

Treatment of Young Perpetrators of Sexual Abuse

Possibilities and Challenges



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Research has shown that many adult offenders have started their offending or sexual deviant behaviour as teenagers, and they can go on to commit many offences over many years. There is a tentative consensus among researchers and practitioners that intervention at this early stage can prevent some young perpetrators from becoming potential adult abusers. Save the Children believes that these children and young people can change their behaviour. Professionals should be aware of normal sexual development in children, but abusive behaviour should be taken seriously and not be dismissed as experimentation.

Burkhard Gnärig, Chief Executive Officer of the International Save the Children Alliance, welcomed the conference participants and summarised the Alliance's role. One of Save the Children's major priorities is to reclaim the leadership in children's rights policies, he said. "This sort of conference is part of that process."

I. Introductions and Background to the Conference

Lars Lööf, Daphne project coordinator and clinical psychologist with Save the Children Sweden

The Daphne programme is one of the EU's responses to both the UNICEF world conference on the Commercial Sexual Exploitation of Children, in Stockholm in 1996, and to the events surrounding the arrest of paedophile Marc Dutroux in Belgium. It sets out to help NGOs to create innovative programmes to combat abuse and violence against children, young people and women, and to increase knowledge and expertise.

Save the Children's project on the Treatment of Young Perpetrators of Sexual Abuse is an offshoot of an earlier project carried out in 1998, during which five seminars on child abuse were held in different EU countries.

"It became clear that the issue of young perpetrators was a potent one, and that the approach to the problem and knowledge about it was very different in different countries," explained Lars Lööf. "Knowing that the step from being a victim to being a perpetrator can be very short, it is important for Save the Children to look not only at the victims but also at the perpetrators. What exactly is a victim, and what is a perpetrator?"

It is our feeling that young perpetrators, all over Europe, do not get the treatment or the chance of rehabilitation they are entitled to. We want to enhance the right of all children to be treated equally, and for these children to have their needs attended to.

Lars Lööf

Diana Sutton, International Save the Children Alliance European Officer

One of the most important findings from Save the Children's first Daphne project was that a lot of sex abusers – perhaps 30% – are under 18, said Diana Sutton. It became clear that more in-depth analysis of this issue was needed, especially focusing on young boys. Gathering more information is crucial to the development of appropriate policies at national and European level, and to the harmonisation of EU legislation.

If work can be successfully carried out to rehabilitate this group of offenders, there is a real opportunity to break the cycle of abuse which can lead to former victims themselves assaulting other children.

Save the Children's pan-European work shows that different countries in Europe have very different ways of working with the issue. Some are quite advanced, while others talk about a "culture of silence", or say the problem is "not on the agenda". It is therefore important to draw wider policy conclusions. Save the Children hopes to use the conference to set the agenda both at national and European policy level.

2. The Current Situation in some EU Countries

Spain: the host country

Purificación Llaquet, Chairperson of Save the Children, Spain

Spain has only recently started to come to terms with the problems of child sexual abuse, Purificación Llaquet told the conference. So far, there are very few programmes designed to prevent sexual abuse. But with a growing public awareness, largely due to reports in the mass media, and following research by Professor Félix Lopez, work is now going on to find the best ways of treating cases of sexual abuse, and to train all those concerned with young people.

“It is not often that people will accept the idea that the perpetrators need help, especially those who are below the legal age of consent,” she pointed out.

A new law on minors’ criminal responsibility has just been passed in Spain, and will come into force in 2001. This allows for rehabilitation measures for children who have committed offences. Llaquet stressed that over the next few months it is crucial to formulate the best methods for helping and rehabilitating young offenders, so that the law will prove to be an effective measure, complementing legislation on children’s rights.

Save the Children Spain was set up 10 years ago, and joined the European Alliance in 1998.

Elena Hayward, Psychologist, Save the Children, Spain

Elena Hayward said the current legal system provides for prosecution of the aggressor, not treatment. It is extremely difficult to impose treatment, and therapeutic interventions are close to impossible. She called for reforms to penal procedures to shorten time limits, develop infrastructure, unify legal and social interventions, mandate treatment, and clearly define sexual abuse.

At present, the younger the age of minors entering prison, the more likely they are to reoffend, locking them into “the wheel of the penal system”.

She drew attention to the current reform of the judicial process regarding minors. The new law will provide for educational interventions, and procedures for mediation and reconciliation between the victim and the abuser. A technical team will advise the judge of the minor’s best interests. The law will distinguish between youngsters aged 18-21, and 14-18, with a subdivision at 16.

Better detection and diagnostic tools are needed to evaluate whether offences are primarily sexual, and determine the correct treatment. Spain suffers from a lack of

training for professionals, and a lack of support for victims. Supervision of young offenders in prison is also inadequate.

Centres working with young sexual aggressors now exist in Barcelona, Valencia, Seville, Madrid and Cadiz. Except in Seville and Cadiz, these follow a cognitive behavioural approach. They work with individuals and groups, trying to integrate families and reach out to local communities. Barcelona is a “closed” juvenile detention centre. Centres in Madrid, Seville and Cadiz are privately run, two of them by Vinculos, an NGO which works with child protection services.

“There is a need for networking between professionals. They have no way to share good practice,” argued Hayward. “We also need to raise awareness among national decision-makers and the public about rehabilitation. People still tend to think criminalisation of young perpetrators is an appropriate solution. We hope that this meeting will enable us to develop new approaches and practices which could have an impact.”

Alfonso Marina, Sub-Director of the Children’s section of the Family Department of the Spanish Ministry of Labour and Social Affairs

Alfonso Marina said the main objective of the new Spanish law on children’s criminal liability is educational. In the run-up to its implementation, a wide range of activities is being carried out, including experimental programmes and research, in an effort to formulate models and apply best practice from other countries.

With regard to child sex abuse, government efforts in the field of prevention and education are vital. The abuser’s background is important in influencing his or her future behaviour, and some measures could reduce the likelihood of further offences taking place.

When the abusers themselves are minors, it is even more important to intervene to change their behavioural patterns.

“Regardless of the natural repugnance felt towards these offences, the main emphasis must be on education,” he insisted.

The government is giving funding to NGOs working on behalf of children, and coordinating meetings with Spanish regional authorities. It is discussing the possibility of drawing up a protocol for reporting cases of child sex abuse, in line with existing protocols for police or health interventions, so that any professional becoming aware of a case of abuse would immediately know where and how to report it. Steps will be taken to avoid children having to confront their abuser in court proceedings.

In a European context, the work of the Daphne programme is very significant. It is vital, said Alfonso Marina, for governments, NGOs and experts to follow the same objectives, so as to ensure a coordinated approach throughout the EU.

Sweden

Anders Nyman, Psychologist and psychotherapist at Save the Children Sweden's Centre for Children and Adolescents in Crisis, Stockholm

As a field of research and knowledge, the problem of young sexual offenders is still relatively unexplored in Sweden. However, over the last five years some work has started, compared with 20-25 years' study of the victims of sexual abuse.

Two reports have been published, the most recent by the National Board of Health. Less than 150 individual cases are documented. This shortage of comparable studies means "we depend on networking in groups like this", said Nyman. No preventive measures or treatments are available for potential offenders. "In Sweden, it seems as if you have to commit a crime before you are offered any help." All convicted sex offenders are offered psychotherapy in prison. Although the age of responsibility is 15, children of 13 or 14 may be interrogated by police.

No consensus exists about the most effective methods of treatment, prognoses, causes and risk factors. "We are, at the moment, occupied with describing and understanding differences," explained Nyman. For a couple of years now, a debate has gone on as to whether adult sex offenders should be offered medical or psychotherapeutic help.

But there is also, in Swedish society, a growing awareness and interest in developing treatment in this field. Three government institutions now offer placements and treatment to young sex offenders, and more are planned. But it is still very difficult to find placements for slightly mentally retarded youngsters, who are over-represented among young sex offenders. There is a major lack of resources and competence concerning their needs and their ability to benefit from treatment.

Media coverage of young sex offenders focuses on the more sensational aspects such as gang rapes and pornography, and as a result, awareness of the real problem is limited largely to professionals. But there are already formal and informal networks of clinicians, researchers, social workers and officials working in this field.

Save the Children Sweden's experience indicates a rise in reporting of young sexual offenders, with increasingly young children, aged from 7-12, forced into sex acts with others. It is therefore crucial to understand what appears to be a growth in sexualised behaviour among children of lower ages.

Norway

Report from the meeting of Norwegian experts, organised prior to the conference by Redd Barna (Save the Children) in Oslo

Many taboos still surround the issue of young sex offenders in Norway, and are reflected within child and youth psychiatric departments. It is important to confront these prejudices within the health care system. Greater cooperation is needed

between mental health and child welfare services, but at present there is a reluctance to act on both sides. This may be due to a lack of knowledge and expertise, and demonstrates the need for competence-building. The approach to young abusers should be a “holistic”, interdisciplinary one, drawing in child welfare services, family work and individual therapy.

In Norway today, many children and youths have to wait for months before receiving qualified help or therapy, and this can be damaging for their future chances. When cases of abuse are revealed, help should instead be instantly available for both victims and perpetrators, and all the big clinics should have the competence to offer treatment.

A change of attitude is the first requirement. Child welfare and child psychiatric institutions should work together to increase cooperation. Competence-building is needed in all fields relating to young perpetrators, and should include education for psychologists, teachers, police and politicians. Teachers, in particular, if they do not understand the issue, may end up making situations worse. Further research is needed on the ethnic aspects of the problem.

The experts called for a national conference involving therapists, child welfare services, and all professionals in the field. This should be backed up by local conferences. Standard “recipes” for handling cases at a local level are needed.

The experts concluded:

- Interdisciplinary cooperation involving all professional groups must be improved;
- Further education for professionals is crucial;
- A change of attitude towards work with young abusers is also essential;
- Therapy and other help should be available at short notice – children should not have to wait months.

*Svein Mossige, Clinical psychologist, lecturer and researcher
at Oslo University Institute of Psychology*

Mossige described research carried out in Norway with the support of the Ministry of Family Affairs, to assess the “normal” adolescent population’s attitude to sex with children, and any lessons to be learnt about prevention of abuse.

A questionnaire was distributed to a sample group of 700 teenagers around 18 years old.

They were asked whether, if they knew they would not be punished, they would like to have sex with children (a) of unspecified age; (b) aged 13-14; (c) under 12.

Replies:		boys	girls
Might have sex with	(a):	28.6%	7.8%
	(b):	19.1%	3.0%
	(c):	5.9%	0.8%

The group of 19.1% in category (b) totalled 58 boys out of about 300. Therefore the study looked more closely at these individuals, as potentially being at risk of abusing.

They found: 32 were lonely
53 used child pornography
43 had some conduct problems.

Mossige concluded that young sex abusers are in turn surrounded by a wider group of youngsters who “may” abuse children. This can be visualised as:

Figure 1



More research is needed to establish what can be done to stop the middle group moving into the central group, and on the impact of gender roles.

Thore Langfeldt, Clinical psychologist and director of the Institute for Clinical Sexology and Therapy in Oslo

Norway is a big country with few people. This means that some sex offenders have to travel up to 500 kilometres for just one or two hours of therapy.

The Institute for Clinical Sexology and Therapy has treated 50 boys, aged between eight and 17, described by Langfeldt as being “in sexual crisis”. He avoids the terms “abuser” or “offender”, since these boys are still sexually immature, and run the risk of identifying with adult abusers.

He highlighted:

- a) A relatively high proportion of homosexual offences. Langfeldt related these abusive activities to the denial of homosexuality within society. Although the boys may be genuinely homosexual, there is pressure to apply treatment to “make” them heterosexual.
- b) The therapist must work to be “actively empathetic”. This is so tiring that at the Institute, therapists only work with the boys half time.

- c) Sexual behaviour is a “construction”, and the purpose of the treatment is to create a new construction of sexuality.

The Institute has collected information from its 100 adult sex offenders about when they started to abuse, and hopes to develop new programmes. Identifying at-risk groups is especially important.

“Empathy” and “hope” are powerful concepts in therapy. It is important to focus on the abusers’ pain and what they have suffered, before you consider the bad things they have done. During therapy you may lose the empathy, and so you have to go back through this process again. It is very effective.

Thore Langfeldt

Denmark

Vernon Jones, Social worker, Red Barnet (Save the Children) Denmark

Sexual abuse by children and young people is a serious, hidden, social problem which has for too long been neglected and denied in Denmark by academics, practitioners and politicians alike. “Abusers of all ages find it much more in their own interests to be part of a society which ignores the suffering of their victims by denying that sexual abuse takes place at such alarming levels,” argued Jones. “Young perpetrators deserve better professional treatment services than are available at the present time.”

Two recent serious cases of teenage gang rape in the city of Århus attracted the sort of sensationalised media coverage that can be destructive.

It appears that coordinated management and intervention for this very troubled client group does not exist within the statutory welfare system. Although Denmark thinks of itself as one of the most forward-thinking countries in Europe, no facilities exist as yet for assessing the extent of the problem.

However, the Danish Parliament has recently set up an Interministerial Committee to investigate all forms of child sex abuse, with representatives from the Justice, Social, Education and Interior Ministries. The Children’s Council (Børnrådet) has also proposed a national strategy for the prevention of child sexual abuse. At a recent meeting at the Danish Parliament, Interministerial Committee chairperson Brian Nichols drew attention to the need for more research into sexual abuse by young people, affording the hope that better treatment will be developed.

Four years ago, the Danish government established a system for the treatment of adult sex offenders at three centres around the country.

Professionals working with young perpetrators of sexual abuse need to learn from their international counterparts about treatment and assessment models which can be adapted for use in Denmark.

Iceland

Dr Jon Fridrik Sigurdsson, Forensic and clinical psychologist

Dr Sigurdsson described existing procedures for treating young sexual offenders in Iceland:

1. Minor cases: child protection authorities refer the perpetrator directly to a professional therapist (e.g. a psychologist) as an out-patient.
2. Medium cases: child protection authorities arrange for the perpetrator to be assessed, and admitted to a treatment home. There are about eight of these homes around Iceland, housing four to six children each.
3. Serious cases: police prosecution. If convicted, the perpetrator receives either a term of imprisonment, a deferred sentence, or a conditional discharge, and may be referred to a treatment home.

Number of reported young perpetrators in Iceland
between Nov 1998 and Dec 1999

Age of perpetrator	Number
4-8 years	6
9-11 years	4
12-14 years	6
15-17 years	11
No information	2
Total	29

Average age was 12 years. Only one girl, aged 14.

The outcome of 26 of these cases is known:

- eight children had received some kind of therapy;
- six received “support”, e.g. from an adviser;
- four were assessed at the Children’s Assessment Centre in Reykjavik;
- one was admitted to a child/adolescent psychiatric ward;
- five are currently being treated at treatment homes.

Police interviewed only two of the perpetrators.

The age of criminal responsibility in Iceland is 15. Over the last 10 years, nine boys, aged between 15 and 17, have been sent to prison for sexual offences. The two 15-year-olds were jailed for rape and sexual abuse of younger children respectively. The offences of the seven 17-year-olds included sexual abuse, attempted rape, rape, and indecent behaviour. Another 15-year-old boy received a deferred sentence for attempted sexual abuse of a younger child.

Currently, a thorough psychological assessment of young perpetrators of sexual abuse is being carried out. The individuals under scrutiny are being treated at small treatment homes in the north of the island.

Possible future action – under evaluation

1. Establishing a special treatment centre near Reykjavik.
2. Using available resources (treatment homes), but
 - providing specialised psychological supervision;
 - training and counselling staff where appropriate.
3. Providing out-patient facilities to serve the whole country.

Romania

Dr Violeta-Olivia Stan, Professor Assistant in the Department of Child Psychiatry, University of Medicine and Pharmacy, Timisoara, and Vice-President of Salvati Copiii, Save the Children, Romania.

In Romania there is a grave need for further expertise in this field, reported Dr Stan. Save the Children started a centre for counselling and intervention in cases of child abuse in the west of the country near Timisoara.

The large numbers of abandoned children constitute a high-risk group for child abuse. Many of these children have no identity of their own.

Institutional abuse in Romania is well-known and deeply entrenched. There is much denial and ignorance, and no statistics to reveal the extent of the problem. Universities have yet to introduce the study of child abuse.

Child workers in Romania have a desperate need to share information, and Dr Stan appealed for help in conducting research.

3. Setting the Context – the State of Existing Knowledge

Young perpetrators of sexual abuse: Overview of research and current knowledge

Dr Richard Beckett, Head of Oxford Forensic Psychology Service, UK

Dr Beckett's team has carried out pioneering work in the field of identifying "high-risk" young sex abusers, and assessing their treatment.

He stressed that he was talking about young people who had been victimised. "We must be mindful of why they are behaving like this in the first place," he insisted.

He started with a series of questions:

- How do perpetrators differ from young people who do not abuse? Very few studies have compared perpetrators with other young offenders.
- How many young people reabuse? About one third of all sexual assaults are carried out by young people. The majority do not go on to sexually abuse again. **It is important to know which ones will go on to become adult abusers.** These are the people we must target for treatment.
- When we assess young people, what are we assessing them for? For instance, is violent or criminal behaviour relevant? Studies show that a significant number of adult abusers started with problems in adolescence. Therefore, treatment at this stage is very important.
- Does treatment work? Can we measure progress, and is it linked to risk reduction?
- Do family attitudes make a difference?

Victim Studies

Victims of sexual abuse are: mostly female (56-79%)
mostly children

David Finkelhor, USA (1979)¹

10,000 people were surveyed. Of these, 34% of women and 39% of men recalled having a sexual encounter as a child with someone aged 10-19.

David Glasgow, UK (1994)²

Over a two-year period, one third of allegations of sexual abuse identified the perpetrator as aged 17 or less.

1 Finkelhor, D. *Sexually Victimized Children*, Free Press, New York, 1979.

2 Glasgow, D. et al, "Sexual Abuse of Children by Children", *Journal of Child Law*, 1991, 3 (4), 147-151.

Northern Ireland study (1990)³

36% of child sexual abuse was committed by teenagers.

Concerning victims: 50% were aged under nine, 65% were under 12.

Beckett and Brown (in progress)

Average age of victims is nine years.

Work in North America revealed the average age of victims as seven.

If we can identify a group of young perpetrators who are at high risk of going on to be adult offenders, this would be very useful. But there is high level of unknowns. Our ability to predict is very poor.

Dr Richard Beckett

Very little research has been done to follow up young abusers to see whether they reoffend. Most has been retrospective, working backwards from adult offenders. For instance: **Abel et al. (1986)⁴**, studied 561 adult offenders, and found 53% showed “onset of deviant interest in adolescence”. But this sample gives no indication of how many adolescents with similarly deviant interests do not go on to offend. The high-profile Abel clinic may also have recruited an unrepresentative group of particularly deviant and persistent adult sex offenders, of whom a disproportionately large number might have developed early deviant interests.

Only one published study has examined untreated abusers. **Elliot (1994)⁵**, followed up 66 self-reported, mostly undetected young “rapists” over 15 years. 22% reported further sexual offences in that period; 78% reported other offences. This suggests that the majority do not offend again even without treatment. A review of adolescent recidivism studies by **Weinrott (1996)⁶** confirmed that adolescent sex offenders were twice as likely to receive a non-sexual as opposed to a further sexual conviction. Among adolescents, the risk of violent and general reoffending is greater than that of sexual recidivism, argued Dr Beckett.

What happens after treatment?

O’Brian, USA (1990)

Sample of 200 young perpetrators. Following outpatient treatment, 6% committed further sexual abuse.

Steiger and Dizon (1991)

Out of 105 young sex abusers who received residential treatment, 12% were convicted of further sexual offences within 6.5 years, whereas 68% were convicted of other offences.

3 Northern Ireland Research team, *Child Sexual Abuse in Northern Ireland*, Greytstone, Belfast, 1991.

4 Abel, G. et al, “Self-reported Crimes of 561 Non-incarcerated Paraphiliacs”, *Journal of Interpersonal Violence*, 1987, 2 (6), 3-25.

5 Elliot, 1994.

6 Weinrott, 1996.

Therefore, those who receive treatment have very low reoffending rates.

Dr Beckett referred back to a 1943 study of adolescents who had been “shamed” in court. Their reconviction rate was 8-9%.

The general conclusion is that reconviction rates for young sex offenders after treatment do not rise above 12% over six years. But how do we identify this 12%? What characteristics might these recidivist young perpetrators have in common?

A range of “static predictors” (fixed – not subject to change through treatment) already exists for high-risk adult child sexual abusers:

- Previous sexual offences
- Previous non-sexual offences
- Previous non-contact sexual offences
- Male victims
- Extra familial victims
- Cross-over from one group of victims to another (male-female/intra-extra familial/adult-child)
- Separated from family before age of 16
- Never married

All these predictors together bring a 40% risk of recidivism over five years.

“Static variables” pointing towards recidivism in adult sex offenders also include a sexual preference for children; general deviant interests, and previous criminality. However, so little research has been carried out on adolescent sex offenders that it is not known whether these same criteria apply, except in the case of previous criminality, which appears to be an important pointer (Thornton and Travers 1991).⁷

High-risk adult child sexual abusers also share a range of “dynamic predictors”, (susceptible to change via treatment):

- deviant sexual interest
- emotional loneliness
- claiming to relate more easily to children
- high levels of cognitive distortions (distorted thinking), such as believing children can give consent to sex, that children are sexually active, that sex does not harm children
- low self-esteem
- low social skills

⁷ Thornton, D. and Travers, R. *A Longitudinal Study of the Criminal Behaviour of Convicted Sex Offenders*, paper presented at Prison Psychologists Conference, Scarborough, UK, 1991.

Again, we do not know whether adolescent abusers also share these characteristics. Dr Beckett offered a list of psychological tests for adolescent abusers (see annex 1).

Looking at all adolescent delinquents, we find that the majority of them do not develop into adult criminals. They “grow out of it”. In the UK, for instance, about 40% of the population has a criminal conviction, but most of these offences were committed during adolescence. Only 5% of all juvenile delinquents go on to become adult offenders, although these 5% account for 50% of adult crime.

The risk factors for “life course persistent” delinquency are:

- bad conduct during childhood (stealing etc)
- low verbal IQ
- low school attainment/dropping out
- drug/alcohol abuse
- high impulsivity
- thrill seeking
- aggressive/hostile, negative emotionality
- psychopathy

Dr Beckett argued that adolescent sexual offenders should also be assessed for these characteristics, in order to establish “the big picture”. **Prentky and Knight (1993)**⁸ found that sexual abusers who started to offend during adolescence were more likely to have a history of impulsive, anti-social behaviour, and be less socially competent than those who began as adults.

A possible profile of high-risk adolescent child sexual abusers (drawn up on the basis of research carried out on adult sexual offenders):

- previous sexual convictions
- a sexual preference for children
- high levels of distorted thinking (e.g. believing that children enjoy sex)
- major social competency problems – problems with peer relationships
- emotional loneliness
- a history of severe physical abuse. Studies show that severe physical abuse is a major risk factor for child abusers, whereas previous emotional abuse and neglect is more of a risk factor among rapists.

“These are some of the characteristics we think we are going to be finding from our research on adolescents who carry on reabusing children,” argued Dr Beckett.

8 Prentky and Knight (1993)

He also put forward a possible profile of adolescents at high risk of sexual aggression towards people of their own age or adult women:

- psychopathy
- conduct disorders in childhood
- anti-social behaviour, truancy, delinquency, aggression and high impulsivity.
- association with delinquent friends
- drug/alcohol abuse
- history of severe emotional neglect.

He pointed out that a lot of adult rapists have a previous record of other forms of criminality.

Dr Beckett argued that his work suggested these were the bases from which a profile of high-risk young perpetrators could be constructed. “These are some of the issues we have to bear in mind in research over the next five to six years,” he concluded.

Overview of treatment attempts: Developments in Britain during the 90s and the establishment of pan-European research

Dr Hilary Eldridge, Director of the Lucy Faithfull Foundation, UK, and Chair of the Harreveld Group

Dr Hilary Eldridge stressed the crucial importance of work designed to change young sex “offenders” before they embarked on a life of abuse. She set out to outline a) where experts in the UK got things wrong prior to the 1990s; b) where they continued to go wrong in the 1990s; and c) where they are now starting to get things right.

What UK experts did wrong before the 1990s:

- Believed abusers were just “experimenting”;
- Believed their abuse was less severe than that of adults;
- Believed they would all grow out of it;
- Did no work, or else worked with youngsters individually, or on family relationships.

The assumption that all young perpetrators would “grow out of it” was wrong, but not so stupid, since evidence indicates that young people do grow out of other forms of behaviour.

Research now shows that adolescents are responsible for about one third of sex offences; that some 11-19-year-olds perpetrate worse sexual abuse than adults; and that many adult offenders report having developed an interest in deviant sex as adolescents. Therefore, although for some youngsters their activity did not have a serious impact and they did grow out of it, for others, the failure to identify and treat their condition was tantamount to gross neglect.

Case study 1: “George” (not his real name) had abused 14 young people by the age of 18, in the context of a babysitting arrangement. He used very sophisticated manipulative tactics to attract them. When talking about the abuse later, he implied that he was just “playing” with the children, and talked about them as if they were on equal terms as regards power, and ability to consent. Although the children protested about the abuse, they were not taken seriously.

In 1992, the **National Children’s Homes** in the UK carried out a study⁹ of Home Office figures on all sex offenders for 1989. They found that 32% of offenders cautioned or convicted of sex offences were under 21, and 17% under 16. However, a large number of offences were never reported. Denial and minimisation of the significance of adolescent abuse is a huge problem.

During the 1990s, attitudes changed, and work with abusers began to draw extensively on experience in the USA, where children as young as six were described as “mini-perpetrators”.

What UK experts then did wrong:

- Believed none of them were experimenting;
- Believed they were all serious offenders;
- Believed none would grow out of it;
- Put them in multi-age groups;
- Called them sex offenders in the UK and “mini-perps” in the USA.

Information about adolescent female abusers

Another mistake was that of assuming that all offenders were male. In fact, said Dr Eldridge, girls make up a minority of abusers, but we do not yet know the exact proportion. She drew attention to the continuing problem of denial, within society, that women can be abusers.

Dr Eldridge drew on evidence from a number of studies including **Risin and Koss (1987)**¹⁰, **Hunter and Mathews (1997)**¹¹ and **Mathews (1997)**¹².

⁹ *Report of the Committee of Enquiry into Children and Young People who Sexually Abuse Other Children*, NCH Press, London 1992.

¹⁰ Risin and Koss, 1987

¹¹ Hunter and Mathews, 1997

¹² Mathews, 1997

20% of cases arise in babysitting situations. Studies show no difference in the gravity of the offences according to whether the abuser is male or female. Adolescents tend to use more force than adults, and are more likely to abuse alone. Among adults, 60% of abuse is carried out in families.

In conclusion, very little is known about the level of female abuse, especially among young women.

Dr Eldridge then turned to examine what is now being done right.

What UK experts are starting to get right:

- Assessing cases individually;
- Using appropriate assessment measures;
- Using evidence-based intervention programmes;
- Matching length, intensity and programme to the young person's
 - level of risk
 - treatment needs
 - real life!

Assessments

One such means of assessment evolved in 1991, when **Ryan and Lane**¹³ identified “four levels of behaviour” in relationships, focusing on the nature of interactions, and not just the age of the participants:

- | | |
|---------------|--|
| Normal | = no coercion, similar age, fun. |
| Yellow flag | = manipulation, peer pressure used in subtle, non-physical ways. |
| Red flag | = coercion, threats, bribes. |
| No questions! | = physical force, weapons, other direct physical threats. |

Dr Eldridge reminded people, when assessing information, to think in terms of “reoffending” rather than “reconviction”. Convictions for sexual abuse are still notoriously hard to achieve, both among adults and adolescents.

Evidence-based practice

What works: evidence-based practice

- Programmes based on the characteristics that rigorous evaluation and follow-up show to be effective in reducing reoffending;
- Programmes that can be replicated by the use of well-documented manuals;
- Programmes that can be monitored to ensure adherence to the manuals.

In the UK, prison and probation services have joined together to assess what programmes for offenders should be doing and ensure that they are effective in reduc-

¹³ Ryan, G. and Lane, S. *Juvenile Sexual Offending – Causes, Consequences and Corrections*, Lexington MA, Lexington Books, 1991.

ing reoffending. The Prison/Probation Accreditation Panel grants accredited status to programmes that fulfil this requirement. Close monitoring ensures that they are run exactly as the designer intended. This is important, since changes in delivery style and content can drag programmes off course. Improvements are introduced on the basis of detailed evaluation.

Criteria to use when looking at the effectiveness of a programme

Programme accreditation criteria

1. A realistic plan for creating change, supported by research.
2. Selection of participants likely to respond to what the programme offers.
3. Focus on a range of areas of risk that need to and can be reduced.
4. Effective methods, shown by research to work.
5. A skills-oriented approach, focusing on teaching abilities that can be used to construct an abuse-free life.
6. Length, intensity and pattern of intervention designed to maximise effectiveness.
7. A committed approach designed to motivate and encourage a positive response from each individual.
8. Continuity between programmes and services to maximise the impact of treatment.
9. Effective monitoring of all elements surrounding the programme.
10. Ongoing evaluation of the effects, and research designed to formulate improvements.

These programmes must draw on the best of worldwide research and be subject to rigorous evaluation. This is more difficult to apply to schemes involving young people. The accreditation system is not used in the UK for adolescents' programmes, even though it should be.

The UK has now shifted its focus away from the USA and is looking increasingly towards Europe for models of good practice, said Dr Eldridge. The **Harreveld Group** was set up in 1995, in a bid to standardise treatment outcome measures across Europe. It was founded by Dr Hilary Eldridge and Ruud Bullens, from the Ambulant Bureau Jeugdweelzinjnszorg (ABJ) in the Netherlands. Experts from eight countries currently participate, and this is expected to expand, partly as a result of networking at this conference.

The Group aims to identify a raft of psychological tests for young sex abusers, to use these to measure risk, treatment need and outcome, to translate and standardise them across participating countries, and to build up a database of shared information.

At its last meeting, the Harreveld Group set up **ESSAY, the European Society working with Sexually Abusive Youth**. This is a multi-disciplinary, pan-European body, promoting research and treatment to reduce sex abuse by young people, and raising awareness of the issue. Its aims include sharing information, producing a newsletter, running international workshops, and organising training.

Dr Eldridge described these pan-European initiatives as “really exciting”. “If we are to have a good means of evaluating what really works in cases involving abusive youth, this is the way forward,” she concluded.

4. Treatment: Possibilities

Treating young perpetrators in an out-patient setting: Matching the intervention to the young person's risk and treatment needs

Dr Hilary Eldridge

The Lucy Faithfull Foundation in the UK works with adult sex abuse perpetrators, both male and female. Dr Eldridge has been dealing with men for 26 years, and women for 10 years. High-risk male offenders are treated at the residential centre in Wolvercote in Surrey. Women and young abusers are treated non-residentially.

Therapist Alix Brown leads the work with young people aged between 10 and 20, while Robert Tucker also treats children from four upwards who are acting in a sexually aggressive way. Dr Eldridge cautioned that these children should not be classed as “sex offenders” or – as in the USA – as “mini-perps”. The age of criminal responsibility in the UK is 10.

Dr Eldridge described treatment of young abusers in the UK as “terribly, terribly patchy”. For instance, in some areas a boy might be taken straight to court and prosecuted, in others there will be no court appearance. This contrasts with the treatment regime for adult offenders which is “rather good”. Well-run and well-monitored programmes exist in 25 prisons. This system is unparalleled elsewhere in the world: “We have reason to be proud of it,” said Dr Eldridge.

At Wolvercote, offenders are not “locked up”, but are supervised 24 hours a day and need permission to go out. The men are referred by prison or probation services, and tend to be emotionally lonely and poor at relating to others on an intimate level.

“We are teaching them the skills they need to lead an abuse-free life,” explained Dr Eldridge.

Treatment for adolescents is by no means so well organised. Little had changed over the last decade until recently, when:

- the government set up a Youth Justice Board to establish national standards;
- Youth Offending Teams (YOTs) were established at local authority level to formulate local youth justice plans aimed at preventing offending by children and young people.

One of the errors made in the UK and the USA has been to transfer techniques from adult offenders to youngsters – “to try to treat young offenders as if they were little adults”. For instance, young abusers are included in the system whereby sex

offenders are registered with local police. This can be counter-productive. It is important for parents to be able to seek help when they realise something is going wrong, but if they think their child will automatically be registered with the police if they admit to a sexual offence, they are unwilling to encourage the child to own up.

Models of good practice for treatment

1. The Shropshire Model – developed by Alix Brown

- any child can be referred for “sexually inappropriate behaviour” – helping to remove the stigma;
- a preliminary assessment leads to the option of an initial intervention of eight individual sessions;
- options for longer-term individual or family intervention, or short-term focused groupwork.

This model avoids putting youngsters through complicated programmes if they do not need them. “It is wrong to see all youngsters as needing extensive intervention – they do not.”

Preliminary Assessment

1. Visit young person and family and explain what unit offers.
2. Hear young person’s story.
3. Check young person and family’s attitude to the abuse.
4. Identify differences between the victim’s and the abuser’s account.
5. Find out about young abuser’s environment and risk of abusing.
6. Make recommendation.

Assessment key areas include:

- how long has the individual been offending?
- what is the level of congruence between fantasy and reality?
- do the abuser’s beliefs suggest he is interpreting the victim’s behaviour as legitimising the offence?

Initial Intervention

1. Information gathering sessions.
2. Sexual knowledge and experiences and initial account of offending.
3. Exploration of abusive patterns.
4. Identifying abusive attitudes, fantasies, victim awareness, relevant personal issues.

5. Plan for further work/risk management discussed with all those involved.

Longer-term Intervention

1. Acceptance of responsibility.
2. Victim empathy.
3. Fantasy work.
4. Sex and relationship education.
5. Self-confidence and self-esteem.
6. Consequences of offending.
7. Steps to a positive, abuse-free life.
8. Additional personal work.

NB. Involve family, carers, social workers throughout.

Short-term Focused Groupwork

Six weeks for each group

1. Young people are brought together a) when and if they need it; b) when there are sufficient young people who are suited to working together.
2. Areas covered: offending patterns
sex education
victim empathy
planning an abuse-free life.

For groupwork, it may be necessary to link up with adjoining areas if not enough suitable youngsters are found in one locality. It is important not to put people in inappropriate groups, for instance 10-year-olds with 15-year-olds. In this case it is better to work individually, with the support of the family.

Case study 2: “Graham” was the victim of organised abuse by a teacher in a paedophile group. He in turn set up a football team in order to attract children to abuse. His was a “tragic” story, stressed Dr Eldridge, and it was important to empathise with him and his suffering. Through treatment, he started to empathise with himself as a child, and with his victims. At the same time, he had to be treated with care as a very high-risk case. The people who had abused him were experts in convincing him of their view that their activities were just homosexual behaviour, not child abuse. “It is very difficult for a boy to sort that out, to find someone to ask ‘Am I really gay or not?’ because of society’s homophobia,” she argued.

If you do not demonstrate empathy you might as well go home. I am not talking about colluding with the abuser, but being able to identify with their pain – showing the person that you care about them.

Dr Hilary Eldridge

2. The Greater Manchester Adolescent Project (G-MAP) model

This model operates through long-term groupwork following a pre-group assessment of risk and need. The assessment covers non-sexual conduct problems, social functioning, influences on participation in the treatment, sexuality, family, and problems relating to specific offending. Treatment focuses on each aspect of this analysis. Outcomes include evaluation, service refinement and risk management.

Dr Eldridge gave some details of research into the background of high-risk cases. No more than 50% of young abusers were themselves sexually abused. However, in the case of young girls, the vast majority were sexually abused. In general, female offenders tend to have suffered horrific emotional and sexual abuse as children.

A team at **Great Ormond Street Hospital** in London¹⁴ investigated the factors leading boys who had not themselves been abused to sexually abuse others. They studied 86 adolescents between the ages of 11 and 15. They comprised:

- *victims*: boys who had been sexually abused but had not abused others;
- *victimised perpetrators*: boys who were known to have been sexually abused and had sexually abused other children;
- *non-victimised perpetrators*: boys who sexually abused other children but were not known to be victims of sexual abuse;
- *antisocial boys*: comparison group of behaviourally disturbed boys who were neither victims nor perpetrators.

They found the key risk factors for non-victimised perpetrators to be:

1. exposure to a climate of violence in the home;
2. experience of physical violence;
3. discontinuity of care;
4. a feeling of being rejected;
5. the mother having been a victim of sexual abuse.*

* Fathers were rarely in contact with these youngsters, and therefore could not supply information.

3. Multisystemic Therapy (MST)

This focuses on variables commonly associated with young offenders/sexual abusers.

- **Individual**: 50% prior history of non-sexual offences, majority not sexually abused, more internalising symptoms among sex abusers, cognitive distortions related to higher reoffending rates.
- **Family**: no warmth, parental difficulties, violence or substance abuse.

¹⁴ Bentovim, A. *Trauma-organized systems in practice: implications for work with abused and abusing children and young people*, 1996.

- **Peers:** low association, isolation, socially inept, immature, able to groom victims and caregivers.
- **School:** academic and behavioural difficulties, learning disabilities, school suspension or expulsion.

MST Principles

1. Assessment to understand the fit between problems and broader systemic context.
2. Emphasise the positive and use systemic strengths as levers for change.
3. Promote responsibility and discourage irresponsible family behaviours.
4. Present-focused, action-oriented, target specific, well-defined problems.
5. Target sequences of behaviour within or between multiple systems that perpetuate the identified problems.
6. Interventions should suit developmental needs of young person.
7. Requires daily or weekly effort by family members.
8. Efficacy is evaluated continuously from multiple perspectives.
9. Change is maintained by empowering caregivers to address family members' needs.

MST involves daily contact between the therapist and the young person and his/her family. The team is available 24 hours a day, seven days a week. The treatment lasts from four to eight months, and demands immediate, maximum effort from both the family and staff in order to achieve its identified goals.

These goals could be, for example, improving individual problem-solving, building parental competence, changing peer groups; developing collaboration at school, and establishing social support networks.

Studies¹⁵ of violent and chronic juvenile offenders have demonstrated that MST reduces long-term reoffending. A comparison of MST and individual therapy showed a much lower rate of recidivism after MST (12.5% compared with 75%).

Adapting MST for sexual abusers means taking the social environment into account, and delivering the treatment wherever possible via parents or caregivers. Dr Eldridge pointed out that most of the youngsters involved had already been removed from their natural parents and placed in foster homes. It is important to involve foster parents, to equip them to continue the work. Engagement is often easier with foster families than with families of origin where problems such as guilt, parental attitudes, or abuse persist. It is important to work with each member of the family individually, and to identify abusers. Otherwise the work will be ineffective. Adult abusers should be treated with caution even if they appear remorseful.

¹⁵ Borduin, 1995; Henggeler et al, 1992,1993,1997.

Sometimes they may try to “manipulate” therapists and continue to reoffend.

Other aspects to be considered include cognitive distortions, deviant fantasies, and patterns of offending such as grooming tactics – techniques used by the young perpetrator to attract child victims.

Dr Eldridge concluded that MST is attractive because it brings together many different approaches. In treating adult offenders, it is rarely possible to impact on so many levels, whereas with youngsters, the therapist can work with the individual, the family, the school, the community, and have a real opportunity to change future behaviour.

Our objective must be to build an abuse-free life. People need to think there is “something better out there”. The notion of “avoiding” things is deeply unhelpful. People need to think about all the things they can do. A new life means not only not abusing, but not being abused either.

Dr Hilary Eldridge

Questions and discussion

Asked about the role of relapse prevention, Dr Eldridge said she did not like this term since it implied “everything you cannot do”. She wanted to turn it round and focus on the “pluses” of an offence-free life. For this reason, her forthcoming workbook on women offenders is entitled *The New Life Manual*. She agreed that relapse prevention constituted an addiction model, and young abusers should not be portrayed as having an addiction. This merely offers them an excuse.

Some discussion focused on the role of the sexual climate in the family i.e. whether the way sex is dealt with, or sexual shame, can make it difficult for young perpetrators to have sexual relations in an intimate context, and lead them to seek contact “at a distance”. Dr Eldridge said abuse of the mother is a particularly important factor in that women who have been victims find it difficult to handle the developing sexuality of their sons.

In relation to the role of peers, she said children needed help in developing the skills required to be assertive rather than aggressive.

Given the earlier mistakes she described, Dr Eldridge was asked what made her sure that the new techniques were right. “We don’t know,” she replied. “All we can do is the best we can. We still have to be open to a variety of approaches.”

Agreeing on the enormous importance of empathy, Dr Eldridge stressed again that the therapist must not collude in the offence. Abusers have to take responsibility for what they have done, without taking responsibility for what they have suffered. “We are walking along a tightrope, helping them to hold it all together, but we can empathise with a human being who has suffered and is suffering.”

The fortress of denial: Adolescent perpetrators in therapy

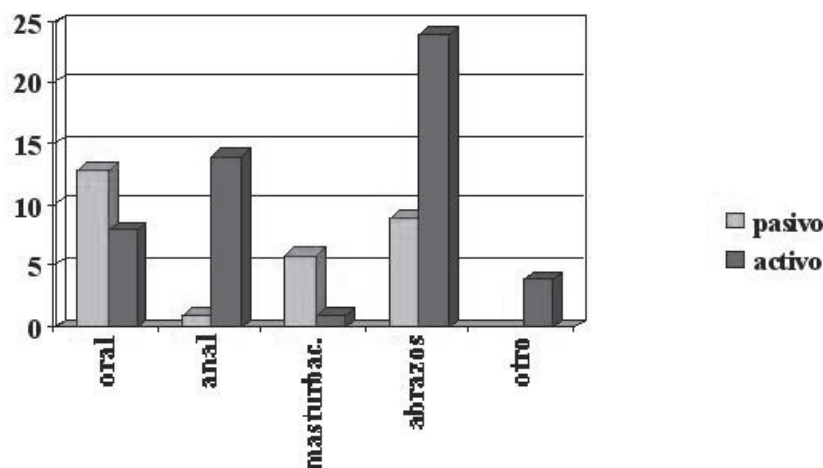
Anders Nyman and Olof Risberg

Nyman and Risberg described the work of the Boys Clinic, set up in Stockholm 10 years ago by Save the Children Sweden to help sexually abused boys.¹⁶

The clinic has treated 55 young sex abusers, (54 boys and one girl). They are referred by social services, police, courts, parents, or child psychiatrists, and many have received no help before. Their ages range from eight to 19 years, the average age being 14. The victims' ages extend from four to 35. Within this, the average age is seven, with one 35-year-old woman accounting for the top end of the age scale. Girls comprised 39 of the victims, and boys 35.

All but three of the 74 victims already knew the abuser, 19 of them being relations, including step-siblings. Four of the victims were mentally retarded.

Figure 2: Type of Abuse



Data on the young abusers show that 16 of them were abused themselves, 18 have criminal records, 23 used violence in connection with the offence, including a higher proportion (15) of those with criminal records. Four of the abusers have a learning disability. With these boys, it is especially important to try to enter their world, by playing and spending a lot of time with them, as well as investigating the environment surrounding the young person.

Looking for patterns among these cases, Risberg said offences by older boys against pre-puberty girls involved more fondling than penetration, suggesting that it was experimental. In contrast, the offences against younger boys involved more pen-

¹⁶ Described in detail in *Boys – Sexual Abuse and Treatment*, Nyman and Svensson, Rädde Barnen, Stockholm, 1995.

etration. Some reported enjoying the offence, while others felt guilty.

Foster homes and institutions seem to be high-risk environments. Swedish research found a high proportion on boys in foster homes were either abused or abusing. Twenty of the 74 victims were associated with foster care. The most tragic cases are those where a boy abuses the foster parents' own children.

Young abusers in general are neglected children. "We work with losers," admitted Risberg. The fact that ideas about treatment are constantly changing and developing makes the challenge even more difficult.

You can do anything, as long as you know what you are doing, or at least you think you know what you are doing.

Professor Tillman Färniss, quoted by Anders Nyman

Anders Nyman gave a series of examples of the sort of offences which brought boys to the clinic. These included:

- five boys, aged 14-17, who took part in the gang rape of a 14-year-old girl;
- a slightly learning-disabled 15-year-old boy who abused a six-year-old boy while babysitting;
- three nine-year-old boys who assault a nine-year-old girl, assisted by two other girls of the same age;
- a six-year-old boy who inserts sticks into the vaginas and anuses of children at a daycare centre;
- a group of eight-year-old boys playing sex games – some compel the others, some are scared, some distressed.

Principles of treatment

"Stop and think" is the most important principle for both therapist and perpetrator. The abuser must develop responsibility and empathy, but can the latter be "taught"? The Canadian researcher and therapist **Bill Marshall** suggested perpetrators do not lack empathy, but just deny it.

Therapy with young abusers is not classical psychotherapy, being more educational. The youngster is sometimes a patient, sometimes a pupil. Each case has different individual causes, psychology, motives, and patterns.

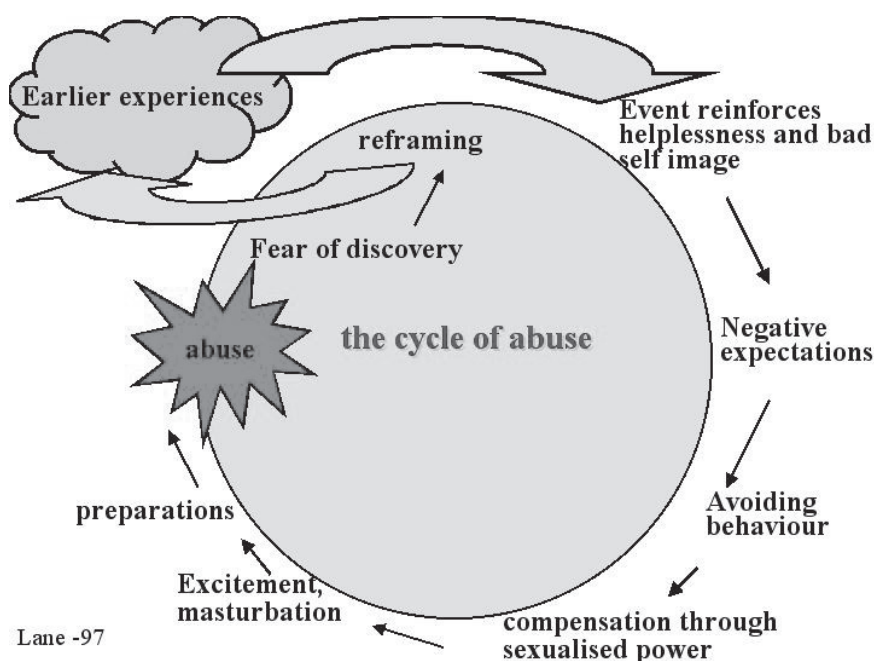
Treatment/psychotherapy/education must lead to change. Since their treatment is mandatory, young abusers seldom recognise the need for change. Therefore understanding and change must be interlinked.

In treatment/psychotherapy/education, the patient's needs and motives interact with the therapist's assessment and decisions. "The relationship is crucial", stressed Nyman.

However the basic assumption underlying the programme is the same as for adult offenders: that the perpetrator follows a personal pattern that can be identified and makes it possible for him to see warning signals and risk situations.

The “cycle of abuse”, starting with early experiences, is drawn from work by Ryan and Lane¹⁷

Figure 3: The Cycle of Abuse



Treatment issues and objectives

Among the issues covered during the treatment are the abuse cycle, cognitive distortions and deviant sexual arousal, victim empathy and awareness, rape prone attitudes and beliefs, sex education, self esteem and self image, relapse prevention and motivation for change.

Sexually abusive behaviour can be caused by traumatic sexualisation, powerlessness, betrayal, stigmatisation, suffering physical violence, witnessing violence in the family, rejection, or bad attachments. The “abuse dynamics” relate to what is going on in the young offender as he undergoes treatment, which helps him to deposit the suffering, reduce the anxiety and reclaim control, sometimes to “destroy” what has caused him harm, to incorporate (becoming, or identifying with the victim) and to move from trauma to triumph.

The objectives for the young perpetrator include describing the abuse in words; taking full responsibility; feeling empathy with the victim; apologising; understanding the cycle of abuse; putting an end to denial or minimising of the offence, to blaming the victim, and to seeking excuses; and deciding “never again”.

¹⁷ Op cit.

Treatment techniques

Treatment takes a wide range of forms, and includes talking, drawing, reading books, watching films, exercises and homework, making genograms and family maps, playing cards, examining the police interrogation of the victim, and sessions of apologising. “We have good experiences of writing, and filling in questionnaires,” added Nyman. The one essential is to find ways to communicate, “otherwise nothing will happen”. He gave one example of a boy who wrote a letter putting himself in the place of his victims:

Dear Nicky,

Why did you do these bad things to us? Didn't you know it would hurt us now and ever on?

He composed his own reply:

It was wrong. It wasn't your fault and I am sorry.

“The relationship is crucial,” Nyman stressed again. The therapist must be gentle and challenging, specific, and assume there is always more to tell. He/she must be prepared to hear anything, but challenge the “fortress of denial” and keep the victim in mind. It is also helpful to share with someone else.

Case study: “James” lived with his grandparents after his parents split up and father died. He worked hard in their store before and after school, taking on grown-up responsibilities. He had no friends, and his grandparents abused him physically. But he was good at repairing motorcycles, and his peers exploited this ability. He was picked up by a man who taught him to hunt, but then sexually abused him, together with two others.

At school he was bullied by the boys, but protected by the girls, who hid him in the toilets. He came to identify the girls' toilets with both security and excitement. Nyman showed examples of the detailed drawings he made of these toilets. James did not know how to masturbate, and expressed all his energies through dreams. When he was taught how to masturbate, this proved a turning point in his treatment.

The Fortress of Denial

Nyman gave examples of different manifestations of the Fortress of Denial. Denial and minimisation are well-documented aspects of the behaviour patterns of adolescent perpetrators.

“I don't remember”. (*Alexitymia or lying*). *Alexitymia* is the name given to an inability to reflect on what is going on inside oneself – not having a language for inner processes. This is more than simple denial. Lying may also be strategic.

“It just happened.” (*denial*)

“I was remote controlled.” (*dissociation*)

“It just happened once. I only fondled her.” (*minimising*)

“She smiled so she liked it,” or “We fell in love.” (*reframing*)

“Being a heterosexual male it's natural to be sexually aroused by a naked girl,” or

“She will not understand nor remember, so she will not be hurt.” (*distorted thinking*)

“She wanted me to do it.” (*blaming*)

“She deserved it.” (*coping/blaming/projection*)

Conclusions

Nyman drew attention to specific factors:

Early losses, betrayals and abuse are important factors. Neglect can lead to the “Hansel and Gretel” syndrome (Förniss 1991) where siblings develop an emotional dependence on one another in lieu of a natural relationship with an adult. In these circumstances, it is therapeutically meaningless to single out an abuser or a victim.

Nyman questioned whether society’s “pornographic rain” – the excess of sexual material available to young people through the media and other sources – might be interfering with their psychosexual development.

A dangerous offender creates himself, he concluded. The way the individual masters the abuse pattern dictates how “dangerous” he will be in future. But Nyman called for more research on risk factors and treatment outcomes, and new materials and methods for assessment and treatment.

Questions and Discussion

Asked what resources society needs to build the strong therapist/patient relationships Nyman talked about, he said it is expensive, but at the same time this preventive work saves money in the long run. Although the treatment might go on for years, this should be set against the cost of some \$500 a day of housing someone in an institution.

This was confirmed by other experts, who said a very good treatment programme could be run for one tenth of the “enormous” cost of keeping a boy in a home. “It’s so important to save society that large amount of money”.

Another questioner pointed out that Marshall stressed the need for both empathy and self-respect. How could these be developed? Nyman said the relationship with the therapist is the key. The young abuser, who has usually never had personal attention from an adult, begins to understand that he is worth the therapist’s time, and that it is possible to live another kind of life, free of humiliation and abuse.

These boys must be told that they have to be more careful about themselves than other children, added Risberg. This is a message of love, and the clinic is a warm and friendly place. It is also important to tell them the consequences of reoffending, and insist, “You are worth something better than prison.”

5. Treatment: Challenges

Adolescent perpetrators: Residential treatment – the Harreveld experience

Margot van Heteren, Director of Harreveld, the Netherlands.

Dr Van Heteren admitted she was quite pessimistic about the outlook for young sex abusers, given the prevailing climate in western society.

In the Netherlands, the Justice Minister laid down that offenders must not be identified. This means therapists “are working in the shadows” and treatment can no longer be community-based. There is also pressure from society for young sex abusers to be “punished”.

Harreveld is the largest residential treatment institution in Europe. It has 271 places in two locations: 80 secure places are reserved for girls, who are placed either for protection or punishment. There are 100 secure places for boys (including 20 sex offenders), 67 open places, and 24 semi-open. Forty young sex abusers are currently being treated – for offences of the most serious nature. Treatment may continue for six years, but not all the boys are high-risk. Harreveld also accommodates boys with problems of violence or addiction, but it offers an environment in which it is quite “normal” to be a sex offender.

Dr Van Heteren stressed the importance of “doing it the European way”. Treatment must be tailored to the local culture, situation and staff in order to be successful. Equally, no one sex offender is like any other.

At Harreveld, 70% of perpetrators have been abused themselves, mostly within the family. Therefore, because of the problem of conflicting loyalties, therapists do not work with families, and a lot of boys decide never to go back.

Dr Van Heteren outlined the different paths followed by adolescent sex offenders. Those on the “delinquent path” commit a range of crimes but are likely to grow out of this behaviour, while the “dead-end path” means they will not offend again. However, those on the “sexual interest pattern path” commit further sexual crimes and develop a paraphilic arousal pattern. These are the high-risk cases. It is important a) to develop ways to evaluate which path the individual will follow after the first offence, and b) to adapt treatment, since similar approaches will not be effective with all three groups.

The first question to be answered is whether a sexual offence has indeed been committed. She drew the distinction between sexual experimenting, and the transgression of sexual boundaries.

Characteristics of sexual experimenting:

- age-appropriate behaviour, normal or seemingly strange, mostly non-verbal, (non)-informed consent;
- behaviour recognisable (empathy);
- sexual motive;
- embarrassment on confrontation;
- psychological equal relationship;
- no harmful (primary) consequences.

In such cases therapy is not necessary, and could cause additional trauma.

Offences which transgress sexual boundaries:

- (objectively) unacceptable behaviour – no informed consent;
- behaviour not recognisable (no empathy);
- motive non-sexual and/or opportunistic;
- psychological denial on confrontation;
- one or more victims;
- aftermath among victims: powerlessness and/or anxiety.

In these cases, therapy is appropriate to confront the behaviour, but not prosecution.

She also distinguished three types of offence:¹⁸

1. **Situational offences:** unacceptable behaviour with one or more victims, coupled with shame or anxiety on discovery, signalling inadequate social skills. These youngsters are “losers”. Therapy offers greater social competence and teaches different forms of control. Relapse is relatively unlikely.
2. **Opportunistic offences:** unacceptable behaviour with many victims as occasions present themselves. Perpetrators show a lack of empathy, excessive pseudo-social skills, and discovery is met by denial. Therapy is more to do with anger management than sexual therapy, and Dr Van Heteren reported a relatively high level of success in treating such cases at Harreveld. “We have warm surroundings, and we do not punish them. The boys like it. We “mother” them better than their own mothers,” she explained.
3. **Premeditated sexual-deviant offences:** high-risk offenders, with a 20% recidivism rate. Offences are carefully planned, usually targeting girls of the same age or younger who are objectified in the abuser’s mind. These are the difficult cases, said Dr Van Heteren, and staff at Harreveld have considered other forms of treatment such as medical invention (anti-depressive drugs) or aversion therapy, for which the subject has to be over 18 and give consent.

The residential treatment comprises three to four phases. After three months to one year in a secure unit, perpetrators spend one year in an open unit before moving

¹⁸ Bruinsma, Frits. *Three Way Typology*, ATSA, Vancouver, 1998.

towards resocialisation. Through group therapy and individual therapy (integrated cognitive behavioural), the programme is designed to progress from external to internal control. Boys may carry cards in their pockets reminding them what situations to avoid.

Control operates at a number of levels:

- **situational control** applies external control, and entails role-play, mastering new social skills, and contingency management.
- **moral control** develops the abuser's moral reasoning, for example through narrative therapy and the therapeutic application of fairy stories. Some boys already have a sense of right and wrong instilled by their parents. Moral control must come from inside, and reflects the individual's idea of how the world should be.
- **cognitive control** means changing attitudes and negative self-talk, cognitive restructuring and developing empathy. Abusers who have suffered social isolation within their family situation do not know how to act towards other people.
- **emotional control** teaches the youngsters to recognise their emotions. Most of the boys do not know the difference between anger and shame, for example. This is done through play, TV "soaps", rational emotive therapy, and anger management. Stress management is used to help young sex abusers cope with going out, and enhanced self-esteem enables them to handle social encounters with the opposite sex. At Harreveld the boys have access to fitness training and sunbeds, new clothes and items like contact lenses, enabling them to look and behave differently and leave not only with a school certificate, but also a new image.
- **bio-physical control** includes relaxation (swimming and diving), creative, dance and psychomotor therapy. Karate is one method used for systematic desensitisation, offering suitable ways of touching. The regime also teaches control of sexual arousal and masturbation training.
- **behavioural control** entails assertiveness training, impulse control and taking responsibility. External control means learning to ask for help when appropriate, while internal self-control and training in alternative behaviour prepares them for life in society. Finally,
- **relational control** teaches communication skills and cognitive and emotional empathy. In the open unit, for example, boys may go to discos with their childcare worker, but will be accompanied to the toilet.

Dr Van Heteren questioned the prevalent view that young sex abusers cannot be "cured", and are likely to reoffend unless external supervision is applied for the rest of their lives. She stressed the many differences between adult sex offenders and abusive adolescents, and said it was crucial to take the nature of the abuse into account in delivering appropriate treatment. "We find that sex offenders can begin to feel greater responsibility and learn to develop empathy," she explained, urging experts in the field to overcome their "basic mistrust" and work to understand the

individual backgrounds leading to deviant behaviour.

She quoted British forensic psychologists **Graeme Richardson** and **Finlay Graham**: “Establishing motivation to address their behaviour and providing them with optimism about gaining mastery over their problem are crucial both to them and to their parents/caregivers.”

Questions and discussion

Participants who had visited Harreveld commented on the warm atmosphere and sense of everyone working together.

Dr Van Heteren said the staff aim to teach by example. Many come from different career backgrounds, such as sport, and there is a mixed ethnic profile. For instance, a disturbed young gang leader from The Hague, who had already been convicted of two murders, was cocky and aggressive when he arrived. But because of the down-to-earth attitude of staff, he soon began to act “naturally”.

Most of the residents with severe behavioural problems have already received treatment before they are admitted. About once a year, Harreveld loses a youngster who is not responding to treatment, and this has a bad impact on both staff and children. But since the only remaining alternative is six week stretches in youth prison, residents have a strong incentive to cooperate.

Spanish experiences in treatment

Victoria Noguerol, Director of the Noguerol Psychology Centre, Madrid, and Coordinator of the Spanish Commission of Post Traumatic Stress and Maltreatment.

Victoria Noguerol said demand for treatment for young sexual aggressors was rising at the centre, as an increasing number of cases came to light. Many had themselves been victims of sexual abuse. She highlighted three cases which were very difficult, but had been resolved quite successfully because the children were able to establish emotional links. This strong attachment enabled them to organise a life free of traumatic experiences.

Case study 1: three children aged four, six and eight all became sexual abusers following physical and emotional violence by their father, who forced them to abuse one another. After the father left, the behaviour continued. A drawing done at the time by the middle child portrayed all the family members as dead.

Therapists dealt with this situation by working in the children’s home everyday, and setting up a system of emotional support which could be maintained by the mother.

Case study 2: a boy of eight started to sexually abuse after being anally and orally raped by his father over a two-year period. The father was a member of a satanic sect, which sanctioned ritual sex with groups of children, and he used hypnosis to

control the boy. Although the father was jailed for 10 years, he managed to continue the abuse during visits.

The boy was resistant to treatment – trapped in a victim-offender cycle. He had been sexually stimulated ever since he was a baby, and his emotional attachment to his father led to cognitive distortions and a lack of empathy for his victims. At one stage he offered to “compromise” by undergoing therapy while at the same time continuing to abuse.

In order to escape from his victimisation, the boy needed to identify with a person with power. In many incestuous families the mother is essentially “absent”, but in this case the mother and her new partner cooperated with the treatment, and the step-father played a key role in forming a strong attachment to the boy, displacing the father’s influence. At moments of stress, the boy’s emotional attachment to the father was revived, and he fantasised about abusing his mother. “In raping, I forgot my own feeling of being a victim”, he said.

The case showed the vital importance of imposing a new masculine role model. Without it, the therapy would not have worked.

Case study 3: a boy of 13 was arrested and sent to a remand home after committing 35 rapes on adult women. At first sight, his family seemed quite conventional and therapists could find no disfunctions to explain his behaviour. However, it turned out that he had been neglected by his parents, who themselves had a difficult relationship. The parents’ main concern regarding the offences was what story they could tell their neighbours. The father never helped his son, but repeatedly told him he was stupid. The boy blamed his father for everything.

He was initiated into pornography and abused outside the home, and turned to rape in a bid to compensate for low self esteem.

He needed someone he could trust, and who would believe in him. This was provided by a member of staff at the home, who fulfilled the “maternal” role he lacked.

In the human condition this problem will always exist. The best way to counter it is to love our children and to teach them how to live properly. A lack of affection creates monsters.

Victoria Noguerol

**Josefa Sánchez Heras, psychologist and criminologist
at the juvenile residence Colonia San Vicente Ferrer, Valencia.**

All the young people Josefa Sánchez Heras works with are in semi-open or closed accommodation. The scheme is now in its second cycle and, on the basis of experience, new features are being introduced.

The young abusers share certain characteristics:

- deficient in social skills, especially when speaking to girls;
- ineffective in resolving personal problems – they do not think of consequences;
- believe in sexual myths and mistaken ideas about children;
- low arousal threshold;
- cannot distinguish their emotions;
- low empathy for victims;
- some have suffered physical abuse, but more often a lack of affection.

The intervention programme consists of evaluation, with families and educators, followed by individual and group therapy, and intervention through the family and the community. The youngsters undergo two one-and-a-half-hour voluntary sessions per week. The approach is behavioural rather than cognitive, as this has been found to work better, and avoids the young abuser thinking he is being “brain-washed”. None of the children has returned to offending.

Group therapy aims at:

- **developing social skills:** although none of the youngsters at the centre is very aggressive, this helps them to escape from the “spiral” of anger.
- **sex education:** they have many gaps in their knowledge, and want information about contraception, sexually transmitted diseases, and other issues.
- **emotional education:** learning to distinguish emotions such as sadness and anger.

Individual therapy focuses on recognising the offence, confronting denial, and teaching strategies to avoid reoffending.

Family work

Some families refuse to take part. Of those who have cooperated, one case involves a father who believes it would have been better if he had not had a child. He is encouraged to spend more time with his child, to enable the boy to identify more with his father rather than his mother. Parents who do not listen to their children are helped to speak directly to them and tell them what they want.

It becomes evident that children sometimes manipulate their parents.

Sánchez Heras said it is important to boost the child’s self-esteem by showing he is cared for. This can be done through little gestures such as remembering birthdays.

Community work is still being developed. One of the aims is to introduce hobbies and activities to take the place of abusive behaviour.

Sánchez Heras said the most urgent needs are for better tools for evaluating young abusers, and improved training for educators, to help them recognise problems.

6. Risk Assessment

Assessing the risks of recidivism

Dr Richard Beckett

There are a lot of questions to think about over the next five years, in assessing risk factors for young sexual abusers, said Dr Beckett.

Cultural issues

The status of children in society: children have little power, and their voice is not heard. In many cultures they are seen as the property of their parents, and not as independent beings with rights of their own.

The sexualisation of children: children have always been sexualised to some extent, and this process starts in early childhood. But they are now also consumers. Many have money of their own, and like to dress well, often to look older than they are. The clothes industry dresses up models of 12 or 13 in provocative designs, and carefully constructed TV adverts suggest that children as young as three or four are interested in sex.

Pornography affects different people in different ways. For a specific sub-group, porn has a special meaning, shaping their values and beliefs. Therefore, for some people, pornography is a risk factor.

The validation of violence and force: modern society's "rape-prone culture" lays too much emphasis on violence in resolving conflicts. Some children are more likely to act in violent ways through watching violent videos. "We live in a culture which gives value to the use of force to obtain your needs, and this applies to sexual violence too," argued Dr Beckett.

Family issues

The presence of a sexual abuser, or physically or emotionally abusive or neglectful parents, means children grow up with problems of attachment.

Non-protective parents fail to guard their children against the sexual interest of others.

Other distorted sexual attitudes and bullying are further risk factors.

Unless we have good measures, we do not know whether what we do changes things.

Dr Richard Beckett

Dr Beckett returned to the dangers inherent in assuming static and dynamic risk factors for adults can be applied to adolescents. For instance, denial is not a predictor of whether adults are likely to reoffend. Paedophiles are quite open about wanting sex with children, but this does not lessen the risk factor. Emotional congruence (identifying with children) is common in adult abusers, but is it a characteristic of adolescent perpetrators?

Problems in assessing risk in adolescent abusers

- Lack of normative data. We do not have a standardised picture of what “ordinary” adolescents are like. We do not know the average level of sexual knowledge of early teenagers. There are enormous practical problems associated with going to schools and asking young people about their sexual feelings and beliefs, and yet this information is needed in order to make comparisons.
- Nature of adolescence. People develop very quickly during this period. In boys, testosterone is increasing by a factor of five. The changes that take place radically affect their size, hair growth, genitals and voice. But not all these things change at the same time in different individuals. We need to be able to distinguish the changes that happen naturally from those that are influenced by treatment.
- Lack of control and comparison groups. We need to be able to compare adolescent sex offenders with other delinquent groups.
- Lack of reliable and valid assessment measures. The areas to be examined should include victim empathy, cognitive distortions, denial, sexual interest and arousal, social skills and rape attitudes. The UK research team has developed good measures to profile and evaluate treatment of adult sex offenders, indicating that treatment produces fewer reconvictions. The team is now focusing on rapists and sexual murderers. Dr Beckett pointed out that some of the worst rapists are “nice young men”. There is nothing about them to indicate that they are rapists. This is why many serial rapists do not get caught. Their underlying attitudes to women only manifest themselves when they are angry or aroused. “We have to dig deep.” For young abusers, measures have been adopted from adult treatment. The crucial question is, insisted Dr Beckett, “Are we measuring the right areas?”
- Low rate of detection and reoffending. The rate of some 12% means only about 120 in every 1,000 young perpetrators reoffend. It is therefore very difficult to study what makes them do so.

Adolescent Sexual Abuser Project (UK)

Aims:

1. to standardise measures – to profile adolescent abusers – how do they differ from “normal” young people?
 - to assess progress through treatment and its impact on reconviction.

2. to assist programmes already assessing/treating adolescent abusers to examine the impact of their work.
3. to establish a framework for a study of recidivism.

Dr Beckett drew attention to the problem of finding sufficiently large numbers (between 100 and 300) of young abusers to make the research reliable. Most treatment programmes only see 20 to 30 people a year. Therefore, the project links 30 treatment centres across the UK and six in Ireland, as well as programmes in other European countries contacted through the Harreveld Group. The team has assessed nearly 300 young people who have abused children. It has interviewed 70 young rapists in prisons.

The project focuses on:

- adolescent abusers (12-18 years) a) who sexually abuse children, and b) peer aggressors and rapists. These two groups show different characteristics;
- non-offending adolescents (three age-groups: 11-13, 14-16, 17+);
- non-violent delinquents;
- violent delinquents;

with a view to determining the characteristics unique to adolescent sexual abusers, and assisting risk prevention by identifying adolescent abusers more likely to carry out violent, as well as sexual offences.

Measures developed from this study should be offence-specific, differentiating between child abusers, characterised by denial and cognitive distortions, and peer aggressors, who show macho and adversarial sexual attitudes. Validity scales should test whether people are telling the truth, and measure “sexual openness”. Many adolescents may be unwilling to talk about sex at all.

Research findings

Dr Beckett presented some statistics drawn from the study.

Age of abusers at onset of abuse: the highest concentration of new abusers was in the 13-14-year-old age group. This could relate to the release of testosterone in the body.

Young people with learning difficulties: this group is over-represented among sex offenders, compared with the population as a whole.

Numbers who have been sexually abused: 26.7% of the young people assessed had been sexually abused. 34.4% had not.

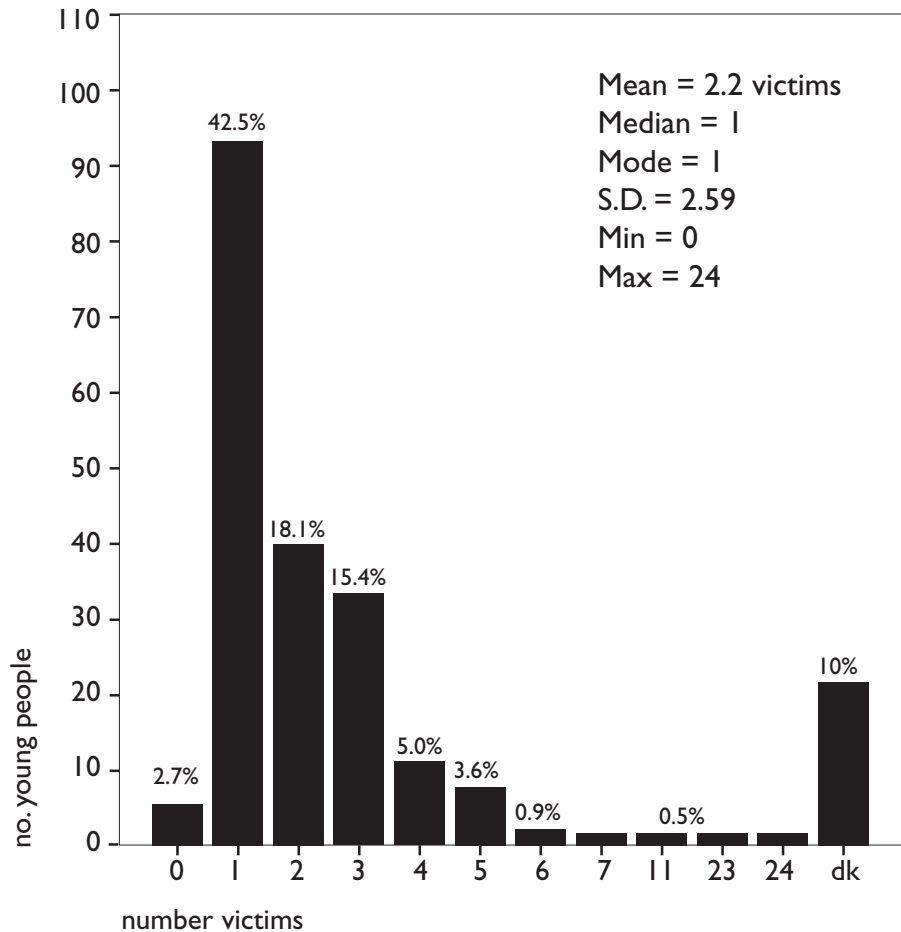
Numbers who have been emotionally abused or neglected: almost 40% of the youngsters had suffered in this way.

Numbers who have been physically abused: 31.2% yes. 37.1% no.

Number of victims: 42.5% of the sample had only one victim. A slightly higher proportion had more than one victim, but the small number with more than five

victims mainly reported non-contact offences such as exposure or obscene phone calls. It cannot automatically be assumed that adolescents with more than one victim are high-risk, as it could be in the case of adults.

Figure 4: Number of victims – how many victims do young people have (n = 221)



Sex of victims: 56.1% of the sample abused only females, 19.9% abused only males, and 19% abused both. In adults, “crossing over” from one sex to another is a high-risk factor. Is this the case also in adolescents?

Two areas for treatment

Cognitive distortions: These are typical in child abusers, who often believe that children are able to consent, that they are sexually sophisticated, interested in sexual contact, and not harmed by it.

The children and sex questionnaire is designed to measure these attitudes. The perpetrator must agree or disagree with statements like “Some children flirt with people of my age,” or “Children know a lot about sex”. The minority with the

highest level of cognitive disorders constitutes the high-risk group. However, a larger proportion showed a level of distorted thinking comparable to the beliefs of samples of “normal” non-offending adult men. It is not possible therefore to assume that they will go on reoffend. Research shows treatment in this area is effective, both among adults and young people, although some men with high levels of distorted thinking can be resistant to treatment.

Increasing victim empathy: Empathy requires an ability to perceive emotions accurately in oneself and others, perspective-taking ability, and a correct emotional-behavioural response to others (sympathy/helpfulness as against indifference/anger). Increasing empathy is an important goal, but it is difficult to measure emotions, and empathy itself can only be assessed after the abuse and not during it. Empathy is blocked during the enactment of abuse.

The victim empathy scale questionnaire asks abusers to think about a specific offence, and then answer questions such as: “Do you think [the victim] enjoyed it/ was sexually aroused/felt fear/was harmed/thought about it afterwards?”

Dr Beckett argued that among all the areas covered by treatment programmes, increasing empathy is the one they most often get right. However, since all sex offenders demonstrate poor empathy, it is not an accurate assessor of risk.

“We can learn a lot from each other, but we need to know what each other is doing well,” he concluded.

7. Treatment: Challenges

“... better than ice-cream”. Sexualised behaviour in young children

Börje Svensson, Clinical social worker and psychotherapist at the Boys' Clinic, Stockholm, and Margaretha Erixon, child psychologist and psychotherapist at Astrid Lindgren Children's Hospital, Stockholm

Börje Svensson pointed to a change occurring in Sweden in recent years. In the early 1990s, there were no referrals of young abusers. But now there is a trend towards younger and younger children “acting out” sexually. Language used between school children is becoming “ruder”, and bullying is expressed in more sexualised ways. Children refer to each other as “whores” or “queers”.

Svensson highlighted the difficulty in assessing these apparent changes, since it is forbidden to carry out research among children under 16 without parental consent. But he drew a possible link between the consumption of pornography and sexualised behaviour. Younger children see more porn than before, and its content has become more dehumanised. Children as young as 11 access porn on the Internet, and 600,000 Swedish homes have pornographic pay-TV channels. Films also portray more violent sex. Newspaper headlines, music and videos contribute to growing sexual self-awareness. All this amounts to a “pornographic rain” dripping on to younger children.

Children are eager to become teenagers as quickly as possible. Adults project notions of sexuality on to them, and they internalise them.

How do children digest what they are exposed to? Studies have found a link between violence in films and acting out among 5-10% of children. It is likely that just as many are influenced by pornography. Adult rapists have been known to imitate scenes from films, and the number of gang rapes has increased in Sweden in recent years.

Svensson concluded that in treating young abusers, it is important to take stock of the whole picture surrounding the individual child.

Case study 1: three seven-year-old boys were abused by an eight-year-old over a period of months. The situation made it hard to distinguish the abuser from the victims.

The three younger children took part in six 90-minute therapy sessions. They comprised:

1. 20 minutes spent around the table, exchanging names, setting rules, and general social talk.

2. 20 minutes of structured play focusing, for example, on boundaries and “good” and “bad” touching.
 3. 20 minutes around the table talking about the play experiences, with biscuits and lemonade.
 4. 15 minutes of free play, which helped to reveal the children’s personalities. Fighting and bad touching was not allowed.
 5. 15 minutes of tidying up and relaxation. The children shouted “never again!”.
- During a final, seventh session, the eight-year-old abuser was admitted. In this way the four children met again and attempted to normalise their lives. Follow-up has shown the children have no ongoing sexual problems.

Margaretha Erixon pointed out that psychosexual development begins in infancy. The capacity for sexual arousal is present at birth or before. Early auto-erotic behaviour is a reflex, with a pleasure-seeking rather than sexual motivation. Research by William Friedrich indicates that pre-school children carry out various forms of sexual activity, of which masturbation is the most common. Up to the age of two, touching arises from curiosity about the body. Thereafter, pleasure is discovered and touching becomes sexual. Children engage in sexual exploration with other children, but this does not mean they understand what they are doing. Small children also use “dirty” words to confuse adults, but this is not sexual behaviour.

Normal psychosexual development in pre-school children includes:

- masturbation
- curiosity/mutual body exploration
- playing doctor
- using dirty words

Erixon raised the question of whether teaching children about sex at an early age leads to premature sexualisation. Children need to have words for things, but if they do not understand what they mean, this places them at risk of experiences which could have adverse effects. Equally, if one imposes too much knowledge at an age when it is not relevant to their experience, children stop listening. Different children show different rates of development.

Erixon pointed to three sources of information:

- studies of children referred for treatment;
- reports from parents and carers;
- retrospective reports from young adults.

Since children have a genuine curiosity and engage in sex play with their own bodies and with other children, it is important to establish the boundary dividing such play from problematic sexual interaction, which may involve:

- coercion;
- threats and compulsion;

- aggression;
- touching in public;
- imitating adult sexuality;
- too much sexual knowledge;
- sexualising with animals or dolls.

Erixon stressed the wide range of factors which may influence such behaviour. **Toni Cavanagh Johnson** of California divided children's sexual activity into four categories:

- Group 1: sex play
- Group 2: sexually-reactive
- Group 3: extensive mutual sexual behaviours
- Group 4: children who molest.

She examined an extensive list of questions with regard to each group, including scope and frequency, motivation, inter-personal relationships, possible etiological factors, and treatment.

In Group 1, children are the same age, and are shy or embarrassed if discovered. The youngsters in Group two are also of around the same age, and may live in the same household, but their activity is often motivated by anxiety or stress, and may be carried out more publicly. It could be provoked by sexual abuse or pornography, and self-understanding is key to successful treatment.

Group 3 children are again of similar ages, and their activity is non-coercive. This category includes sibling incest, and indicates confusion and a need for reassurance and an attachment figure. Discovery can lead to denial or blame. These children tend to be neglected by their parents, and are distrustful of adults. They are prone to victimisation by older people who easily take advantage of their needs. Treatment means learning to substitute emotional contact for sexual contact.

The final group, Group 4, covers children who molest children of different ages, using threats or manipulation. They are preoccupied by sex, and have very limited social skills. Their activity may be motivated by fear, loneliness or anger, and discovery brings an aggressive reaction or denial. They tend to come from families with a long history of abuse, neglect or violence. Intensive treatment is required to help these children, incorporating family therapy and skills training.

Erixon gave some examples of child perpetrators treated in Stockholm:

- a 10-year-old girl who penetrated other girls with her fingers and masturbated boys.
- a six-year-old boy who licked the vagina of an eight-year-old girl, and the penises of several boys, claiming they were "better than ice-cream". He ceased this behaviour as a result of social disapproval.
- a 10-year-old boy who carried out intercourse and anal penetration. He had watched hard-core pornography and was attempting to mimic it. His parents were divorced, and he was angry with his father.

- a 12-year-old boy who put his finger in a three-year-old girl's vagina.

Questions and discussion

A speaker drew attention to the “Stop it Now” campaign in Vermont, USA, which has been publishing easily accessible leaflets about how to talk to children about sex, and to discuss relationships with adolescents.

Börje Svensson said the key issue in treatment is helping children to find their own motivation to change. He also highlighted the question of sex education in schools. In some cases, children are being exposed to sexuality without the opportunity to process this information within their families. They need grown-up help to understand the issue in a healthy way.

8. Summing up – Conclusions

Sweden

Anders Karlsson drew attention to the power of North American influence, and the need to build new European and national models. He would have wished for even more insight into situations in different countries, and more work in small groups. He called for deeper analysis of what “normal” sexuality means, since ideas tend to vary from therapist to therapist. Governments are stepping up their demands for risk assessment procedures, and experts need to discuss what role these should play.

Denmark

Vernon Jones, speaking on behalf of the Danish delegation, believed that bringing together so many European practitioners was a positive step forward and clearly showed that there is a need for further conferences and seminars where research and practice issues can be shared. Many questions remain to be answered, for instance:

- when does sexually abusive behaviour in children and young people become classified as “fixated”;
- assessment and treatment methods: a need for common understanding of “what works”;
- attachment theory – the importance of early childhood trauma.

He highlighted two specific problems in Denmark:

1. In a country which prides itself on its right to freedom of speech, a paedophile association exists openly and is allowed to put forward the paedophile point of view that sex between adults and children is acceptable.
2. Young perpetrators between the ages of 14 and 18 are not receiving effective assessment and treatment services.

Iceland

Bragi Gudbrandsson, General Director of the Government Agency for Child Protection stressed the importance of networking. He highlighted three stages in society’s reaction to child sex abuse:

1. Denial: this existed in Iceland until the UNICEF conference in 1996.
2. Treatment: there are no special programmes for sex abusers in Iceland, which has a population of only 270,000. Some 20-30 adolescents are referred to child protection services each year. Sex offenders are not a homogenous group, and it is

very difficult to set up group therapy because of the small numbers. A solution is needed which will combine not only child protection but also treatment for abusers. “We have been inspired by the Swedish model,” he added.

3. Prevention: Iceland needs to learn from other countries’ experience of registration of offenders and the problems inherent in public notification.

Norway

Speakers from the Norwegian group underlined that different types of offenders should not be confused. In cases involving young perpetrators, therapists are dealing with the offender and the victim at one and the same time. The problem should be approached from a clinical sexological perspective, with a view to creating a positive attitude to sexuality.

Standard support systems are not adequate in these cases. New treatment programmes and more research are required, as well as a Norwegian network of experts, and participation in the European network. The speakers pledged to launch more systematic work in this field and added that the conference had provided new ideas and a new stimulus. Zoë Øiestad, adviser at Redd Barna’s Child Rights Centre in Oslo, said the Norwegian government had financed the group’s participation in the conference, and its members would be looking forward to meeting and reporting back to the Ministries of Family Affairs and Social Services on their return.

Spain

Victoria Noguerol called for more networking, to promote the exchange of research and materials. She suggested that a similar conference might be held every two years. She highlighted three objectives for the future:

- drawing up assessment standards;
- launching public awareness campaigns;
- encouraging all the relevant authorities to work together.

Romania

Dr Violeta-Olivia Stan said she was relieved to discover the problem of denial within society was not confined to Romania. International Children’s Day on 1 June was the focus for a national campaign against child abandonment: a root cause of abuse. The setting up of a small treatment centre – on the Icelandic model – was also being considered. Networking will be crucial – a number of conference participants promised to attend training sessions in Romania, and she urged an exchange of information. As an open society since 1989, Romania could now take a full part in this cultural exchange, and its participation in the debate marked another step towards becoming fully integrated in Europe.

To build a better future for children, we should talk.

Dr Violeta-Olivia Stan

Concluding discussion and remarks

Margot van Heteren pointed out that organised paedophilia has disappeared in the Netherlands. But this is not necessarily a good thing, since paedophiles now operate in secret or on the Internet. Vernon Jones warned against dismissing useful data originating in North America, but called for a separate European culture to be developed. Cultural differences that exist between people living in Chicago and Copenhagen have to be taken into account.

There was a short discussion on the registration of offenders. In the UK, all sex abusers over the age of 10 can be registered. Adult offenders can be imprisoned for six months if they fail to report, but there is no penalty for adolescents. Responsibility lies with the parents, but they are not sanctioned either.

The number of rapes reported by adult women has gone up 300% in 10 years, but the number of convictions has remained stable. registration was introduced largely as a public relations exercise, to make people feel safer, but since the rule is not retrospective, many offenders remain unregistered. It was concluded that registration of adults does no harm – although there is no proof of its effectiveness either – but in the case of adolescents the dangers outweigh the benefits.

In Norway, a new law means that anyone applying to work with children must supply a police declaration that he or she has not been convicted of a sex offence. But since very few convictions are secured (about five each year), it is more significant as an ethical declaration than a protective measure.

Other speakers felt that staff should be trained to understand and not be afraid of healthy sexuality. Sexual abuse is principally related to power rather than sexuality, and can be discouraged by developing a sense of respect for others. However, Dr Van Heteren pointed out that many “normal” sexual fantasies involve power. Therapists must recognise that sex and power are closely related. Dr Eldridge said abusers’ sexual fantasies tend to be bizarre and horrific. In order to empathise with the individual, therapists sometimes have to try to “normalise” them, but should not lose sight of the fact that they may be dealing with sadism and psychopathy.

9. Carrying the Issue Forward

Lars Lööf said the Save the Children Alliance hoped to influence the European Commission and the European Parliament to adopt strategies and recommendations for member states, using the new Amsterdam Treaty Article K.1 relating to offences against children. With this in view, he outlined a number of conclusions drawn from the conference.

1. It is vital to recognise that young perpetrators of child sex abuse are children above all, and have the same rights under the United Nations Convention on the Rights of the Child. Following the principle of non-discrimination, we should always look to the best interest of the child, including the right to rehabilitation, which all government signatories to the UN Convention should provide. Children should also have the right not to be put into adult prisons. The Convention lays down the responsibility of governments to prevent child sex abuse.
2. It is important to develop national programmes for the rehabilitation and reintegration of young abusers, and these should be run in a totally professional manner. But it is equally crucial not to fall into the trap of “over-treatment”, and in small cities or countries to avoid creating unsuitable treatment groups. European and national networking will play an increasingly important role in future work.
3. All countries should recognise the existence of young offenders. The issue should be dealt with in preventive programmes, schools, and at all levels of society, and this will have an impact on public policy-making.
4. Society must re-evaluate its view of childhood. Young offenders who commit serious crimes are sometimes portrayed by society as monsters. Save the Children has an important role to play in countering this dangerous development. They should be viewed as children and young people who have committed sexual offences, not sex offenders who happen to be children.
5. Save the Children must continue to work and consult with experts in the field throughout Europe.
6. Sex education, tailored to the needs of different age groups, must be available for all children in schools.
7. All children, including young sex offenders, have the right to be listened to and to be heard. Societies have an obligation to integrate these young people. We must listen and find out what has happened in these children’s lives.

Psychological tests

Annex I

(compilation for adolescent abusers by Dr Richard Beckett)

Self-esteem (*Thornton*) (*Harter*)

Personal reaction inventory (*social desirability*) (*based on Greenwald and Satow*)

Emotional loneliness (*Russell et al. UCLA*)

Interpersonal reactivity index (*general empathy*) (*Davis*)

Children's assertiveness behaviour scale (*Michelson and Wood*)

Locus of control (*Nowicki*)

Anger control (*Novaco*)

Impulsivity (*Eysenck and Eysenck*)

Children and sex: cognitive distortions; emotional congruence (*Beckett*)

Multiphasic sex inventory (*modified from juvenile MSI*) (*Nichols and Molinder*)

Victim empathy scale (*Beckett and Fisher*)

Treatment of Young Perpetrators of Sexual Abuse Possibilities and Challenges

Annex 2

Madrid, Spain 6- 8 April 2000

Participants

Swedish participants

1. Kersin Völker
2. Inga Tidefors-Andersson
3. Joachim Volckerts
4. Johan Klingborg
5. Anders Karlsson

Norwegian participants

6. Thore Langfeldt
7. Svein Mossige
8. Siri Softestad
9. Jim Aage Nottestad
10. Carin Nordenstam
11. Bard Bugge Pedersen
12. Hans Terland

Icelandic participants

13. Bragi Gudbrandsson
14. Karl Marinósson
15. Dr. Jon Fridrik Sigurdsson
16. Olof Asta Farstveit
17. Torgeir Magnusson

Danish participants

18. Mimi Strange
19. Jorgen Bech Jessen
20. Johny Holm Petersen
21. Susan Harnow Jensen

Romanian participants

Salvati Copiii
(Save the Children Romania)

22. Catalin Luca
23. Dr Violeta-Olivia Stan
24. Georgeta Paunescu

Spanish participants

25. Josefa Sánchez Heras
26. Maria Mar Burbano
27. Amparo Iznájar
28. Roser Perez Simó
29. Félix López
30. Pablo Gotor
31. Victoria Noguerol

Save the Children representatives

32. Burkhard Gnärig
(International Save the Children Alliance. Chief Executive Officer)
33. Purificación Llaquet
(Save the Children Spain. President)
34. Carlos Sanz
(Save the Children Spain. Director-General)
35. Lars Lööf
(Save the Children Sweden)
36. Diana Sutton
(International Save the Children Alliance. European Officer)
37. Ellen Jöjdt Rasmussen
(Save the Children Denmark)
38. Zoë Øiestad
(Save the Children Norway)
39. Sveinbjorg Palsdottir
(Save the Children Iceland)
40. Marianne Borgen
(Save the Children Norway)
41. Anna Frenning
(Save the Children Sweden)
42. Vernon Jones
(Save the Children Denmark)

European Experts

- 43. Hilary Eldridge
- 44. Richard Beckett
- 45. Margot van Heteren
- 46. Anders Nyman
- 47. Börje Svensson
- 48. Margaretha Erixon
- 49. Olof Risberg

Report writer

- 50. Kate Holman

Public Administration Representatives

- 51. Elisabet Svedberg (Sweden)
- 52. Alfonso Marina (Spain)

Seminar Organisation

- 53. Manuel Pozo (Save the Children Spain)
- 54. Elena Hayward (Save the Children Spain)
- 55. Pepa Horno (Save the Children Spain)
- 56. Carmen del Molino (Save the Children Spain)

**Treatment of Young Perpetrators
of Sexual Abuse
Possibilities and Challenges**

Annex 3

Madrid, Spain 6- 8 April 2000

Save the Children Alliance Group

PROGRAMME

THURSDAY 6 APRIL 2000

- 16.00 **Welcome Statement**
Purificación Llaquet, Chairperson, Save the Children Spain
Alfonso Marina, Sub-Director of the Children's Section,
Ministry of Labour and Social Affairs, Spain
- Introduction**
Lars Lööf, Save the Children Sweden
- 16.30 **Setting the Context**
Chair: Diana Sutton
- Young Perpetrators of Sexual Abuse:**
 Overview of Research and Current Knowledge.
 Dr. Richard Beckett
- Overview of Treatment Attempts: Developments in Britain**
 during the 90s and the establishment of pan-European research
 Dr Hilary Eldridge
- Plenary discussion
- 18.00 **Brief Introductions and Discussion:**
 situation in Spain, Sweden, Norway, Denmark, Iceland and Romania

FRIDAY 7 APRIL 2000

- 9.00 **Treatment: Possibilities.**
Chair: Burkhard Gnärig.
- Treating young perpetrators in an outpatient setting: matching
 the intervention to the young person's risk and treatment needs.
 Dr Hilary Eldridge
- Plenary discussion
- 11.00 **The Fortress of Denial: Adolescent Perpetrators in Therapy**
 Anders Nyman, Olof Risberg
- Plenary discussion

- 12.00 Group discussions
- 14.30 **Treatment: Challenges.**
Chair: Purificación Llaquet
- Adolescent Perpetrators: Residential Treatment,
the Harreveld experience**
Margot van Heteren

Questions

- 16.30 Group discussions
- 18.00 **Spanish experiences in treatment.**
Victoria Noguerol and Josefa Sánchez Heras

Questions

- 19.00 Summing up

SATURDAY 8 APRIL 2000

- 10.00 **Risk Assessment.**
Chair: Marianne Borgen
- Assessing the risks of recidivism.**
Dr Richard Beckett

Plenary discussion

- 12.00 Group discussion
- 15.00 **Treatment: challenges.**
Chair: Lars Lööf
- “...better than ice-cream”. Sexualised behaviour in young children.**
Börje Svensson, Margaretha Erixon
- 16.00 Plenary discussion
- 17.00 **Important issues and questions from each country:
Sweden, Denmark, Iceland, Norway, Spain and Romania**
- 18.00 Summing up – Conclusions. How to carry the issue forward
- 19.00 The end