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Dealing with Young Offenders Charged with Sexual Abuse

A 1991 Irish Study has shown that of over 500 confirmed cases of sexual abuse, over 20 per cent of the identified perpetrators were 15 years or under. Juvenile offenders who have committed sexual offences are often both victim and offender. There is urgent need for a more co-ordinated approach in this country for the assessment and treatment of this category of young people with special needs.

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INTRODUCTION

It is fast emerging that sexual abuse is one of the most pervasive forms of child abuse operating in our society. Up to perhaps fifteen years ago sexual abuse was regarded as a relatively uncommon problem. In the late seventies, however, official reports of sexual abuse began to mushroom in North America, Britain and elsewhere. This increased incidence of reporting which accompanied the proliferation of literature and research on the subject, raised awareness in Ireland also.

In this country, between 1984 and 1987 inclusive, child abuse referrals increased by 244%, while child sexual abuse referrals increased by 956%. For the Eastern Health Board area these figures were 208% and 1,458% respectively (McKeown & Gilligan, 1991). In other words sexual abuse became an increasing proportion of all referrals.

STATISTICS

TABLE 1: NUMBER OF NEW CASES OF ALLEGED AND CONFIRMED CHILD ABUSE IN IRELAND AND THE EASTERN HEALTH BOARD (EHB) REGION 1984-1987.

Category	Year				% Increase
	1984	1985	1986	1987	1984-1987
IRELAND					
All child abuse referrals	479	767	1015	1646	243.6
CSA referrals	88	234	475	929	955.7
CSA as % of all referrals	18.4	30.5	46.8	56.4	
All confirmed child abuse	182	304	495	763	319.2
CSA confirmed	33	133	274	456	1281.8
CSA confirmed as % of all referrals	18.1	43.8	55.4	59.8	
EASTERN HEALTH BOARD					
All child abuse referrals	257	353	504	793	208.6
CSA referrals	29*	81	201	452	1458.6
CSA as % of all referrals	11.3	22.9	39.9	57.0	
All confirmed child abuse	100	137	273	350	250.0
CSA confirmed	11	42	134	211	1818.2
CSA confirmed as % of all confirmed	11.0	30.7	49.5	60.3	

* Estimated CSA = Child Sexual Abuse

Source: Statistics on Child Abuse, 1984, 1985, 1986, 1987, Department of Health, Hawkins House, Dublin 2.

While reasonably accurate figures are only available from 1984, this is certainly not to suggest that child sexual abuse did not exist before then. More likely it fell outside the diagnostic frame of reference employed by the health boards and their professionals.

RECENT RESPONSES TO CHILD SEXUAL ABUSE

In January 1988, two Child Sexual Abuse Assessment Units were opened to serve the Eastern Health Board region, one in the Children's Hospital, Temple Street, Dublin and one in Our Lady's Hospital for Sick Children, Crumlin, Dublin. They were launched with Department of Health funding. Also in 1988, IR£500,000 was allocated to the seven other health boards for assessment and investigation of alleged cases of child abuse. In the research area the Department gave a grant to the Irish Council for Civil Liberties Working Party on child sexual abuse reviewing laws, services and policies related to sexual abuse. It also funded research into child sexual abuse in the Eastern Health Board region in Ireland in 1988 (McKeown and Gilligan, 1991).

In addition, various voluntary agencies have been involved in responding to child sexual abuse. These have included the Incest Crisis Service, The Sanctuary Trust, The Dublin Rape Crisis Centre and the Irish Society for the Prevention of Cruelty to Children (I.S.P.C.C.) who established the telephone counselling service *Childline*. While funding for many of these has lapsed or dwindled they have had a high media profile and have been instrumental in heightening public and professional awareness of the problem. They have also pointed to the need for research to establish some firm evidence of the nature, extent and causes of child sexual abuse.

THE NEED FOR ACTION

Studies in Ireland (McKeown and Gilligan, 1991) and elsewhere (Baker and Duncan, 1985) of the prevalence of child sexual abuse suggest that its incidence is extremely underestimated. It is generally conceded to be far greater than statistics on reported cases would indicate.

Most surveys of the incidence of sexual abuse show it to be a pervasive social problem with some inquiries speculating that up to one in four females and one in ten males have experienced it in some form or other. The Irish Council for Civil Liberties (1985) has estimated that two in ten Irish children have been affected by this form of abuse. The true incidence is of course extremely difficult to establish as many incidents, as well as their intensity and duration, are not and may never be disclosed.

ADOLESCENT OFFENDERS

In the recent Irish study by McKeown and Gilligan (1991) of 512 confirmed cases dealt with by the Eastern Health Board in 1988, it was found that 80 (21%) of the identified perpetrators were fifteen years or under and another 63 (16%) were between 16 and 20 years. In addition Hoghughi and Richardson (1990) points to the fact that the number of known abusive acts per adolescent offender may be in excess of one hundred offences, with up to three hundred not unknown. He contends that the number of multiple offenders are increasing since, unless the incidence is particularly horrific, authorities rarely take action against one single act.

McKeown and Gilligan (1991) also found that, in line with other countries, the sex of the abusers in 90% of all confirmed cases was male, although there is a growing recognition of the incidence of sexual abuse being perpetrated by females.

Significantly, Conte and Shore (1982) found that in more than half the cases they worked with they found that the offender had attempted or committed his first sexual assault by the age of 16.

BOTH VICTIM AND OFFENDER

In addition juvenile offenders present special concern for treatment programmes as they are often both victim and offender. Molestation of younger children has often been found to be an indication of the child offenders own victimisation. Three factors may account for this type of behaviour:

1. It is a way of channelling aggression and turning repressed anger at his/her own victimisation into power over someone else.
2. The molester re-enacts his/her victimisation in an attempt to restore his/her feeling of being in control.
3. It is a means of asserting his/her own heterosexuality; particularly for young boy who was abused by a male.

From the perspective of the victim, abuse may produce a kind of learned helplessness or a repeated aggressiveness. They are destined to a future of repeated victimisation (of themselves), an inability to protect others or the development of similar abusive behaviour towards others. While sexuality may be biological and instinctive, the way we behave sexually and our definitions of

appropriate sexual behaviour are learned from both models in our lives and information made available to us in our environment (Ryan, 1987). The high incidence of untreated sexual victimisation in the histories of adult offenders suggests that the lack of treatment in adolescence may be related to their later abusive behaviour. According to Hoghughi and Richardson (1990):

> Hard evidence shows that about 25 per cent of all abusive adolescents have themselves been sexually abused. However, clinical indicators of abuse, in its wider sense of physical and emotional, shows the number to be nearer to 100 per cent. Rapists are more likely to have been subjected to serious physical abuse. In reality many more of the perpetrators seem to have been abused than had been supported by our finding that 50 per cent of all sexual abuse is against male victims who will, in turn, grow up with a greater propensity to become sexually abusive (Hoghughi and Richardson, 1990, p.4).

Treatment of young offenders, up to and including adolescence, is crucial in breaking the cycle of abuse because permanent adult preferences have not yet crystallised.

PART OF A PATTERN OF BEHAVIOUR

Young sexual offenders are children in need of treatment and protection, often from serious self-injury. Sexual assault usually belongs to a spectrum of behaviour which includes: depression, diminished self-esteem, suicidal behaviour, fire setting, confused self-concept, poor impulse control, drug, alcohol and substance abuse, an inability to trust or experience intimacy in relationships and little or no experience of satisfying relationships with females of their own age. They are often high-risk takers, morally "primitive" (i.e. it's wrong only if you're caught etc.) and have an externalised locus of control; believing their lives are controlled by outside rather than internal forces.

In summary then, we believe that these youths feel lonely, isolated and depressed. They are often themselves the victims of abuse in their homes (most commonly) or in the community; almost always by another male. Most never receive treatment which addresses their distorted sexual orientation and hence many of them will go on to be adult sexual abusers.

ASSESSMENT OF ADOLESCENT ABUSERS

When an adolescent abuser has been identified a thorough, in depth assessment is necessary. The aim of such an assessment is to identify the nature and the extent of the abuse, its complexity and meaning for the offender and the pervasiveness and preoccupation with the behaviour in the young person's psychological make-up. This is with a view to estimating probable risk, the amenability to treatment and thus an appropriate and effective recommendation.

Having emphasised the critical nature of the assessment process; as much information and as many strategies as possible must be available to those who attempt treatment. Each case is unique, each individual is different, so each course of treatment may need to vary, even if only marginally. Therefore thorough assessment of particular needs is vital; it is useless to decide on group therapy for the first twenty offenders in a given year and expect it to work. Some individuals will succeed in group therapy, others need intensive individual work, still others will require a combination. Identification of potentially influential family dynamics, character traits, psycho-social adjustment, sexual orientation and risk evaluation in each individual case will be required before an effective treatment programme can be decided upon. Only with a total and fully comprehensive assessment can we hope to effectively treat our adolescent sex offenders and hopefully save thousands of future potential victims from a trauma which could damage them irrevocably. The earlier the intervention occurs, the more likely it is that the treatment will be successful.

TREATMENT OF ADOLESCENT OFFENDERS

Interest in the treatment of adolescent offenders is growing, for reasons already stated. However, the treatment of offenders is varied ranging from individual to group to family therapy. No evidence has been put forward to suggest that one approach is superior to another. In recent years, especially in North America, group treatment has replaced individual and family treatment as the primary focus. Whether group treatment is the most effective model has yet to be substantiated. Group experiences may, however, be more helpful for adolescent rather than adult abusers, because peer groups are more congruent with their developmental needs for peer acceptance. However, care must be taken in this situation that a group of young sex-offenders does not reinforce the possibly latent group feeling that because all members have offended sexually then their behaviour is acceptable.

In the Irish experience, for example, treatment which does not involve the parents, or indeed the entire family is of limited use. Most of the treatment facilities in this country include family support as a criterion for acceptance into their programmes. The parents must be willing to confront and work through the issues with the adolescent, and in several facilities, separate parental counselling is provided to help the parents through the personal crisis they are experiencing. A suggested outline of the stages in the treatment of juvenile offenders has been contributed by Dr. Pat Walsh, St. John of God Child and Family Centre, Orwell Road, Dublin.

STAGES OF TREATMENT

1. The youngster is brought to the stage where he can acknowledge what he did and describe it in detail.
2. The parents are involved in the response to the events.
3. The emotional aspects of the offender's life are explored, particularly those relating to social development, self-esteem and the sources of satisfaction he has in his life.
4. Work is done on managing the boundary between the abuser and the victim and between the parents of both.
5. A beginning must be made in exploring the confusion relating to sexuality which usually exists in this situation. A process of clarification is carried out over a number of sessions. Further, the extent to which the youngster has developed masturbatory fantasies which may be pulling him towards seeking sexual gratification in the sexual abuse of children is examined. Usually this can only be acknowledged fully later in the treatment.
6. There often occurs a "happy stage" in the therapy when the youngster appears to experience a level of well-being, and this can be used to point to more positive directions in his life in general.
7. There must then be a follow up for some time at regular intervals to ensure that the youngster is kept on the new path.
8. It is very valuable to keep in touch with whoever is seeing the victim both to check the facts and to better manage relations between all the parties involved.

In Britain and North America, there are many treatment programmes in operation. Obviously many elements will be common to different programmes, and similar themes are tackled in various ways by different theorists. While it is impossible to review programmes outside Ireland within the confines of this article, several of the most noteworthy include those of:

1. Masud Hoghughi, Aycliffe Children's Centre, Durham, England.
2. Ray Wyre, Graceland Clinic, England.
3. Gail Ryan, Kempe National Centre, Denver, Colorado, USA.
4. Smets and Cebula, Chippewa County Guidance Clinic, Chippewa Falls, Wisconsin, U.S.A.

CONCLUSION AND RECOMMENDATIONS

In this country, the development of assessment and treatment programmes for adolescent sex offenders had occurred without central guidance or direction. Most of these have been initiated by professionals or individual agencies who have already come in contact with these adolescent perpetrators and realised the urgent need for treatment not only of victims but also of offenders.

1. There is an obvious need for a more co-ordinated approach to the treatment of adolescent sex offenders. The setting up of a specialist service to deal with this problem is indicated. This service would be the initial referral agency for all cases of adolescent sex offences. It would assess each case individually, provide advice and recommend and appropriate placement and treatment. It would also pilot and co-ordinate treatment programmes, and provide outcome studies to indicate the effectiveness of the treatment. St. Michael's Assessment Unit in Finglas, Dublin, may be an appropriate site for such a service as many of the facilities are already in place. Otherwise, each Health Board area may provide their own such regional service.
2. Every psychological service in the country should be willing to provide adequate treatment facilities. At present the provision of treatment depends largely on the willingness of individual psychologists to work in this area.
3. There is a great lack of secure therapeutic accommodation for serious offenders. The problem needs to be urgently addressed to ensure potential victims are protected.
4. Group treatment is regarded by many writers as a more effective approach for adolescent offenders because it is more in keeping with their developmental needs. Emphasis is being placed on the use of group therapy in conjunction with family therapy. The Irish experience focuses largely on individual work, and the development of more group treatment programmes is indicated.
5. Follow up services and continuing support for adolescents finishing their course of treatment is vital. The offender must feel that he may avail of further treatment/counselling should he be in danger of re-offending.
6. Statistical data on the effectiveness of the treatment of juvenile abusers is not available in Ireland. A collation of such data is essential so that treatment may be

modified or updated so as to be as effective as possible.
7. Early identification and intervention is seen as the key to successful treatment.

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