

Working With Adolescents And Children Who Have Committed Sex Offences

Wendy Bunston*

Young people are capable of committing serious sexual offences against their siblings, other young people, and adults. This paper defines adolescent sexual offending, explores assessment and treatment approaches, and examines the role of family therapy. Its aim is to encourage family therapists to acknowledge the existence of sex offending behaviours amongst our young and to become more informed about how to respond therapeutically to this complex issue.

PREAMBLE

'Snowdropping' was a term with which I was not very familiar. I knew it had something to do with stealing women's underwear, but that was about all. It wasn't until some seven years ago I met Andrew, a sixteen year old who had been referred to my place of work, that I realised the full extent of what was involved.

Andrew had been stealing women's underwear for two years. He would put on the underwear and masturbate until ejaculation. It was only when a neighbour discovered him in her backyard that the police intervened and Andrew was cautioned. On two separate occasions Andrew had been found standing in the bedroom of female visitors, staying at his family home, watching them while they were slept. When discovered, he claimed that he must have been sleepwalking.

At that time I had no experience of working with adult sex offenders, let alone adolescent offenders, and proceeded with collecting background information, talking about Andrew's level of motivation to change and exploring his and the family's (he lived with his father and two brothers) perception of the problem. It was during individual sessions that Andrew revealed he not only liked stealing and wearing women's underwear but was also aroused by fantasies that involved raping and killing his victim.

Concerned by Andrew's potential to harm others, I consulted a senior clinician within my organisation for some sense of direction. He cautioned me not to label this young boy, as the diagnosis might become a self-fulfilling prophecy. This failed to quell my anxieties, so I went about exploring the literature. At that time the only accessible information related to adult offenders, and referred to interventions involving chemical treat-

ments, desensitisation, and other techniques of which I had little knowledge. Before I could pursue any further work with Andrew, his father decided to move the family interstate. To this day this case disturbs me, and I often wonder what has happened to Andrew, and what I could have done differently.

Subsequent adolescent clients who presented with worrying sexualised behaviours led me to become interested in the work of the Children's Protection Society in Victoria. The CPS offers a state-wide Sex Offender Treatment Program for adolescents (the only other program is for adolescent males who have been charged with sex offences and operates out of the Melbourne Juvenile Justice Centre), and I have since undertaken some collaborative work with staff from their program, as well as carrying my own clinical caseload. In 1996, I undertook a Masters in Family Therapy program and my thesis focused on the gender identity and gender perceptions of adolescent males who commit sex offences (Bunston, 1998).

It is on this research, as well as on my increased experience of working with adolescents and children who are engaging in sexually abusive behaviours, that this personal and exploratory paper is based. It provides a rudimentary insight into a very complex and to some degree still uncharted area, and explores some of the challenges that it presents to us as professionals in the family therapy field.

INTRODUCTION

Historically, when male adolescents have been involved in sexual offences, many of these cases have been minimised by a 'boys will be boys' attitude and the consequences have been similarly minimised (Ryan, Lane, Davis and Isaac, 1987). As with Andrew, the adolescents concerned have usually received warnings or been given a formal caution by police and little else. The family and community in general have been reluctant to label behaviours committed by a child or young person as a 'sex offence', despite those behaviours being blatantly sexual and criminal.

* Manager and Senior Social Worker, Community Group Program, Mental Health Services For Kids And Youth, 50 Flemington Street, Flemington, Vic 3039. Address for correspondence: 11 Ormond Road, Moonee Ponds Victoria 3039.

Many professionals, myself included, have also been reluctant to confront sexually offending behaviours in young people. We have often minimised the seriousness of their offences, either in a misguided effort to protect our young clients from stigmatisation, or from a fear of dealing with such a confronting issue. 'Outing' sexually abusive behaviours, undertaking thorough assessments, and providing timely treatment will do more towards creating a healthy future for a young person than minimising or normalising potentially dangerous sexual behaviour.

There is no concrete evidence to suggest that every child or young person who commits a sexual offence will re-offend. However, minimising or ignoring behaviours that are clearly abusive will do little to establish either internal or external limits for the child or young person to respond to. Over a number of years of working with children and adolescents who have sexually assaulted other children, and with a smaller number who have assaulted adults, I have found that few have committed only the one offence. On the contrary, most disclose a troubling history of sexual behaviours that have escalated over time, and most, although anxious about what treatment will involve, are relieved that their offending behaviours have been brought into the open and that they can get help to do something about them.

Currently, the predominant treatment model for working with young perpetrators is individual and/or group work. Although an awareness of family issues is encouraged in treatment, family work is still somewhat under-utilised. Establishing how solution-focused and systemic approaches in family therapy can complement current treatment approaches is the next step in developing a more comprehensive service. Whilst a relatively small number of authors have begun to broach the area of sexual violence (Jenkins, 1997; Madanes, Kiem and Smelser, 1995; Gonsiorek, Bera and Le Tourneau 1994), the family therapy field has produced limited published material on the difficult issues involved in working with this particular client group.

The existing literature, however, makes one thing abundantly clear: young people are capable of committing serious sexual offences against their siblings, other children, their own peer group and even adults. More recently, adolescent sexual offending has gained attention because of the increase in literature and research available on adult perpetrators of sexual assault, and an increasing media scrutiny of paedophilic activities. As society overall has come to terms with the existence of child sexual abuse and other forms of sexual violence, the need to construct a profile of the perpetrators of such abuse has been seen as an important dimension in creating preventative programs.

Research from the late 1970s onwards has consistently shown that a significant number (approximately 50%) of adult male sex offenders began committing sex offences in their early adolescence (Gonsiorek et al., 1994; Groth, Longo and McFadin (1982, cited in Scavo and Buchanan, 1989). Those incarcerated for sex offences (91%–95%) are almost always male (Morrison, 1994; Lakey, 1994; Koonin,

1993) and it is estimated that the average adult male sex offender will have committed as many as 380 sexual crimes in his life time (Abel 1984, cited in Perry and Orchard 1992).

A smaller number of studies (Saradjian, 1996; Fehrenbach and Monastersky, 1988), have begun to explore the incidence of sexual offending amongst adult and adolescent females. To date, however, the focus within the literature has been on male perpetrators. Whether this reflects a reality that it is predominantly males who commit sex offences, or reveals a deeply embedded societal reluctance to acknowledge female sex offending, remains to be seen. The lack of research into the area of female offending, however, does have implications for children and adults alike. When it does occur, the victims of that abuse may be in danger of being disbelieved, and consequently experience 'double pain, double shame and double isolation' (Koonin 1993: 2).

The climate of denial surrounding adolescent sexual offending is being challenged, as much by society's acknowledgment that sexual abuse occurs as by the retrospective research indicating that some adults' offending histories began between the ages of eight and eighteen (Groth et al., 1982 cited in Scavo and Buchanan, 1989). Early intervention with adolescents is encouraged as they are seen as less entrenched in deviant arousal patterns, with generally less chronic behaviours than their adult counterparts and consequently, as more receptive to treatment (Perry and Orchard 1992; Scavo and Buchanan 1989).

DEFINITION AND PROFILE OF AN ADOLESCENT SEX OFFENDER

Developing a definition of what constitutes sexually offending behaviour by a young person is an important first step in acknowledging that it exists. Perry and Orchard (1992) define an adolescent who commits sex offences as either a male or a female, aged between twelve and eighteen years, who engages in sexual behaviour deemed by society to be illegal, e.g. rape, exhibitionism. Sexual offences comprise both coercive and non-consensual sexual acts including oral and vaginal penetration (by penis, hand or other objects) or sexual touching and fondling and so called 'hands off offences', such as exhibitionism, voyeurism and obscene telephone calls.

Legally, and developmentally, children are regarded as too young to give consent to any sexual interaction between themselves and an adolescent. If the young offender is more than two years older than their victim, and/or the victim has some significant physical or intellectual impairment, the sexual offence may be considered non-consensual, whether force is involved or not. Within Victoria, a child as young as ten can be charged with a sex offence.

I have not as yet worked with any child under twelve who has been charged with sexual or indecent assault. Rather, it is more frequent for children, and indeed many adolescents, only to be questioned and/or cautioned by police. Children and younger adolescents are generally

interviewed by members of the Community Policing Squad who are experienced in working with children and families, and who are required to notify the Child Protection Unit of the Victorian Department of Human Services if concerns about the safety of other family members or siblings are raised.

On numerous occasions I have been referred cases where sexual offending behaviours have been evident prior to any police or Protective Services involvement. In instances where 'hands on' offences have occurred in a family where the victim/s resides and/or there are younger siblings, I will notify Protective Services myself (always informing the client and parents when and why I will be doing so) and/or encourage the family to do so themselves. I have also encouraged the family to instigate contact with the police. This has important implications for treatment, irrespective of whether charges are laid, and to date the emotional turmoil following such a step, even when the result has been the removal of the child who committed the offences, has resulted in only one client or family dropping out of treatment.

Understanding of adolescents who have committed sex offences has been aided by the descriptive categories proposed by the O'Brien-Bera PHASE (Program for Healthy Adolescent Sexual Expression) typology (Gonsiorek et al., 1994). This can be a useful guide to assist clinicians in defining what ranges from mild to serious offending profiles and patterns, and the development of appropriate treatment responses. The PHASE categories differentiate between seven specific types, and examine behaviours ranging from those that are attributed more to naive experimentation and group influenced assaults, to those that involve more complex presentations. The latter are influenced by difficulties with under- and pseudo-socialisation, disturbed impulsivity, compulsions, and aggression.

Utilising such typologies, consulting with organisations like Victoria's Children's Protection Society (as already mentioned), and trusting my own clinical judgement and experience, have gone some way to addressing my own anxieties about ensuring that I make an appropriate assessment of behaviours that are sexually abusive. So too, has been familiarising myself with the current literature, which in many respects is still in its infancy.

This literature suggests that adolescent offenders are as diverse as their adult counterparts (Knight and Prentky, 1993). Salter (1996), in discussing the profile of adult male offenders, refers to a recent study with a sample of 5,000 which could not produce an absolute picture of how to identify a person who commits sex offences. She suggests that this is a class of offenders that is atypical in the criminal courts. Similarly, adolescents who commit sex offences, in contrast to their non-sexually offending delinquent peers, come from all socioeconomic levels and diverse backgrounds. They do not fit a standardised mould and can range from those who experience a variety of emotional and intellectual difficulties to those who possess a very high level of intelligence.

The studies pertaining to adolescent males paint a picture of high family and/or social instability, poor peer relationships, poor school achievements, isolation,

neurological difficulties and previous history of delinquent criminal activity (Scavo and Buchanan, 1989; Saunders and Awad, 1988; Carpenter, Peed and Eastman, 1995; Knight and Prentky, 1993). However, the conclusions drawn from many of these studies have been retrospective, having been taken from incarcerated adult populations amongst whom the less educated and less wealthy may well be over-represented.

Similarly, the portrait drawn of the families of adolescent sex offenders is not flattering. Young male offenders are often described as having been exposed to domestic violence, having come from highly transient families, having had numerous separations from their parents, and as having parents who have had numerous separations and/or partners (Flanagan and Patterson, 1996; Adams, McClellan, Douglass, McCurry and Storck, 1995; Morrison, 1994; Lakey, 1994; Marshall, Hudson and Hodgkinson, 1993). Substance abuse (Adams et al., 1995; Aljizireh, 1993) also features in this familial profile, with emotional neglect, exposure and subjection to physical violence predominating in family life (Ford and Linney, 1995; Kobayashi, Sales, Becker and Fifueredo, 1995; Morrison, 1994; Awad and Saunders, 1991).

The research to date suggests that a great many adolescent sex offenders present with a history of having been exposed to and/or having been victims themselves of physical and/or sexual abuse (Kobayashi et al., 1995; Briggs et al. 1994; Aljizinah, 1993). Ryan et al. (1987) contend that prior sexual abuse is the most significant factor. They believe that sexual abuse is a learned behaviour which, if left untreated, can trigger a cycle of sexual abuse that entrenches itself in each subsequent act of assault. Various studies have suggested that as many as 60–80% of sex offenders were victimised as children, although a West Australian study (Briggs, Hawkins and Williams, 1994) found all 84 of the perpetrators they interviewed had been victims as children.

I think it is premature at this stage to postulate any single cause, as the sexual offending patterns in adolescent males as well as females are extremely complex, and appear to involve a multiplicity of contributing factors. Disappointingly, what the literature has failed to do, thus far, is to adequately explore the broader sociopolitical and cultural context, as well as the intergenerational experiences of these young people and their families.

In emphasising the problematic nature of some adolescent offenders' family backgrounds, there has been a failure to develop any discussion around families who do not present with any significant or apparently problematic profile, and yet who produce an adolescent who offends sexually. By not addressing or even raising this issue, the literature by implication tends to suggest that some level of pathology resides within the family of all offenders. From my own clinical experience, I have not observed anything unique about these families in comparison with those of other client groups. Nor does this explanation adequately address the exceptions—those young people who have been victims of sexual and/or physical abuse but who do not go on to become perpetrators.

The greatest point of agreement within the literature is that adolescent offenders suffer from significant cognitive distortions, with belief systems that support erroneous thinking around their sexualised behaviours, enabling them to attribute much of the responsibility for their behaviours to the victim (Knight and Prentky, 1993; Perry and Orchard, 1992; Ross and Loss, 1991; Saunders and Awad, 1998). Adolescent sex offenders often suggest that the victim 'asked for it', 'wanted it', or 'did nothing to stop it'. In undertaking work with adolescent offenders it is important to recognise that the thinking of the perpetrator is also reflected in the voice of the victim. That is, the victim often takes on the voice of the perpetrator and blames himself/herself for not stopping it, or takes part of the responsibility for causing it to happen. This becomes a very important area of treatment to address not just for the perpetrator but also for the victim, untangling the feeling of responsibility from the victim and laying it squarely at the feet of the offender.

THE ASSESSMENT AND TREATMENT PROCESS

Groth and Longo (1981, in Saunders and Awad, 1988) outline eight factors to consider when undertaking an assessment of an adolescent who commits sex offences:

1. The age discrepancy between the perpetrator and victim
2. The pre-existing social relationship between perpetrator and victim
3. The nature of the sexual activity
4. The extent of coercion (from persuasion to full force)
5. The persistence of the offences (frequency, compulsiveness of activities)
6. Progression—the development of offences over time
7. Fantasies that occur before, during and after the offence
8. Victims' vulnerability due to some impediment or disadvantage

I have found that one of the biggest challenges in this work is obtaining information about the extent and nature of the abuse, as the offenders are seldom willing to admit the full extent of their offending behaviours to themselves, let alone disclose them to others. I anticipate that the young people will minimise their behaviours, remain devoid of empathy for their victims (Flanagan, 1996; Morrison, 1994; Ryan, 1989), and deny the level of persuasion or coercion used in committing their offence. Morrison argues that a pivotal purpose of assessment is to

evaluate risk and dangerousness, decide who to treat, to predict recidivism and to evaluate treatment efficacy. What the assessment cannot do is distinguish reliably between who is and is not a sex offender, prove the guilt of a non-admitter and reliably predict on the basis of deviant arousal who will re-offend (1994: 14).

An assessment will only be effective, I believe, if you can build a safe, honest and respectful relationship with both the young person and their family. A respectful

relationship entails separating out the sexually offending behaviours from who the adolescent is as a person, and creating a 'holding' environment for the family (particularly in cases of sibling abuse) whilst they endeavour to do the same. It is not about adopting a punitive stance toward the client, it is about offering hope for change. These are behaviours that can be addressed, and the family and the young person need to know that you will stick by them throughout this difficult process.

Had I been referred Andrew now, I would openly voice my concerns and presume that there may have been other worrying sexual activities which he had engaged in and never told anybody about. I would also perhaps state (as I often do with adolescents who have sexually assaulted younger children) that offenders of sexual crimes can be charged, even years after the event, if victims come forward to report the crime. It is in the interest of young offenders to deal with sexual assaults they have committed through the juvenile courts rather than being charged years later and dealt with through the adult criminal system.

I would also emphasise to Andrew that I could only offer him limited confidentiality, and that any disclosures of additional indecent sexual acts or assaults that he told me about would be reported to the police and dealt with now, both legally and therapeutically. This way, he could get on with addressing his sex offending behaviours and proceed with creating an alternative future to the one that is currently requiring him to live a secret life and that is perhaps leaving him feeling quite isolated.

As the major focus of treatment is to prevent the young person from re-offending, therapy needs to focus on breaking through the adolescent sex offenders' denial (in Andrew's case his claim to be sleepwalking), to process their motivation for offending, and to recognise the signals and triggers that lead to re-offending. Ultimately young offenders need to confront and take responsibility for their own behaviour.

Targeting violent, age-inappropriate, non-consensual sexual fantasies (as opposed to eradicating sexual fantasies altogether) is an important part of treatment. So too is addressing the thinking patterns and attitudes underpinning such fantasies. Counter to traditional insight-orientated client-led therapeutic methods, this requires integrating a more direct and challenging educational and cognitive approach. A style which is both direct and challenging is not one devoid of sensitivity and respect, but is enhanced by an awareness of psychodynamic and family sensitive practice principles.

A critical part of treatment is investigating the clients' ability to assess their feelings of empathy for their victims and remorse for their behaviour. This sometimes can only occur when they have accessed their own experiences of feeling victimised and hurt. This does not provide them with an excuse, but offers a chance perhaps to return any internalisation of an abuse they experienced to the person who may have abused them. Offender need to face responsibility for the impact their abuse has had on their victim/s and to understand that the voice of the victim is privileged within the treatment process.

It has been interesting to explore with staff of the Children's Protection Society Adolescent Sex Offender Treatment Program the treatment issues involved when the young person is both an offender and a victim. When they began this work some years ago they held the philosophy that 'You must deal with their offending behaviours before you can address the offenders' own victim issues'. They have since discovered that it is more useful to deal with the issue most current. That is, if an offender has current victim issues or is still a victim of abuse, it may be important to address those issues, in order for the young people to shift to a space where they can effectively deal with their own offending behaviours.

Group work is recognised as one of the most effective forms of treatment for adolescent offenders, as peer pressure often operates to ensure a greater degree of disclosure and confrontation amongst the participants. Knopp states that group work is most widely used as the 'value of group treatment is that offenders best understand how other offenders think, respond, what they fear and why they lie' (1985, cited in Saunders and Awad, 1988: 61).

My experience has been limited to all-male groups, and what has struck me is how much the group functions as both a safe space where participants can honestly disclose their individual struggles, and as a powerful reality check for each member. In particular, the boys who have been in the group for a longer period are able to challenge the newer members directly and this process appears often to achieve a swifter level of accountability and disclosure than would occur within individual treatment sessions. Individual work is, however, at times preferable for particular clients and may better suit their needs. In reality, it is also sometimes the only available treatment option, as too few group work treatment programs have been government funded within Victoria, and I suspect within the rest of Australia.

Individual and group work treatment usually have specific goals. These goals often include positive sexuality training and education, taking responsibility for thinking, feelings and behaviour that lead to offending, anger management, and understanding the sexual assault cycle. The intention is to assist young offenders to recognise and articulate their own offending cycle, their fantasies, how they specifically target and groom their victim, and what are the danger signals/triggers specific to them. This process explores the behaviours that belong to offending, and those behaviours that bring about a sense of control or power in their lives through appropriate means. The process explores as well how they now feel about the offence (Ryan, 1989).

The process of facilitating change in treatment involves the following: *word change* shows that the young people have altered the language they use to talk about themselves, their victims and others; *thinking change* is reflected in the way in which they challenge and interact with others; and *feeling change*, the most difficult to achieve, is demonstrated by empathy for their victims and exhibiting truly remorseful feelings for their actions. These changes lead to a *belief change* which ultimately aims to result in behaviour change and a non offending lifestyle. It has

been my experience that the younger the offender, the more important the role of the family and/or system in assisting this change process. Creating externally appropriate boundaries and rules for the child offers a developmentally more accessible path for them to internalise change.

Group and/or individual treatment cannot act in isolation from the rest of the young person's support system. Clear communication and collaboration with other professionals and key players, especially the therapist of the victim/s, is critical to developing and delivering a thorough, accountable and sensitive therapeutic response. Parents and/or carers need to be involved in feedback sessions in which the offender is present, and have access to their own supports. It is here that family therapists can significantly contribute to the overall treatment plan.

RESPONDING AS A FAMILY THERAPIST

Goldner (1992) and Jenkins (1997) are two therapists who have developed treatment models that grapple with the complexities of working with perpetrators of abuse. They clearly place accountability for the abuse with the perpetrators, whilst advocating a move away from the mad/bad dichotomy. Jenkins separates the behaviour from the person, identifies abusive behaviour as a chosen behaviour, and engages the young person around accepting invitations to responsibility. This is a Narrative approach that understands violence and abuse as a culturally constructed behaviour and highlights alternative ideas and practices.

Goldner advocates a stance that

embodies an intellectual, political and psychological ideal: the attempt to recognise the value of competing and contradictory perspectives and to tolerate the psychological experience of extreme ambivalence without splitting ideas and people into good and bad (1982: 57).

I find managing this ambivalence a particular challenge when working with sibling incest, as the victim often expresses a desire to maintain contact with the offender. The victim often has a significant attachment to that person and finds it difficult to comprehend that there will be limited or even no contact in the immediate future—the victim just wants the sexual abuse to stop.

Similarly parents are often caught in the bind of wanting to support both the offender and the victim. Making decisions about removing the perpetrator from the family home can be gut wrenching but may also give parents a sense of relief. They are likely to struggle with guilt, even while they can breathe easier about the safety of their other children; feel anxiety about the welfare of the child removed from home; experience anger and betrayal over what has occurred; and blame themselves for failing to stop it from happening. The families with which I have worked have not, in all instances, had the offender removed from home. When the offences involve incest and/or there are children in the home who are around the same age or younger than the offender's victims, however, this is usually the safest option.

The consideration of re-contact and possible reunion needs to be a gradual, planned process, keeping the victim's needs uppermost, setting clear rules and expectations about appropriate conduct within the home, and ensuring that the offender does not have unsupervised access to the victim and/or other children of a similar or younger age. O'Connell, Leberg and Donaldson (1996), in their work with adult incest offenders and their families, emphasised the importance of protecting the victim from being re-victimised by premature contact with the offender, or from assuming guilt and responsibility for family turmoil as a result of reporting their abuse. They contend that adult offenders, through the course of their treatment, need to have taken responsibility for their offending behaviour before resuming contact with the victim or reinvolving themselves in family life.

The complexity of the family's emotional responses to a member committing sexual abuse should not be underestimated, particularly when the offenders themselves are still only children. I have needed to support different individual family and extended family members at different times, to arrange concurrent individual work for the victim—whether a sibling, a family friend or a neighbour—thus linking them into the counselling. I have also found it critical to provide space for couple and parent work to occur as within the couple system different dynamics emerge, particularly in cases where it is a step-family and the attachment with the offender and/or victim may vary considerably.

Family therapy can provide a safe holding place to support other family members, the victim, and (if and when appropriate) the offender. As the offender moves through treatment, the family needs to be kept aware of progress and opportunities need to be made for different family sessions involving different members at different stages in order to negotiate the arduous and usually lengthy journey of treatment. This needs to operate against a backdrop of consulting with individual and/or group work therapists (those of the victim and offender) and other professionals involved in the case.

Intergenerational abuse adds another layer of complexity, as the young person's offending may be part of a larger systemic undercurrent that will prove difficult to access. Ross and Loss (1991) claim that 'high risk parents' will either remove themselves from, or sabotage, the assessment and therapeutic process. Refusal to believe that the abuse occurred, blaming the victim, or apathy may prevail, along with longstanding patterns of abuse, neglect and/or destructive interactions within the family.

I think the best treatment mix is one that is family sensitive but offender-focused (Le Tourneau et al., 1994; Thomas, 1991). In Andrew's instance this would have meant actively involving his father in the treatment process right from the very beginning. It would have meant providing Andrew and all family members with regular information, feedback and family sessions, in tandem with Andrew's own individual work and or participation in a group work program if one had been available. Engaging the whole system might have provided an

opportunity for his family, in particular his father, to commit to a treatment plan that would hopefully have resulted in some therapeutic resolution of Andrew's issues, rather than what I suspect occurred—that Andrew's difficulties were simply moved to a new location.

The dynamics that operate within the young person's family or immediate system (such as institutionalised care) form an integral component of assessment and treatment both in recognising what patterns may reinforce or maintain certain attitudes and behaviours, and in providing a background to understanding each young person's own unique context. Family or systems work should also be seen as one of a range of different interventions and skills necessary to ensuring an effective treatment plan.

CONCLUSION

As therapists, we need to recognise that sex offending does occur amongst our young. We need to challenge and to work with that behaviour, and not be intimidated by the complexities that this issue presents to us as individual professionals and to the family therapy profession as a whole. We need to work alongside other professionals and systems undertaking this important work and to model practices that are open, collaborative and accountable.

I have struggled to find my confidence in undertaking this work and to completely trust my own assessment of sexual offending behaviours, as well as my ability to adequately participate in the treatment of these behaviours. Undoubtedly this is very complex and draining work. With the limitations in the literature already highlighted, to some extent I have jumped in headfirst, drawing on my existing skills and knowledge, guided by the old adage 'Do no harm'. This has meant keeping the needs and safety of the victim paramount whilst not ignoring the needs of other family members. It also requires building supportive networks for myself as a therapist, consulting with others undertaking this type of clinical work and being prepared to hang in there with clients for the long haul.

I constantly question the effectiveness of what I am doing with young offenders and their families and if it is effective, I challenge myself with the further questions: 'What happens if as a therapist I receive some hint of sexual offending between siblings, and I ignore it?' 'What happens if I have some knowledge, as I did with Andrew, that there is something perilously wrong with the young person with whom I am working, and I do nothing about it?' In the final analysis, leaving possible sex offending behaviours untreated in the young people with whom I work is simply not a risk that I am prepared to take.

Acknowledgments

Many thanks to Karen Flanagan, Jeannie McIntyre and the marvellous staff working within the Adolescent Sex Offender Treatment Program, Children's Protection Society, Heidelberg, Victoria. And Ruth Rechner, for your constant feedback and support.

References

- Adams, J., McClellan, Douglass D., McCurry, C. and Storck, M., 1995. Sexually Inappropriate Behaviours in Seriously Mentally Ill Children and Adolescents, *Child Abuse and Neglect*, 119, 5: 555-568.

- Alijzireh, L., 1993. Historical, Environmental, and Behavioural Correlates of Sexual Offending by Male Adolescents: A Critical Review, *Behavioural Sciences and the Law*, 11: 323–440.
- Awad, G. A. and Saunders, E. B., 1991. Male Adolescent Sexual Assaulters, *Journal of Interpersonal Violence*, 6, 4: 446–460.
- Bischof, G. P., Stith, S. M. and Whitney, M. L., 1995. Family Environments of Adolescent Sex Offenders and Other Juvenile Delinquents, *Adolescence*, 30, 117: 157–70.
- Briggs, F., Hawkins, R. and Williams, M., 1994. *A Comparison of the Early Childhood and Family Experiences of Incarcerated, Convicted Male Child Molesters and Men who were Sexually Abused and have no Convictions for Sexual Offences against Children*, Magill, University of South Australia, Magill Campus, South Australia.
- Bunston, W., 1998. Gender Identity and Gender Perceptions of Adolescent Males Who have Committed Sex Offences, Bundoora, LaTrobe University, Victoria (unpublished thesis).
- Carpenter, D. R., Peed, S. F. and Eastman, B., 1995. Personality Characteristics of Adolescent Sexual Offenders: A Pilot Study, *Sexual Abuse: A Journal of Research and Treatment*, 7, 3: 195–203.
- Fehrenbach, P. A. and Monastersky, C., 1988. Characteristics of Female Adolescent Sexual Offenders, *American Journal of Orthopsychiatry*, 58, 1: 148–151.
- Flanagan, K., 1996. Reflections on Working with Male Adolescent Sex Offenders, *Psychotherapy in Australia*, 2, 2: 45–49.
- Flanagan, K. and Patterson, J., 1996. Working with Sibling Incest: Maintaining the Balance, *Children Australia*, 21, 2: 12–16.
- Ford, M. E. and Linney, J. A., 1995. Comparative Analysis of Juvenile Sexual Offenders, Violent Nonsexual Offenders, and Status Offenders, *Journal of Interpersonal Violence*, 10, 1: 56–70.
- Goldner, V., 1992. Making Room for Both/And, *The Family Therapy Networker*, March/April: 55–61.
- Gonsiorek, J. C., Bera, W. H. and Le Tourneau, D., 1994. *Male Sexual Abuse*, Newbury Park, CA, Sage.
- Jenkins, A., 1997. Invitations to Responsibility—Therapeutic Engagement of Adolescent Boys Who have Enacted Violent and Abusive Behaviour and A Family Context for Intervention with Adolescents who have Abused: From Engagement to Restitution and Reconciliation, Seminar Handouts, Melbourne.
- Knight, R. A. and Prentky, R. A. (1993) Exploring Characteristics for Classifying Juvenile Sex Offenders. In H. Barbaree, W. Marshall and S. Hudson (Eds), *The Juvenile Offender*, NY, Guilford.
- Koonin, R., 1993. Breaking the Last Taboo: Sexual Abuse by Women. Paper presented to the Fourth Australasian Conference on Child Abuse and Neglect, *Rights and Responsibilities: Wrongs and Remedies*, Brisbane, 11–15 July.
- Kobayashi, J., Sales, B. D., Becker, J. V., Fifueredo, A. J. and Kaplan, M. S., 1995. Perceived Parental Deviance, Parent–Child Bonding, Child Abuse, and Child Sexual Aggression, *Sexual Abuse: A Journal of Research and Treatment*, 7, 1: 25–44.
- Lakey, J. F., 1994. The Profile and Treatment for Male Adolescent Sex Offenders. A Model for Residential Treatment, *Residential Treatment for Children and Youth*, 7, 2: 59–75.
- Madanes, C., Keim, J. P. and Smelser, D., 1995. *The Violence of Men*, San Francisco, Jossey-Bass.
- Marshall, W. L. and Hudson, S. M. and Hodgkinson, S., 1993. The Importance of Attachment Bonds in the Development of Juvenile Sex Offending. In H. Barbaree, W. Marshall and S. Hudson (Eds), *The Juvenile Offender*, NY, Guilford Press.
- Morrison, T., 1994. *Male Juvenile Sex Offenders: An Information Pack*, Rochdale, UK.
- O’Connell, M., Leberg, E. and Donaldson, C., 1996. *Working with Sex Offenders*, London, Sage.
- Perry, G. P. and Orchard, J., 1992. *Assessment and Treatment of Adolescent Sex Offenders*, Professional Resource Press, Australia.
- Ross, J. and Loss, P., 1991. Assessment of the Juvenile Sex Offender. In G. Ryan and S. Lane (Eds), *Juvenile Sex Offending*, Lexington.
- Ryan, G., 1989. Victim to Victimiser, *Journal of Interpersonal Violence*, 4, 1: 325–340.
- Ryan, G., Lane, S., Davis, J. and Isaac, C., 1987. Juvenile Sex Offenders: Development and Correction, *Child Abuse and Neglect*, 11, 3: 385–395.
- Salter, H., 1996. Working with Sex Offenders and Victims of Child Sexual Abuse [interview], *Psychotherapy in Australia*, 2, 2: 50–53.
- Saradjian, J., 1996. *Women Who Sexually Abuse Children*, London, Wiley.
- Saunders, E. B. and Awad, G., 1988. Assessment, Management and Treatment Planning for Male Adolescent Sexual Offenders, *American Journal of Orthopsychiatry*, 58, 4: 571–579.
- Saunders, E. B. and Awad, G. A. and White, G., 1986. Male Adolescent Sex Offenders: The Offender and the Office, *Canadian Journal of Psychiatry*, 31, 6: 542–549.
- Scavo, R. and Buchanan, B. D., 1989. Group Therapy for Male Adolescent Sex Offenders: A Model for Residential Treatment, *Residential Treatment for Children and Youth*, 7, 2: 9–75.
- Thomas, J., 1991. The Adolescent Sex Offender’s Family in Treatment. In G. Ryan and S. Lane (Eds), *Juvenile Sex Offending*, Lexington Books, USA.

In *The Firmament of Time* (London, Gollancz, 1961: 134) Loren Eisley asks:

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