs. The session ends with a discussion of the role healthy sexuality plays in a person's life and validates healthy sexual fantasizing.

Healthy sexual fantasies envision the youth participating in non-exploitive consenting sexual acts with age appropriate partners. We encourage youths to practice using the Ross and Loss (1987) criteria presented above to guide their sexual fantasies.

Parents of group members receive information about healthy sexuality and other aspects of the psychoed group through family sessions with a therapist. Families need to formulate ways to support the youth's healthy sexual behaviour (e.g., privacy). Facilitators also meet with the youths' probation workers and home placements to provide information and consultation.

The expected outcomes for the sex education component of the psychoed group are:

1. to promote the metaphor of youth on a developmental journey;
2. to normalize much of the youths' behaviour while beginning to tease out those behaviours, feelings, and beliefs which are unhealthy;
3. to help youths begin to assess how will they meet their needs and wants in prosocial ways;
4. to discuss empathy with emphasis being placed on the youths becoming aware that sex offenses hurt people in a variety of ways;
5. to provide information on healthy sexuality and provide a forum for youths to discuss sexuality and the role it plays in their lives and help them learn to practice safe sex;
6. to learn about the difference between consenting and coercive sexual contacts; and
7. to set the stage for developing healthy lifestyles which will reduce risk and assist the youths to meet needs in healthy ways.

Treatment providers build on the information presented to youths from this intervention throughout the rest of their treatment. After completing this essential training they are referred on to other individual, group, or family therapy interventions. As the youths grapple with demands of becoming a person who meet their needs in healthy ways they will continually need feedback and, at times, booster sessions.

As the youths develop community safety plans, the clinicians assist them in assessing and planning how they will meet their needs, both sexual and other, in healthy/prosocial ways. The youths are taught that they are responsible for controlling their behaviours and they need to continually balance the pros and cons of the decisions they make in the light of the impact on themselves and others. For example, in the process groups as the youths discuss their past and present relationships and life experiences, questions of responsibility and impact are highlighted.

The writers and other clinicians at our clinic assist the youths to openly discuss issues related to their sexuality throughout the rest of their treatment at our clinic, to build on this information and to look at developing healthy prosocial ways to meet sexual needs. This ongoing support and feedback is an aspect of the program that the youths and their families have found helpful. There is someone available who is open to discussing the youths' sexual issues in a supportive, nonjudgmental way.

SECTION THREE: SOME PRACTICAL CONSIDERATIONS FOR PROFESSIONALS WORKING WITH ADOLESCENT SEX OFFENDERS

It is essential for professionals working with adolescent sex offenders to be aware of their own attitudes and beliefs about healthy sexuality and to understand how these attitudes and beliefs affect their interactions with their clients (Perry & Orchard, 1992). Professionals working with adoles-

cent sex offenders need to be aware that these youths are likely to elicit a full range of emotional responses within the professionals themselves. Because many of these youths have had traumatic personal experiences (e.g., unresolved sexual abuse, physical abuse, grief and loss, disrupted familial relationships) and because these same youths have engaged in behaviours that sexually traumatize others, providers often experience intense, concurrent, empathic and antagonistic feelings towards them. Such conflicting responses can make it difficult to appreciate a youth's needs and effectively support them in meeting those needs.

Gay, lesbian, and bi-sexual youths may have particular needs in the context of a predominantly heterosexual group. Despite the fact that attention is paid to present homosexual lifestyles as a valid and healthy choice, and group leaders are clear that they endorse this view, our experience has been that gay youth often do not feel safe enough to openly discuss issues related to their sexual orientation within a group setting. Because of this they have generally sought out group leaders privately. Group leaders respect the youth's choices and maintain confidentiality.

Another population needing to explore issues related to homosexuality are youths who have experienced same-sex victimization. This type of experience can raise questions in a youth's mind about his sexual orientation, particularly if his sexual offending included same-sex victims as part of reenactment of his traumatic experiences. Leaders must be aware that such uncertainties may arise. DiGiorgio-Miller (1994) recommends that issues of sexual orientation need to be explored separately from offending behaviour so that the reasons for offending are not confused with either sexual orientation or the need to explore one's orientation.

Blanchard (1995), Marshall (1996), National Task Force (1993), and Perry and Orchard (1992) outline the following qualities and skills a professional needs when working with sex offenders.⁴ The professional should:

1. be aware of their own sexuality and how they meet their needs in healthy ways;
2. realize that victims of sexual abuse need to be aware of the impact of their victimization when working with sex offenders;
3. accept and permit lifestyles that differ from their own, realizing the distinction between sexual behaviours that are socially acceptable and those that are criminal, exploitive and assaultive;
4. have the ability to talk freely and knowledgeably about sexuality and sexual behaviour, including harmful behaviour;
5. have the ability to model comfortable and responsible sexual attitudes and values;
6. have an open, non-judgmental approach when discussing adolescents' perceptions of their lives;
7. understand the role of sexual fantasies and masturbation;

8. maintain a professional code of ethics in the provision of services;
9. be aware of adolescent developmental needs and be able to apply this understanding to information they are presenting;
10. present with a comprehensive command of communication skills and not rely on the control/expertise model to present information;

Training seminars for professionals working with adolescent sex offenders need to address these ten points. The writers have also found the following guidelines useful in training professionals working with this population:

1. take into consideration developmental and cultural factors when developing programs for adolescents;
2. discuss what they believe to be the aspects of a healthy sexuality lifestyle for adolescents;
3. provide information on healthy sexuality and overview current adolescent trends;
4. remember that each youth is an individual and has a distinctive personality, skills and history when formulating healthy sexuality plans;
5. keep healthy sexuality as a goal—one of the most consistent obstacles to fostering healthy sexuality among the professionals working with adolescent sex offenders is a belief that once a youth has committed a sexual offence he cannot be permitted to enjoy or engage in *any* sexual activity;
6. ongoing training and support, follow-up meetings and workshops and where necessary individual consultation.

The writers have utilized the following process to assist professionals and adults working with adolescent sex offenders to help the youth meet their sexual needs in healthy ways.

Step One: Formulating an individualized healthy sexuality plan for each youth. Every youth who enters our program has a distinctive personality and personal history. Many of the youths have experienced fragmentation of their primary relationships from an early age. Some have good social skills while others are lacking in confidence when socializing with peers. Some of the youths have had devastating experiences of being sexually victimized themselves. Our assumption has been that all of these experiences engender specific needs that must be addressed if a youth is to develop healthy outlets and emotionally satisfying relationships.

Step Two: Defining and clarifying roles with a focus on supporting healthy sexuality. Once a healthy lifestyle plan is developed, we find it important to define the different roles of all the adults involved in the youth's treatment, including community home operators, social workers, parents, psychologists and youth workers.

Step Three: Training in developmental signposts and needs of all adolescents including definitions of healthy adolescent sexuality. The writers and their colleagues provide training workshops for paraprofessionals and professionals working with adolescent sex offenders in our area. This process facilitates collaboration and further clarifies roles and needs.

Step Four: Integrating the first three steps. The first three steps outlined focus on establishing a reference point of healthy sexuality, assisting the providers to envision how this would manifest behaviourally in the youths they work with, and assisting providers to operationalize means of supporting the youths. All or any of these steps could entail substantial emotional or cognitive challenges for the providers. We found the means for integrating these steps by exploring the providers' own youthful experiences. In separate workshops we explored providers' personal experiences with catastrophic life events, facilitated reminiscences about their own behaviours as adolescents attempting to meet compelling needs, and created inventories of the components of each person's fulfilled life schemas. These were used to contextualize the behaviour and needs of the youths in their care.

Step Five: Ongoing training and support. The program we are involved with provides monthly support group meetings for all community home parents working with sexually offending youths. Bi-weekly case conferences and monthly workshops and training sessions are also held. Because cognitive, behavioural and emotional challenges continuously arise, we see this type of support as essential in maintaining the quality of care provided to the youths.

Summary

Encouraging a perspective of healthy sexuality in adolescent sex offenders is only one aspect of our endeavour to help them develop a prosocial lifestyle in the community. If we can assist these youths to develop healthy relationships and prosocial ways of meeting sexual needs, we believe that their likelihood to reoffend will be reduced. The focus on healthy sexuality needs to be incorporated into other aspects of sex offender treatment to maximize the youth's ability to not reoffend, to be safe in the community and to find socially healthy ways of meeting needs.

A major challenge faced by adolescent sex offenders is to develop socially acceptable behaviour that fosters connection and intimate relationships. A reference point of healthy sexuality and the belief that this is personally applicable is a prerequisite for the development of that healthy sexuality. Our approach to change identifies desirable behaviours which youths are able to substitute for undesirable ones (Prochaska, Norcross, and DiClementi, 1994). Through being knowledgeable about the goal of healthy sexuality, professionals working with these youths can be effective agents of change.

Assisting individuals to develop a healthy lifestyle is a primary goal of treatment interventions. Our approach to working with youths who have committed sexual offences is to develop a comprehensive safety plan that will assist them in not reoffending. To do this the writers not only focus

on aspects of preventing offending behaviours but emphasize healthy/prosocial ways of meeting needs. Healthy sexuality is one aspect of a prosocial lifestyle that will assist these youths in meeting their needs in nonabusive ways.

Notes

- ¹ The membership in this group has been exclusively males.
- ² We have found smaller groups more productive and ultimately more cost effective because participants gain more from their involvement than in larger groups. With larger groups we have found an increased demand for individual sessions to process intense intra-personal material evoked in group. With smaller groups, this material is explored in group, cutting down on the demand for individual clinical time, and allowing for group support as the individual confronts painful and difficult intrapsychic issues.
- ³ A more in depth discussion of the materials, resources and procedures can be found in Perry et al., 1998 or by contacting the authors.
- ⁴ The writers believe that these qualities and skills also apply to individuals who are providing sex education or counselling to youths and their families.

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