PERCEPTION ON THE USE OF COGNITIVE BEHAVIORAL THERAPY IN TREATING ADOLESCENT SEXUAL OFFENDING

Neng Her
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PERCEPTION ON THE USE OF COGNITIVE BEHAVIORAL THERAPY IN TREATING ADOLESCENT SEXUAL OFFENDING

A Project

by

Neng Her

Approved by:

__________________________________, Committee Chair
Serge Lee, Ph.D.

____________________________
Date
Student:  Neng Her

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__________________________, Graduate Coordinator

Teiahsha Bankhead, Ph.D., L.C.S.W.  

Date

Divison of Social Work
Abstract

of

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Sexual offending is a serious problem among male adolescent sex offenders. Through literature review regarding adolescent sex offenders, it was found that there are common behavioral problems among male adolescent sex offenders. The purpose of this study is to examine the perceptions treatment providers have regarding the use of cognitive behavioral therapy to treat behavioral problems of male adolescent sex offenders. The participants for the study are professionally trained experts, from the Children’s Home of Stockton and California State University of Sacramento, who have worked more than one year with male adolescent sex offenders. Findings from the study concluded that participants perceived cognitive behavioral therapy to be an effective method in addressing various behavioral issues of male adolescent sex offenders.

____________________, Committee Chair
Serge Lee, Ph.D.

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Date
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Chapter 1

PROBLEM STATEMENT

Introduction

In today’s society, sex offending is a serious crime among male adolescents. It is estimated that each year adolescents (ages 13 to 17) account for one-fifth of all rapes and one-half of all cases of child molestation (Lakey, 1994). Lakey added that a male adolescent sex offender is a youth, under the age of 18, who sexually engages with a person against their will, without consent, or in an aggressive, exploitive, or threatening manner.

Although there is no single profile that can properly describes all male adolescent sex offenders, there are certain commonalities about male adolescent sex offenders. The youth sex offender population is about 91 to 93 percent male (Ryan & Lane, 1997). The common age of a male adolescent sex offender is about fourteen years old (Ryan & Lane, 1997). Ryan and Lane (1997) stated that there is one in three chances that prior to their first sexual offense arrest; many of these youths have been convicted of nonsexual delinquent crimes [such as theft, drug dealing, gang affiliations, etc.]

Many male adolescent sex offenders are also known to have a history of abuse in their childhood background. Majority of the youth sex offenders are victims of physical abuse, domestic violence or having been exposed to inappropriate sexualized environments. Becker and Murphy (1998) reported that male adolescent sex offenders have a higher rate of having sexual abuse in their histories than expected in the general population of adolescents. Ryan and Lane (1997) also reported that 30 percent of sex
offenders have a history of being sexually abused by someone known to the adolescent or is a member of the adolescent’s family.

*Background of the Problem*

Over the years, there is an increasing number of youth entering the juvenile justice system for committing sexual offenses. There are roughly 250,000 and 300,000 cases of child sexual abuse each year in the United States (NRCCSA, 1994). According to the Uniform Crime Report (2002), since 1980, juvenile sexual crimes have steadily increase at a rate of 7.6 percent each year.

As the rate of juvenile sex offending increases, many youth sex offenders are being referred to treatment programs to receive help, rather than receiving punitive measures to correct sexual deviancy. Present research shows that adolescent sex offenders who complete sex offender treatment programs have a lower chance of sexual reoffending, in comparison to the adolescent sex offenders who does not undergo the treatment programs.

In 1982, it was estimated that there were only 20 sex offender treatment programs nationally; however, by 2000, the number of sex offender treatment programs in the United States have increased to over 750 (Hunter & Figueredo, 2000). Among these treatment programs, Hunter and Figueredo (2000) believed that the majority of them use cognitive behavioral therapy to treat adolescent sexual deviant behaviors.

Researchers (Goisman, 1997; Ryan & Lane, 1997; Marshall, Anderson & Fernandez, 1999) suggested that comprehensive cognitive-behavioral approaches may yield significant decreases in deviant acting-out behaviors. According to Goisman,
cognitive behavioral therapy is a treatment method that is based on cognitive and behavioral principles, such as, classical condition (where existing patterns of stimulus and responses pair with new stimuli to create new responses), patterning reward and punishment (to alter behavior), and social learning (which includes learning by observation, role playing, rehearsal, and practicing appropriate problem-solving skills).

**Purpose of the Study**

As mentioned earlier, cognitive behavioral therapy is a popular set of treatment methods that is used in many of the sex offender programs to address deviant behaviors of male adolescent sex offenders (Hunter & Figueredo, 2000). The writer felt that a study needed to be completed in order to better understand how cognitive behavioral therapy can help address behavioral problems of male adolescent sexual offenders.

Secondly, the writer hoped that in writing this Master’s project, it would allow social work clinicians, those who work directly with male adolescent sexual offenders, an opportunity to express if Cognitive Behavioral Therapy is effective or ineffective in treating behavioral problems in male adolescent sex offenders. Since social work clinicians are professionally trained and have first hand experience of working with male adolescent sexual offenders, the writer felt that they could better analyze and identify if there are other treatments that would best work with behavioral problems (low self-esteem, empathy deficit, poor social skills, cognitive distortions, denial and minimization) of male adolescent sex offenders.

Lastly, due to the seriousness of the crime and its victim population, some professionals may not want to or find it difficult to work with the adolescent sex offender
population. The writer hoped that in writing this thesis project, it will help educate professionals to better understand juvenile sex offending from a helping perspective and behavioral standpoint, rather than the harmful label that extends into the criminal justice system.

*Theoretical Framework*

According to Ryan and Lane (1997), the cognitive theory can be used to better understand the etiology of adolescent sexual deviancy. The cognitive theory explains on the idea that individuals are capable of having cognitive distortions or “thinking errors” in their thought process that affect to their ability to overcome abusive behavior. Ryan and Lane explained that cognitive distortions are partly related to the earliest developmental stages where infants first form their worldview and accommodated their first experience of life. Many juvenile sex offenders often have a background of growing up in an abused or neglected environment, which can traumatize individuals and cause them to develop thinking errors in their thought process. Thus, these thinking errors could often lead the adolescent to process false information about their sexual offense or any deviant acts, such as, “I won’t get caught” or “She deserved it because she was mean to me.”

According to Ryan and Lane (1997), in treatment, clinicians could use the cognitive theory to help adolescent sex offenders to work on cognitive restructuring. Cognitive restructuring is based on changing the person's thinking in order to change his/her worldview and behaviors. In addition, in order to do so, individuals must first confront their basic belief systems, so they could better recognize how their beliefs
systems affect their behaviors. Adolescents, especially, often will forget that their belief systems played an essential role in how they behave, interact, respond and interpret life experiences.

The Social Learning (Ryan & Lane, 1997) perspective can also help professionals to better understand more how adolescent offenders can learn deviant behaviors from their family or life experiences. Ryan and Lane explained that often when adolescent experienced sexualized behaviors that were encouraged by caregivers, where it was used as a form of punishment or exploited by a perpetrator, it can cause a child’s perception to be confused; such as, labeling the behavior, in the youth’s growing awareness, as cultural norm and at some point act out in deviant behaviors.

Although it does not necessarily mean that abused children will become sex offender in the future, there appears to be a link between being abused and becoming an abuser. As mentioned earlier, 30 percent of sex offenders have a history of being sexually abused (Ryan & Lane, 1997). Thus, from the social learning perspective, believed that individual, who is exposed to sadistic environment, are more prone to mimic the way in which they were abused and repeat the cycle of violence.

Assumptions

In efforts to help address such violence among male adolescent sexual offenders, there are over 750 sex offender treatment program throughout the United States (Hunter & Figueredo, 2000). Among many of the methods used in treatment programs, cognitive-behavioral therapy appeared to be popularly used in many youth sex offending treatment programs (Hunter & Figueredo, 2000). According to Marshall and Law
cognitive-behavioral therapy is a psycho-education therapy method that is used to help sex offenders to identify their sexual assault cycle, to address sexual offensive behaviors and to create a relapse prevention plan. Hence, the writer presumes that cognitive-behavioral therapy is an effective method in redirecting behavioral problems of male adolescent sex offenders.

**Justification**

The writer felt that male adolescent sex offenders should not be acknowledge just because of their sexual crime. Youths who sexually offend are also a part of the vulnerable population that requires assistance. Although they have committed such taboo and deviant acts, these individuals are still very young and are still in need of help and guidance from society, and in many of the cases, juvenile sex offenders were often victimized prior to victimizing others. Thus, through helping adolescent sex offenders with their behavioral problems, we can help them to be more productive and function well with society, rather than casting them out with adult criminals.
This literature review presents the eight themes that emerged from the review of journal articles, books, and electronic resources that are relevant on the idea of using cognitive behavioral therapy to treat sexual deviant behaviors in male adolescents. The themes are the following: brief overview of male adolescent sexual offenders, behaviors found in male adolescent sexual offenders, overview history on the early development of cognitive and behavioral approaches, characteristics of cognitive behavioral therapy, and research studies on cognitive behavioral therapy.

Overview of Male Adolescent Sexual Offenders

A male adolescent sex offender can be define as a youth between the ages of 12 and 17, who had committed deviant sexual interactions with a person against the victim’s will, without consent, or in an aggressive, exploitive, or threatening manner (Lakey, 1994). By law, children ages 12 to 17 are considered too young to give consent to sexual engagement; hence, any sexual interaction with an adolescent (with a 2 year age different) is considered to be a sexual assault, whether force was used or not (Davis & Leitenberg, 1987).

In the literature reviews regarding male adolescent sexual offenders, researchers (Perry & Orchard, 1992; Ryan & Lane, 1997; Marshall, Anderson & Fernandez, 1999) pointed out that adolescent sexual offenders are a
heterogeneous group. They differ in ways of their life experiences, expectations, sexual influences, victims, sexual assaults, and personalities. Perry and Orchard (1992), Ryan and Lane, (1997) Marshall, Anderson and Fernandez (1999) believed that due to these heterogeneous characteristics, it often presents problems for clinical treatments, theory, and clinical researches to effectively address adolescent sexual deviancy.

In efforts to provide a framework for understanding adolescent sexual offenders, Perry and Orchard (1992) constructed a classifying system to identify the different typologies of adolescent sex offenders. Perry and Orchard used literature reviews, clinical experiences and workshop presentations to help them construct such classifying system of adolescent sex offenders. Following are the seven typologies of adolescent sex offenders:

1. The Naive Experimenter. A Naive Experimenter is between the ages of 11 and 14 years old. This individual is known to have a history of acting-out and is usually sexually immature. A Naive Experimenter will sexually engage with children (ages 3 to 6 years old) for exploration and is more likely to use no force or threat in their sexual offense.

2. Under socialized Child Exploiter. This individual is often socially isolated and socially incompetence. The abusive behaviors of an under socialized child exploiter is manipulation, rewards or other enticement. This individual will often commit sexual acts by a desire for greater self-importance and intimacy.
3. *Pseudo-Socialized Child Exploiter.* A pseudo-socialized child exploiter has good social skills, self confident, and a history of acting-out behaviors. Therapist will find that a pseudo-socialized child exploiter have a long history of being abused. This type of sex offender usually engages in sexual behaviors with their victims for sexual pleasure, through using exploitative measures. A pseudo-socialized child exploiter often will rationalize their sexual assaults and feels little remorse for their victims.

4. *Sexual Aggressive.* Sexual aggressive offenders come from chaotic and abusive family background. They have a history of antisocial acts, poor impulse control, and substance abuse. Sexual aggressive offenders usually use force toward their victims and are motivated to commit sexual offenses to experience power by domination, express anger, and/or to humiliate their victims.

5. *Sexual Compulsive.* A sexually compulsive offender comes from an emotionally repressed and severely enmeshed family background. This type of adolescent sexual offender is more likely to engage in repetitive offenses that can be compulsive in nature and hands-off (i.e. peeping or exposing). A sexual compulsive sexual offender is likely to sexually engage with victims to alleviate anxiety.

6. *Disturbed Impulsive.* The disturbed impulsive sexual offender often has a history of psychological disorder, severe family dysfunction, substance abuse, and significant learning problems. His offenses are reckless and reflect trouble of reality testing.
7. Group-Influenced. The group-influenced sexual offender is a younger adolescent with no previous delinquent history. A group-influenced sexual offender is likely to engage in sexual abuse because of peer pressure and desire to seek approval from peer group (p.18-19).

Overall, the sex offender population is a very complex population to understand. They differ in many ways. Many sex offenders, in general, are known to be deceitful and manipulative individuals. Evaluating these clients could take some time for the clinicians. Their distorted way of thinking can make it challenging for clinicians to work with them. Thus, in using the classifying system, it is hoped that it will educate professionals about the different personality styles, thinking patterns and typical offense patterns of adolescent sexual offenders.

Challenges in Male Adolescent Sexual Offenders

Aside from the different typologies of sex offending, this population also has many behavioral issues. It is believe that many behavioral problems found among male adolescent sex offenders contribute to their ability to commit sexual abusive acts. Ryan and Lane (1997) mentioned of how these acting out behaviors can sometimes mimic the way in which they were abused. As mentioned earlier, many of the youth sex offenders come from very dysfunctional and abusive homes. With such a traumatic experience, no one can really tell how the traumatic experience(s) will affect the way these youth will behave after the
events. These behavior problems are identified as: low self-esteem, cognitive distortions, denial and minimization, empathy, and social functioning.

*Low Self-Esteem*

Present literature on male adolescent sexual offenders pointed out that there is a link between low self-esteem and sexual offending. Male adolescent sexual offenders with low self-esteem will often have poor self-concepts, be more focused on the negative aspects of their self-schemas and be more drawn to maladaptive ways of doing things. These youths will often see themselves as little or no value to life, and often feel powerless in their daily life. By lacking a sense of self worth in their lives, it could trigger the male adolescent sex offender to sexually victimize other individuals(s) to regain some sense of power and control. Also with such low self-esteem, these youths do not have the self-confidence to find a positive way to improve such feelings of hopelessness. Therefore, it is believed that through sexually victimizing others, it gives the sex offender a sense of power and control over someone; thus replacing the feeling of hopelessness and powerlessness.

Not only does having low self-esteem make the youth sex offender feel powerless and hopeless, studies have shown that male adolescent sex offender are more lonely because of their low self-esteem. In a study done by Marshall, Anderson and Fernandez (1999), where they measured social self-esteem of offenders and non-offenders in social situations; results showed that male adolescent sexual offenders scored the lowest, non-sexual offenders scored in the
middle; and non-offenders scored the highest on having good self-esteem in the social situation test. The results of the social situation testing concluded that male adolescent sexual offenders with low self-esteem are lonelier and experienced far more relational problems than the average male adolescents.

Marshall, Barbaree and Fernandez (1995) explained that loneliness could lead to sexual deviancy, especially in adolescents who have such low self-esteem. Low self-esteem can cause them to be more susceptible to accept and focus on the negative feedback, rather than focusing on adaptive responses to cope or to resolve their problems (Marshall, Barbaree & Fernandez, 1995). Often when adolescent sex offenders feel lonely from multiple failed relationships, they are more tempted to engage in sexual abusive acts to fulfill such feelings of loneliness and, perhaps, to seek out feelings of closeness through sex, even if it requires force. Hence, low self-esteem is a serious behavioral problem among male adolescent sex offenders.

**Cognitive Distortions**

Cognitive distortions play a vital role in sexual deviancy. Cognitive distortions are destructive thoughts or “thinking errors” that cause the individual to have misperceptions and distorted interpretation of information (Ryan & Lane, 1997). Such destructive thoughts can contribute to the male adolescent’s ability to commit sexual abusive acts, where it is used to justify the crimes that are committed by the sex offender. Brown (2005) mentioned that sex offenders are able to continue in sexual assaults because they use cognitive distortions to adjust
their internal beliefs, so they could view the experience to be more personally pleasurable.

In a studied done by Calder (1999) regarding cognitive distortion of sexual offender, he found that there are four common cognitive distortions that are shared among male adolescent sex offenders. The following are the four common cognitive distortions:

- children want sexual contact with older individuals;
- sexual contact with children is not harmful
- children are sexually seductive
- I am entitled to satisfy my sexual needs, no matter what the cost is to others (p. 37).

Calder also explained that these cognitive distortions are not exclusively just to male adolescent sexual offender, but, also to adult sex offenders, who sexually abuse children and adults.

It is believed that when sex offenders commit criminal act and have negative feelings about their behavior, they use cognitive distortions to minimize the negative feelings, so they can rationalize the criminal behavior. In time, if the sex offender continues to allow himself to offend without guilt, there is a chance that he will become entrenched to these beliefs, attitudes, and perceptions and accept these cognitive responses (Marshall, Anderson & Fernandez, 1999). For instance, if the sex offender continues to sexually abuse without guilt, the sex offender would share the perception that sexually victimizing other people is an acceptable social behavior and will continue
to do so each time they commit a sexual crime. Thus, not only can the sex offender’s distorted way of thinking help the sex offender to accept the criminal behavior, but also help to support the sadistic behavior, as well.

Denial and Minimization

Denial and minimization are serious problems among sexual offenders. Sexual offenders are known to use denial and minimization to help them cope with their sexual assaults. Denial is an attempt used by sex offender to minimize their responsibility in the sexual assault. Minimization, on the other hand, is used as an attempt to minimize the extent and nature of the sexual assault. It is believed that when male adolescent sex offenders use denial and minimization, they will often share the view that such sexual act was consensual and no harm was done to the victim; thus shifting their responsibility for sexually assaulting others (Marshall, Anderson & Fernandez, 1999).

In three separate studies, where researchers (Maletzkly, 1991; Sefarbi, 1990, Barbaree; 1991) studied denial and minimize in criminal offenders, they clearly concluded that sexual offenders are more likely to use denial and minimization, in comparison to other criminal offenders. Maletzkly concluded that 87 percent of the sexual offenders, in his studied, denied committing crimes. Sefarbi similarly concluded that 50 percent of the sexual offender, in her study, denied responsibility for the sexual assaults. When Barbaree interviewed rapists, child molester and sexual offenders, he concluded that 66 percent of child molester and 54 percent of rapists denied committing sexual offense, while 98
percent of all his sexual offender participants either denied or minimized their sexual offense. Hence, these studies clearly demonstrate that denial and minimization is more problematic among sex offenders than other criminal offenders.

*Empathy*

Developing empathy is an important recovery process for sex offenders. Many sex offenders are able to continue abusing other because they lack affection or closeness with others. Briggs, Doyle, Gooch and Kennington (1998) explained that through increasing victim empathy, it improves the sex offender’s capacity to seek appropriate intimacy in interpersonal relationships and strengthen their internal inhibitions of sexually re-offending. Empathy can motivate the sex offender to continue to change, once they are made aware of the impact their offenses have caused the victims. Through getting the sex offender to be emotionally aware of other people’s feelings, it can help the sex offender to recognize the impact of their actions and respond more compassionately to others.

Not only can empathy help the sex offender to be more compassionate, it can also help the sex offenders to deal with their own emotions. Briggs, Doyle, Gooch and Kennington (1998) also explained that many men who sexually abuse other people often have trouble dealing with their own emotions and problems. Since many of these sex offenders were often abused, neglected or sexual victimized in their history, they still have a lot of unresolved emotions and problems. Through years of not dealing with those emotions, many sex offenders
may have turned to unhealthy ways of dealing with their emotions and problems; such as sexually abusing others.

Sexual abuse is often how many sex offenders dealt with unresolved emotions and problems because sexually abusing others allows them to emotionally isolate themselves from others and their problems. Sexually abusing others is also another way for sex offenders to deal with unresolved feelings of loneliness, anger and rejection. Through helping sex offenders to identify their emotional and behavioral responses to their problems, it can help them to build empathic skills. Empathy come a variety of emotional and behavioral awareness. By assessing their emotional and behavioral awareness, clinicians can help the sex offender to learn better ways to cope with their problems and unblock the development of empathy.

Social Relationship

Intimacy is another deficiency among many male adolescent sex offenders. Marshall (1989) explains that sex offenders often experience many relational problems because they have poor quality relationships with their parents. Marshall added that when adolescents are neglected and rejected by their parents, they lack the developmental skill to acquire the necessary skills to help them engage in appropriate relationships with their peers. Thus, many male adolescent sex offenders see themselves as not loveable human beings and often would isolate themselves.
It is believed that when adolescent sexual offenders are rejected by their peers and family, they will engage in sexual behaviors with children to fulfill their needs in intimacy. Adolescent sex offenders will engage in sexual behaviors because they identify intimacy with sex (Marshall, 1989). Children are targeted by sex offenders because children are less intimidating and easily persuade; which, in turn, creates opportunity for sexual offenders to sexually abuse children (Marshall).

**History on Cognitive and Behavioral Approaches**

It wasn’t until the 1920’s and 1930’s that behavioral analysis of human sexuality began to emerge in the psychological world of trying to understand human behavior. Marshall and Laws (2003) suggested that Sigmund Freud was one of the earliest individual to draw attention and to study about sexual behavior in people. He was one of the first one to write about the existence of deviant sexuality in human behavior. Marshall and Law added that it was Freud who published the three essays on the “Theory of Sexuality”, which talked of how sexual deviant behaviors could exist among individuals.

According to Marshall and Laws (2003), the first essay in Freud’s theory of sexuality was about sexual deviation. In the second essay, he discussed about infantile sexuality of people, and the third essay was about sexuality in puberty. Marshall and Law added that soon after Freud published these three essays, it sparked a lot of controversy and attention on human sexuality, which led to more research on human behavioral and sexuality. Currently, it seems that Freudian
approaches on human behavior and sexuality provided a framework for psychological explanations of human behavior and sexuality.

After Freud’s three essays, Marshall and Law also suggested that Watson’s Behaviorism and Kinsey’s work on sexology led to the development of behavioral and cognitive behavioral theories. During the early mid-20th century, psychologists John Watson and Alfred Kinsey developed behavioral approaches that were related to Freud’s talks of sexual deviations (as cited by Marshall, Laws, 2003). In John Watson’s Behaviorism, he explained about how human behaviors have psychologically response to stimuli in their environment (Marshall and Laws, 2003). As for Alfred Kinsey’s sexology theory, he argued on the perception that human sexuality is the drive to human behavior. To support Kinsey’s theory on sexology, he wrote about the sexuality behavior of man and woman (Marshall, Law, 2003). It is believed that due to these early theorists and their works, cognitive and behavior approaches began to develop as organized theories to conceptualize and treat human problems.

**Characteristics of Cognitive Behavioral Therapy**

According to the National Association of Cognitive Behavioral Therapy (2009), cognitive behavioral therapy is an evidence-based form of psychotherapy that analyzes how thoughts and feelings affect our actions. Cognitive behavioral therapy is a general term for a classification of therapies that are similar—such as Rational Emotive Behavior Therapy (REBT), Rational Behavior Therapy (RBT),
Rational Living Therapy (RLT), Cognitive Therapy (CT) and Dialectic Behavioral Therapy (DBT) (NACBT, 2009).

According to NACBT, they believe that cognitive behavioral therapy consists of the following ten characteristics:

1. Cognitive Model of Emotional Response. Cognitive behavioral therapy emphasizes on the idea that our thoughts cause our feelings and behavior, not external things like people, life experiences and events.

For instance, in treatment, clinicians can use this model to help male adolescent sex offender to recognize that prior to sexually assaulting their victim, they had already thought about it and/or planned it beforehand; not because it was an accident or because the victim was asking for it. Allowing the male adolescent to recognize that their thoughts also caused them to react to the sexual assaults is also important to help the sex offender understand their emotional responses.

2. Time-Limited. According to the NACBT (2009), the appropriate amount of time clients should spend in treatment is 16 sessions. NACBT (2009) explains that in having such time line, it helps clients to understand that treatment is not an on-going process. There is a beginning and formal ending to the treatment. However, it should be noted that only the therapist and client know when to stop the treatment.

In different treatment programs, there are different time lines given to the sex offender clients. Some treatment programs may run from two years or more, while others may be linked to the amount of time the sex offender is incarcerated.
for or is order by the court. Treatment sessions for the sex offender may vary more than 16 sessions and the time limits for the sex offender clients may vary, depending on the treatment program and court order.

3. Positive Therapeutic Relations. A positive therapeutic relationship, between client and therapist, is considered necessary for effective therapy and treatment progress. NACBT (2009) explains that although the therapeutic relationship is not the primary focus, it is assumed that the main reason for making progress is based on the positive relationship between the therapist and clients.

For instance, when therapist maintains a positive client relationship with the sex offender client, it encourages the offender to think, feel, learn and behave more positively. In addition, in having positive relationship, it can help the therapist to build trust with the sex offender client, so he/she would be more willing to share information with the therapist, increase the sex offender’s self-esteem, self-regard, empathy and other things that can come from a positive client-therapist relationship.

4. Collaborative Efforts among Therapist and Client. NACBT explains that when the therapist and client invest collaborative efforts into each session, therapist can learn more about the client’s goals and help clients to achieve such goals.
When working with sex offender clients, the therapist’s role is to listen, teach, and encourage, while the sexual offender’s role is to express concerns, learn, and implement that learning.

5. Stoic Philosophy. Stoicism practice is about teaching people to stay calm when they encounter an undesirable situation (NACBT).

During treatment sessions, the therapist can use this method to help the sex offender clients to recognize that they do not have to be upset or act-out when they do not like the situation; instead, they should remain calm, so they can resort to their intelligence and resources to resolve the problem.

6. Socratic Method. Socratic Method is a practice where one asks questions to further learn about something. NACBT (2009) explains that when therapist wants to learn about their clients concerns, they ask questions.

In asking questions, it can help therapist and the sex offender client to learn more about their concerns, goals, personality, thought-process and self-reflect (NACBT, 2009).

7. Structure and Directive. Cognitive behavioral therapy is structured and directive. NACBT (2009) explains that therapist teaches specific techniques/concepts in each session and therapist teaches their clients how to think and behave in appropriate ways to obtain their goals.

Often in many residential sex offender programs, clinicians greatly insist that the offender practice well-mannered social skills, such as: saying thank you, after someone had assisted you and be respectful to other people. In doing so, the
program’s objective is to encourage the sex offender to practice good social skills and be more aware of their behaviors. Many adolescent sexual offenders were never taught good etiquette from their parents or caregivers.

8. Inductive method. Inductive method encourages the individual to look at their thoughts as hypotheses or guesses that needs to be tested (NACBT).

In using inductive methods, the therapist should encourage their sex offender clients to recognize positive ways to explore and analyze their frustrations, so they can recognize that what they are feelings may be hypothetical guesses so they do not dwell over it. For instance, when the sex offender client is having a tough time with treatment, there is a great chance that due to their distorted way of thinking, many sex offenders will often assume the worst, such as, believing that they are not treatable, rather than recognizing that there may be other treatment methods that would work best for them. Thus, when the sex offender client is frustrated with a situation, the therapist should always encouraged the sex offender client to reach out to their peers or staffs to discuss their frustration, so the sex offender clients do not always have to assume the worst.

9. Educational Model. Education is also an important aspect of the cognitive behavioral therapy. It is believed that most emotional and behavioral responses are learned (NACBT, 2009). The therapist can help clients to unlearn unwanted emotional and behavioral responses by helping them understand how
and why they are doing well, so they would be able to recognize what to do to continue doing well (NACBT, 2009).

In treatment, when the sex offender client is progressing well in treatment, the therapist should encourage them to self reflect on what they are doing that is helping them in treatment or encourage them to write in their journals to explore what is different that they are doing, in comparison to the bad weeks that they are having.

10. Homework. Homework is believed to be a central feature in cognitive behavioral therapy. Since each session is time limiting, it does not allow sexual offenders enough time to fully practice and study the techniques and topic that were taught to them during each therapy sessions (NACBT, 2009). Psychotherapy is only effective and remembered if clients (sexual offenders) spend a great deal of time to study and practice the technique and topics taught to them, during each session; for example, learning how to read and write for the first time. (NACBT, 2009).

In treatment, therapist can assign therapeutic homework and reading assignments to create opportunities for the male adolescent sexual offender to study and practice the technique after the session.

Studies on Cognitive Behavioral Treatment

As cognitive behavioral therapy become more widely used in rehabilitating sexual offenders, it created more opportunities for scholars, theorists, and clinical therapists to further research about the use of cognitive
behavioral therapy in treating sexual deviancy. Following are some of the studies found during the review of journal articles, books, and electronic resources for this research, regarding the use of Cognitive Behavioral Therapy to treat sexual deviancy among male adolescents. These studies are organized according to different research methods used by the researchers: Meta-Analysis Study, Systematic Review, Follow-Up Studies and Assessment Study

Meta-Analysis Study

In 1999, Alexander did a study regarding the efficacy of using cognitive behavioral treatment in reducing sexual recidivism among juvenile sex offender treatment. In her study, she used meta-analysis to review 55 sexual offender treatment programs that uses cognitive behavioral therapy in their sex offender treatment programs. The meta-analysis was done using a three-step procedure to combine the archival data. These programs are located throughout the United States and were randomly selected by Alexander.

The current pool of subjects did not include subjects who dropped out or were terminated during the course of treatment. Alexander felt that the data on the dropout or non-completers would skew the results. Thus, the data in the studied only included individuals who have completed or are currently in treatment and untreated male adolescent sex offenders.

After analyzing the results, Alexander (1999) concluded that the male adolescent sex offenders, who are currently in treatment or have finished treatment, have a 14.4% chance of sexually acting out again. As for the male
adolescent sex offenders who never received any treatments, they have a 23% chance of sexually acting out again.

Even though, Alexander’s findings did not show that cognitive behavioral therapy was a hundred percent effective, it did show that individuals who had completed the therapy had a lower chance of sexually re-offending.

**Systematic Review Study**

In order to demonstrate the effectiveness of CBT for offenders, Lipsey, Chapman, and Landenberg (2001) conducted a systematic review to provide evidence on the effectiveness of cognitive-behavioral programs. They were interested in investigating the direct changes in male adolescent sex offender’s cognitions. In their study, Lipsey, Chapman, and Landenberg selected juveniles (n=7), between the ages 12 to 21, and adult criminal offenders (n=7) as participant for his study. Participants for this studied were randomly selected from the general population of sexual offenders. All the participants were classified as sex offenders and were currently attending treatment to address sexual deviancy. Although all the participants were already receiving treatment to address sexual deviancy, their treatment did not include cognitive behavioral therapy. Lipsey, Chapman, and Landenberg’s objectives were to assess if anything would happen if cognitive behavioral therapy was added to their current treatment.

Participants in the study were randomly assigned into two groups. In the first group (experimental group), participants received cognitive behavioral therapy in addition to their current treatment and in the second group (control
group), participants were told they are also undergoing cognitive behavioral therapy; however, nothing was added in addition to their current treatment (placebo).

After several months of treatment, Lipsey, Chapman, and Landenberg (2001) assessed all the participants’ progress to help them determine the likelihood that each group would sexually re-offend. As a result, participants in the first group (intervention) had a lower chance of sexually re-offending than the second group (control). The intervention group was also found to be making good progress in addressing sexual deviancy. Results from the study showed that the intervention group had .26 (26 percent) chance of deviant sexual recidivism.

As for the second group (control), results showed that participants were not doing as well as the first group (intervention) in addressing sexual deviancy. The participants in the control group demonstrated a .38 (38 percent) chance of deviant sexual recidivism (Lipsey, Chapman, & Landenberg, pp. 153).

In conclusion, the results in Lipsey, Chapman, and Landenberg’s study clearly indicated that there is a .10 (10 percent) difference, among the intervention and control group, regarding sexual re-offending. Lipsey, Chapman, and Landenberg, also noted that even though they were sure if the current treatment or the participants’ experience in jail had any influenced in the results, they clearly believed that cognitive behavioral therapy can help lower sexual offender’s chances of sexual recidivism.
Follow-Up Studies

In 1996, Hanson did a follow-up study at the Juvenile Correctional Service of North Carolina to assess the effectiveness of using cognitive behavioral therapy among adolescent male sex offenders. The study was done in 1988. Out of 590 sex offenders in the Juvenile Correctional Services of North Carolina, Hanson randomly selected 84 participants (n=84) and used the experimental research design. With the 84 participants, he randomly assigned participants (n=84) into two groups, consisted of 42 participants in each group. Hanson (1996) divided the participants into an experiment group (n=42) and a control group (n=42). Participants in the experimental groups received cognitive behavioral treatment and the other 42 participants, who were put in the control group, did not receive any significant treatment.

About twelve months later, he did a follow-up on the chances that these participants were going to sexually abuse others. As a result, Hanson (1996) concluded that individuals in the experimental group had a 30.2% chance of sexual recidivism; while individuals in the control group had a 45.7% chance of sexual recidivism. Like previous studies, Hanson’s study also concluded that using cognitive/behavioral treatment could lower the chances of sexually re-offending for many sex offenders.

Later in 2001, Aytes, Olsen, Zakrajsek, Murray, and Ireson also conducted a follow-up study. In their study, they evaluated the outcomes of the combined supervision and treatment program of Jackson County Community Juvenile
Correctional. The results were gathered through a 3 to 5 year observation study. In the study, there were about 846 participants. These participants were randomly selected from the entire caseload, supervised in Jackson County, for the referenced time interval.

In the study, participants were placed in one of the following four subgroups: (1) successful treatment, (2) unsuccessful treatment, (3) incomplete treatment, and (4) non-treatment group. The successful treatment group had 170 individuals. These individuals met the criteria for a successful completion and demonstrated understanding of the cognitive and behavioral treatment.

The unsuccessful treatment group had 157 individuals. These individuals failed to successfully complete the sex offender program and were terminated from the program for non-compliance or violation of probation or both.

There was the incomplete treatment group. There were a total of was 68 participants who successfully participated, but were unable to complete the program due to: physical, cognitive or developmental limitation or were transferred out of the Jackson County or the length of sentence did not allow them to complete the program.

Lastly, there was the non-treatment group. This group had 149 individuals who (although were eligible for treatment) did not participate for these reasons: individual absconded from supervision, transferred to another jurisdiction or deemed inappropriate for the program by treatment provider or correctional staff.
When all four groups were compared together, the sexual recidivism rate went up to 4.8%. When a chi-square test was done, it concluded that there were meaningful differences in sexual recidivism among each subgroup. The sexual recidivism rate for Jackson’s successful group was 6.5%, Jackson’s unsuccessful group was about 32.5%, Jackson’s incomplete group was about 20.6%, and lastly Jackson’s non-treatment group was not reported to the study. Overall, this study concluded that individuals who successfully completed the sex offender treatment program had a low chance of re-offending, in comparison to the other group that did not complete the sex offender treatment program.

*Assessment Study*

Along with studying the effectiveness on juvenile sex offenders, Shenk and Brown (2007) took a different approach. Their research purpose was to see if cognitive behavioral therapy would have any effect with adolescent sex offender, who has an intellectual disability. According to Shenk and Brown (2007), there is very little data and literature regarding adolescent sex offender with intellectual disability and treatment progress. This study was done to further assess if cognitive behavioral therapy can help improve sexual deviancy among intellectually disabled male adolescent sex offenders.

In the studied, there were a total of 6 cases (n=6) that were assessed. To make sure that there were enough findings to measure, the participants went through 7 courses of treatment and assessment processes. Shenk and Brown (2007) later did a 3 months post-discharge and then again at 6 months post-...
discharge to collect the results for this studied. As a result, Shenk and Brown (2007) found that even though participants were intellectually disabled, all participants have a 25% to 33% reduced chance in sexual recidivism if they were to complete the 7 courses of treatment. Overall, Shenk and Brown’s (2007) study proved that cognitive behavioral treatment had a positive effect on intellectually disabled adolescent sex offenders. In addition, Shenk and Brown (2007) mentioned that due to their cognitive and behavioral therapy, the intellectually disabled sex offenders in their study were able to transition back into the community and their family.

**Conclusion**

The literature review explore the different types of sexual offenses, behavioral problems and how to better understand how cognitive behavioral therapy can help treat sexual deviancy among male adolescent sex offenders. It also reflects on past studies that demonstrated the outcome of using cognitive behavioral therapy to treat and address sexual deviancy in male adolescent sex offenders. Although past studies did not conclude that cognitive behavioral therapy was a hundred percent effective in rehabilitating sexual offenders, all of the studies indicate that those who did complete treatment had a lower chance of sexually recidivism. Thus, this study is conducted in attempt to see if clinical therapists, who work male adolescent sexual offenders, still perceive cognitive behavioral therapy to be an effective method in today’s treatment program for male adolescent sexual offenders.
Chapter 3

METHODOLOGY

Introduction

This section of the Project includes discussion about study questions, study design, sampling procedures, data collection, human subjects’ protection protocol, protection of confidentiality, and consent forms that were used in the study. As mentioned in Chapter 2, the male adolescent sex offender population has many behavioral problems. These behavioral problems contribute to their ability to sexually abuse other people. These behaviors are known as: low self-esteem, poor social skills, cognitive distortions, denial and minimization to justify their offense, and lack of empathy.

Study Design

This study was designed to gather qualitative information to evaluate the perceptions clinicians have on the effectiveness of using Cognitive Behavioral Therapy in treating behavioral issues (low self-esteem, poor social skills with peers and family, thinking errors, empathy deficit, and denial and minimization) of sex offenders. A qualitative approach was used because it allows the researcher to obtain extensive, in-depth, and rich detail information that is presented by the research participants (Rubin & Babbie, 2008).

Subjects

This study population consisted of clinicians who have been working with male juvenile sex offenders for more than two years. The subjects for this study were males.
and females. The sample size for this study was 5 clinicians (n=5), who have worked for two or more years with the male adolescent sex offenders population. Since this study was qualitative, it was not necessary to obtain a large study sample for this study.

The sample for the study is consisted of four subjects (n=4) with a Master Degree in Social Work and one subject (n=1) with a Master Degree in Psychology. All the subjects in the study are considered experts because they have two or more years of clinical training and work experience in working with the male juvenile sex offender population.

All of the clinicians have interest in utilizing their professional knowledge and were willing to participate in this study. All subjects felt that it would bring great benefits in helping others to see how clinicians feel about using Cognitive Behavioral Therapy to help improve behavioral problems of male adolescent sexual offenders.

The participants were recruited by using the convenience or availability sampling method. Availability sampling method is when elements for the study are chosen based on their availability and convenience (Rubin & Babbie, 2008). Due to confidentiality issues, not too many agencies wanted their staff to participate in the study. Therefore, the researcher was able to recruit three clinicians (n=3) from Children’s Home of Stockton and two clinicians (n=2) from Sacramento State University, who have more than six years of experiences in working with male adolescent sex offenders.

**Study Questions**

The survey questionnaire used in this research sought to elicit information about the perceptions social work clinicians’ have on using Cognitive Behavioral Therapy to
treat behavior problems of male adolescent sex offenders. Clinicians are required to use their clinical training and work experience to evaluate if Cognitive Behavioral Therapy is an effective method on improving behavior issues of male adolescent sex offenders.

The interview questions were constructed using the behavioral issues (low self-esteem, poor social skills, having cognitive distortions, using denial and minimizations to justify their offense, and lacking empathy) that are found among many male adolescent sex offenders, as mentioned in Chapter 2. There are sixteen questions in the survey questionnaire (See Appendix A). The researcher chose to focus on these behavioral issues because literature reviews and researches (in Chapter 2) indicated that these are common behavior problems among the male adolescent sex offender population. In addition, the researcher is interested to know how Cognitive Behavioral Therapy can help improve behavioral problems of male adolescent sex offenders. These behavioral issues were put together using literature reviews and researches that were done in Chapter 2.

A comment section was provided in the questionnaire to allow the clinicians an opportunity to freely share any concerns or comments, regarding their thoughts or feelings about the study or questionnaire.

_Data Collection Procedure_

The research questionnaire was distributed to participants from Sacramento State and Children’s Home of Stockton. The researcher met with each participant separately to conduct the survey. The survey process took place in the private office of each participant. Participants took about 40 minutes to complete each survey. Prior to the giving participants the survey, the researcher discussed the purpose of the study, as well
as, the method of data collection. Confidentiality issues were also discussed. Participants understand that their names would not be cited in the study. The only person to see the completed questionnaire would be the researcher. The participants were then asked if they have any questions or concerns regarding the research study or questionnaire. Upon the participant’s verbal agreement, an informed consent form was signed by the participant and the interview process started.

*Data Analysis*

The researcher has gathered the completed questionnaire from the participants and placed the findings into categories, pertaining to common themes as they emerged from the participant’s responses. The researcher will also identify the differences and similarities in the participant’s responses. Results had been achieved through aggregate narrative information from the participants.

*Human Protection Protocol*

The researcher followed the guidelines established by the Protection of Human Subjects Committee for the Division of Social Work, California State University-Sacramento. The researcher downloaded the Human Subject application from the Graduate Studies website. The researcher met several time with the thesis advisor to formally complete the application. On October 13, 2009, an application was submitted to the Committee for the Protection of Human Subjects. On November 2, 2009, the study was approved and the approval number given by the Committee is 09-10-039. The study was determined by the Committee to be “no risk” (See Appendix C).
Participant’s anonymity was completely protected. Participants were provided a written consent form, detailing and explaining the purpose of this research study (See Appendix B). Participant’s right to privacy was secured because the participants were able to remain completely anonymous while participating in this research project. All completed questionnaires were collected by the researcher and placed in a sealed envelopes. Sealed envelopes with completed survey questionnaires were placed in a locked box at the researcher’s residence. The information collected from the study will be destroyed after one year.

The researcher also underwent a formal request process with Children’s Home of Stockton. On November 9, 2009, the researcher met former field instructor, Mike Galindo, to discuss research request with Children’s Home of Stockton. On November 13, 2009, the researcher submitted a request letter and research proposal to Mr. Galindo to have the Program Director, Mark Phelps, reviewed. On November 24, 2009, the researcher was informed by Mr. Galindo that the research request was approved and permission was granted by Mr. Phelps.
Chapter 4

FINDINGS

This chapter presents findings collected from the respondents. The findings were analyzed using aggregate narrative information from the participants. Findings are organized into the following subtopics: social skills, denial and minimization, cognitive distortion, low self-esteem, empathy, and sexual thoughts and behaviors.

Demographics

The participants include five clinicians who have worked two or more years with male adolescent sex offenders. With their clinical expertise and work experiences, the researcher felt that it would be appropriate to obtain demographic information from them for this study.

In addition, due to their clinical knowledge and work experiences, the researcher felt that they could better analyze and provide explanations as to why cognitive behavioral therapy is an effective or ineffective method in treating behavioral problems such as low self-esteem, poor social skills, having cognitive distortions, using denial and minimizations to justify their offense, and lacking empathy of male adolescent sex offenders. In addition, these clinicians could identify if there are other treatment programs that would best work with behavioral problems of male adolescent sex offenders.

The subjects that participated in this study were identified as clinician A, B, C, D, or E. There is no special ordering of these characters to each participant’s identity. The
clinicians are identified by letters in order to help readers follow along with the participant’s responses.

Social Skills

When clinicians were asked to provide cognitive behavioral therapy techniques that can help male adolescent sex offenders to obtain healthy relationships with peers, three specific techniques were identified by the five clinicians. The top suggested technique was to help the sex offender become aware of their cognitive distortions. For example, clinician B stated, “since many sex offenders are known to have poor relationship skills, it is possible that they could turn to distorted ways of dealing with their needs for intimacy.” In addition, clinician E explained, “due to their past experiences with bad relationships, many offenders will respond to social situations and events with inaccurate information and faulty perceptions.” “Thus, sex offenders need help to change inappropriate feelings and perceptions, so they can accurately reflect to the social situation,” further stated by clinician E.

Behavior modification through award and consequences was the second recommended technique. Regarding this issues, clinician C stated that “rules of interactions are taught to the sex offender.” “They are praised when they work will with peers and they are given consequences for negative behavior.” Clinician D explained, “award and consequences can help the sex offender obtain healthy relationships with peers because it encourages the sex offender to think about their behavior, before and after they interact with peers.”
Social skill training through role-play, coaching, and modeling was the third suggestion among the participants. In term of social skills, clinician A explained, “role playing, coaching, and modeling can help the sex offender to practice and receive proper feedback from their peers.” “Through practice and feedback, it will help the sex offender to become more comfortable and confident around his peers and self aware of his behaviors,” as commented by clinician A.

When clinicians were asked about cognitive behavioral therapy techniques that can help male adolescent sex offenders obtain healthy relationships with their family, two techniques were identified. Addressing cognitive distortions in therapy sessions with the sex offenders and the family was highly recommended by the participants. Clinician E explained that “addressing cognitive distortions with the family can help the family clarify things with the sex offenders, such as understanding what the offender has done and understanding why the sex offender was able to commit such vicious acts.” In addition, clinician B believed that “many distorted thoughts and belief systems are from family experiences and beliefs.” “Through addressing these distorted thoughts and belief, it can help change and correct family deficiencies and improve family relationships, overall,” explained, clinician B.

Providing family counseling sessions with the sex offender and their family was the second suggestion. Clinician C stated, “family involvement and support is very critical to the recovery process because it lets the sex offender knows that he’s not alone in the treatment process.” “Often, not only does the sex offender need help, but the family also need time to heal from the aftermath and time to reconcile with the sex
"offender," added, clinician C. Clinician D also agrees with clinician C and stated, "family sessions can help create opportunities for the family and the offender to talk to each other and sort problems out, which is an important step to recovery for the sex offender."

**Denial and Minimization**

When clinicians were asked about cognitive behavioral therapy techniques that can help male adolescent sex offender to accept responsibility of their sexual crime, there were two techniques suggested by the participants. Addressing the personal cycle of abuse with the sex offender was the highly recommended by the participants. Clinician A, C and E similarly explained that through addressing the personal cycle of abuse with the sex offender, it helps the male adolescent sex offenders to accept responsibility of their sexual crime. "The personal cycle of abuse could be factors or events that trigger behavioral responses from the sex offender every time he acts out," stated Clinician C. "These factors or events could be identified as bad or abusive experiences in the sex offender’s history, thinking patterns or behavior patterns that trigger deviant behavioral responses," further explained by clinician C. In addition, clinician A, explained, “not only does addressing the personal cycle of abuse help sex offenders to accept responsibility, but it also, help them to recognize maladaptive patterns of behaviors they have been using to help them cope with stress or unpleasant situations and how it is a continuous cycle.”

Teaching responsibility and accountability for their actions was the second technique. Clinician B and D similarly responded that teaching responsibility and
accountability for their actions can help the sex offenders to accept responsibility for crimes they committed. Clinician D stated, “sex offenders often do not want to see the consequences of their actions.” “Through teaching responsibility and accountability to the sex offender, it forces the sex offender to see and think about the consequences of their actions.” Clinician B, on the other hand, stated that “we teach them accountability daily.” “We teach them that half-truths are still treated as full lies.” “If they minimize, they are confronted and will still take responsibility for the lie,” further explained by clinician B.

When clinicians were asked about Cognitive Behavioral Therapy techniques that can help change the way male adolescent sex offenders minimize or deny their part in sexual crime, two techniques were identified. The top suggested method was to help the sex offender understand their cognitive distortions. Clinician A, B, C, and E similarly believed that cognitive distortions have to be present in order for the sex offender to commit sexual abusive acts. Clinician E explained that “denial and minimization is often used by the sex offender because they do not want to realize what is true or real about the problem; thus, it is vital to address how cognitive distortions, denial and minimization are connected.” In contrast to clinician E, clinician B explained that “through helping the sex offender explore their thinking errors, it will encourage the sex offender to develop empathy for their victims; thus, changing the way how they take responsibility for their sex crime.”

Aside from the four, Clinician D believed that teaching accountability to the offender will help the sex offender change their way of using minimization and denial in
their sexual crime. This clinician explained, “the only way to help a sex offender is to
directly address the issue when it occurs and not allow time for the sex offender to come
up with lies.” “Only through such practice, will it stop the sex offender from denying and
minimizing their sexual crime.”

Cognitive Distortion

When the clinicians were asked for cognitive behavioral therapy techniques that
can help change “thinking errors” among male adolescent sex offenders, three methods
were suggested. Encouragement and structure was highly recommended by the
participants. Clinician C, D, and E similarly responded that the therapist should provide
encouragement and structure for the sex offender to change their thinking errors.
Clinician C stated, “it is the therapist who must show the way for the sex offender to
change their thinking; without such guidance, the sex offender won’t know where to
start.”

Challenging the sex offender was the second method identified. Clinician B
believed that “the therapist should challenge the sex offender’s thinking ability by
teaching common thinking errors and having the offender identify their own thinking
errors.” “Through using such technique, it is believed to help the sex offender understand
and recognize how their thinking errors contribute to negative choices,” further
explained, clinician B.

As for the third suggestion, Clinician A did not specify any specific technique and
stated, “this topic is too big to be discussed because it would take forever.”
Low Self-Esteem

When clinicians were asked about cognitive behavioral therapy techniques that can help improve low self-esteem in male adolescent sex offenders, different techniques were given by the participants. Clinician A answered “without question,” and did not provide any other explanations.

Clinician B provided a different response, stating that “sex offender can increase their self-esteem through developing appropriate relationships with their group members.” “Treating their group members with respect, helping other members with their problems, and asking for help can help the sex offender develop relationships with group members and increase their self esteem.”

Clinician C differently suggested, “the therapist should provide therapy sessions for the sex offender to practice self awareness.” “By providing a time for the sex offender to practice self awareness, it helps the sex offender to feel more confident and be more aware of their positive attributes,” added clinician C.

As for clinician D, giving responsibility to the sex offender can help improve their self-esteem is the suggested method for improving low self-esteem in male adolescent sex offenders. “Giving responsibility to sex offender can help them feel more responsible and gain a sense of trust with other people,” as commented by clinician D.

In contrast to the other clinicians, Clinician E recommended that “helping the sex offender to recognize their true strengths and changing the old recording of negative self statements, such as: nobody likes me and I can never do anything right, can help improve self-esteem.” This clinician explained, “by recognizing their strengths and changing
negative self statements, it helps the sex offender to accept their weaknesses and strengths, it will help them to recognize how their weaknesses and strengths affect them.”

**Empathy**

When clinicians were asked to identified cognitive behavioral therapy techniques that can effectively help male adolescent sex offender clients with the ability to recognize and explore the emotions of their sexual victims, three approaches were given. Clinician B and E similarly stated that Cognitive Behavioral Therapy is effective, however, only if it is used with other therapy modalities, such as, Narrative therapy or Family Systems Theory. For instance, clinician B explained that “recognizing and exploring the emotions of their victims is not an easy thing for sex offenders.” “Often, it will take other therapy models to help the sex offender to reflect and connect to their victims,” further explained by clinician B. In addition, clinician E stated, “through using Narrative Theory, it encourages the sex offender to explore the victim’s emotions and reactions, as if they were the victims themselves.” “By using Family Systems Theory, it encourages the sex offender to see their victims as individuals with family relation, such a sister or brother of someone else,” added Clinician E.

In contrast to Clinician B and E, encouraging sex offenders to talk about their own feelings will help the sex offender to develop empathy for their sexual victims, suggested by clinician C and D. In regards to empathy, Clinician C responded that “sex offenders need help to be more in touch with their own feelings, so they can transfer those feelings toward their victims.” Clinician D, on the other hand, explained that “since many sex offenders grew up being neglected and abused by their family, they would need
help to process their feelings and experiences, prior to developing empathy for their
victims.” “Only after doing so, will they be able to understand how they affected their
victims and connect to the feeling of victimization,” added clinician D.

As for clinician A, this clinician does not believe that sex offenders really lack
empathy. Clinician A believed that “on the surface, sex offenders can learn to identify
emotions of their sexual victims and there is no concern for violent empathy.”

When clinicians were asked about cognitive behavioral therapy techniques that
can effectively help male adolescent sex offenders to develop empathy for other people,
two methods were identified. Clinician A, B, C, and E greatly believed that cognitive
behavioral therapy alone cannot help. For example, clinician B explained that “this is a
big issue and it takes more than cognitive behavioral therapy to help the sex offender
develop empathy for other people.” “Cognitive behavioral therapy is only one method,”
added clinician B. Clinician E, on other hand, explained, “by using other therapy method
like Narrative Therapy, it allows the sex offender to use personal experiences and
feelings to explore the lives of other people.” “Only through using such method, it can
help create an opportunity for the sex offender to connect to other people,” further
explained by clinician E

Helping the sex offender connect to their emotions was secondly recommended.
Clinician D explained, “if there is no other mental functioning, such as mental
retardation, to interfere with their functioning, then the therapist can help sex offenders to
connect their emotions to other people, so they can put themselves in other people’s
shoes.”
Sexual Thoughts

When the clinicians were asked about cognitive behavioral therapy techniques that can help change deviant sexual thoughts of male adolescent sex offenders, two techniques were provided by the clinicians. Helping the sex offender identify deviant sexual thoughts and understanding how those thoughts are connected to their crimes was the top suggested method. Clinician C responded that, “sex offenders are so used to their maladaptive way of thinking; they are not unaware of what deviant thoughts are.” Clinician B further explained that “even if sex offenders know what deviant thoughts are, they, however, do not understand it because, it makes them feel good inside.” “As a clinician, it is really important that we help them to see the consequences of their thoughts, so they can understand why it is wrong to have such desire,” as commented by clinician B, in regards to sexual thoughts of male adolescent sex offenders. Clinician D also expressed a similar perception and stated that “often, sex offenders need help to redirect their sexual desire, helping them to see the consequences of how deviant thoughts play out is just a beginning in the process of change.”

The second suggested method was to use other therapy models with Cognitive Behavioral Therapy in order to help change deviant sexual thoughts of sex offenders. One of the two of the clinicians who suggested using other therapy models explained that “when dealing with their sexual desire and thoughts, Narrative Therapy and Systems theory would better help them to explore and understand what triggers these deviant thoughts and desire.”
When asked if any cognitive behavioral therapy techniques can help change sexual behaviors of male adolescent sex offenders, two techniques were identified by the clinicians. Three clinicians similarly suggested that clinicians should talk about cognitive distortions and personal experiences with the sex offender. Clinician D explained, “therapists can help the sex offender recognize how cognitive distortions and personal experiences affect their behavior.” “In doing so, it will help the sex offender to see patterns of bad behaviors and perhaps, practice interventions that can help stop these patterns of bad behaviors,” added clinician D.

Allowing the sex offender time to take the first step to getting help was the second recommended method. Two clinicians believed that prior to being able to change deviant sexual behaviors of sex offenders, the sex offenders must first want to change the behaviors. Clinician E explained, “a lot of the times, the sex offenders are so used to the behavior that they do not want to change their ways or do not see a need for change.” “Without their desire to change, there is nothing anyone can do,” added clinician E. In addition, clinician C stated, “when they are ready to make these changes, then they are ready to take responsibility for what they have done.”
Chapter 5

CONCLUSION

Introduction

This chapter includes the major findings of the study, followed by a summary of literature review, implications for social work practice, recommendation for future research, and study of limitation.

Summary of Findings

Overall, findings from the study concluded that participants perceived cognitive behavioral therapy to be an effective method in treating the behavioral problems of male adolescent sex offenders. Although studies from the literature may have suggested that cognitive behavioral therapy is not a hundred percent effective in treating sexual deviancy, many of the participants strongly agreed that cognitive behavioral therapy could help lower the chances of sexual re-offending and help deal with behavioral issues of male adolescent sex offenders. For instance, one participant stated, “cognitive behavioral therapy encompasses a variety of techniques that can be used primarily for dealing with thinking and behavioral domains.” According to the National Association of Cognitive Behavioral Therapy (2009), cognitive behavioral therapy is effective in helping people make emotional and behavioral changes because it consists of a variety of approaches such as: rational emotive behavior therapy, rational behavior therapy, rational living therapy, cognitive therapy and dialectic behavior therapy; therefore, there are several techniques in cognitive behavioral therapy that treatment providers can use to address the behavioral problems of male adolescent sex offenders.
Addressing and redirecting distorted thoughts of the sex offender was also a significant finding in the study. Many participants greatly believed that distorted thoughts of male adolescent sex offenders play a vital role in how the sex offenders feel and behave. For instance, as one participant puts it, “distortions have to be present in order for the sex offenders to commit the crimes they have committed.” This significant finding is congruent to the research in the literature reviews. Existing literature reflects that cognitive distortions guide the processes of perceptions and interpretation of information for many sex offenders. It is likely that many sex offenders will distort information to fit their beliefs and use it to rationalize deviant behaviors. Hence, as time progresses, these distorted thoughts can become actual beliefs of the sex offender, where it leads the sex offender to believe the deviant behavior to be self-serving.

Helping the male adolescent sex offender identify and understand behavior patterns was another significant finding from the study. Many participants perceived the idea that since male adolescent sex offenders are accustomed to behaving in a certain manner; they failed to recognize the negatives of their deviant behaviors. Existing literature concerning this topic also expressed the importance of understanding behavior patterns of sex offenders. Marshall, Anderson, and Fernandez (1999) reported that behavior patterns can provide useful insights about the sex offender’s triggers, thinking patterns, and coping mechanisms. Since many of these youth are known to have experienced abuse in their history, it is possible that these youths associate their own personal experiences with abuse and have maladaptive ways of dealing with their
problems. Thus, understanding the behavior patterns of the sex offender is a great insight to understanding why sex offenders behave the way they do.

Summary of Literature Review

Treatment for sex offenders is very complex. Like adult sex offenders, adolescent sex offenders are just as difficult to treat. They are a diverse group and many of them come from an abusive and violent background, where experiences of abused and violence are still fresh in their mind. Treatments for male adolescent sex offenders involve more than just helping male adolescent sex offenders change deviant behaviors. Treatment providers would also have to deal with life experiences and other contributing factors that led them to be able to commit sexual deviant acts.

From my literature review, the research found that many male adolescent sex offenders experienced similar behavioral problems, which included low self esteem, cognitive distortions, lack empathy towards others, poor social skills, and using denial and minimization to escape responsibility of their crime. Studies from the literature reviews pointed out that these behavior problems are more common among male adolescent sex offenders than other non-sexual offenders. In addition, these behaviors are also known to contribute to the sex offender’s ability to sexually victimize other individuals. For example, such behaviors contribute in a way where it is used by the sex offender to rationalize sadistic acts or to help them continue abusing others.

The literature also suggested that many of these behavioral problems were developed due to the offender’s environmental situations and other contributing factors. Many of them are known to come from dysfunctional family environments and have poor
relationships with their family. Unlike other adolescents, many male adolescent sex offenders are known to have a history of being sexually abused or have experienced some form of abused prior to their sexual offenses. Thus, one can say that, due to previous experience of abuse, many sex offenders could be sexually acting out in response to the way they were abused by others.

**Implications for Social Work**

*Macro.* The sex offender population is very diverse. The researcher felt that in order to properly assist these youths, there should be social policies that require correctional and treatment programs to separately rehabilitate adolescents from adult sex offenders. Even though there are treatment programs available to separately treat adolescent sex offenders from adult sex offenders, there are no laws to reinforce such practice. For example, in correctional facilities, where youth sex offenders are placed with adult sex offenders, youth sex offenders are often placed in the same rehabilitation program as adult sex offenders.

This researcher hoped that with the information of the study, lawmakers could take into consideration that adult and adolescent sex offenders function at different levels. Unlike adult sex offenders, many adolescent sex offenders have not yet completed their developmental stages. They are still undergoing physical and puberty changes. They are still transitioning from childhood to adolescence and are still easily influenced by others. Thus, there should be separate treatment programs for adolescent and adult sex offenders, so treatment providers could better meet the different needs of adolescent sex offenders.
Micro. In the field of social work, it is essential that social workers understand how to work with male adolescent sex offenders. Often due to the nature of the crime, many social workers find it difficult to work this population. Information from this research would help social workers to obtain a better perspective about adolescent sex offenders. For instance, instead of seeing them as a sex offender, information from the research can help social workers to see these adolescents from a behavioral standpoint. In addition, not only will the information from the research provide useful insight to social workers, the information can help social workers to be more effective in providing therapeutic interventions to male adolescent sex offenders.

Recommendations for Future Research

For future research, it is recommended that other therapy models be included in the study questions. Although other therapy models were brought up by a few of the participants, the researcher felt that with the inclusion of other therapy models in the studies, it would allowed participants to further assess the effectiveness of cognitive behavioral therapy, in comparison to other therapy models. In addition, with such comparison, it can provide helpful insight of how other therapy models are used to address behavioral issues of male adolescent sex offenders.

Limitations of Study

The research method utilized for this study was a limitation factor for this study. Since this study was a qualitative study, it did not focus on numerical data. In addition, there is a concern for external validity of the study. Although there were in-depth
questions in the study, it is possible that the results found in the study may not fully represent the entire population of treatment providers.
APPENDIX A

Study Questionnaire
Study Questionnaire

Instructions: Please answer the following questions to the best of your knowledge. Only volunteer answers you are willing to share about yourself and your perception on Cognitive Behavioral Therapy.

1. As a social work clinician, what therapy models do you prescribe to?

2. What therapy model do you prescribe to when working with male adolescent sexual offenders?

3. How long have you been counseling male adolescent sexual offenders?

4. How long have you use Cognitive Behavioral Therapy in treating male adolescent sexual offenders?

5. Where did you receive your training on Cognitive Behavioral Therapy?

6. As a clinicians, who works with male adolescent sexual offenders, are there techniques in Cognitive Behavioral Therapy that can help the offenders to obtain healthy relationships with peers?

   Please explain your answer. If “Yes,” please describe some techniques and how they help. If “No,” please describe why no techniques can help.

7. Are there techniques in Cognitive Behavioral Therapy that can help the male adolescent sexual offenders to obtain healthy relationships with family (i.e. parents and siblings)?

   Please explain your answer. If “Yes,” please describe some techniques and how they help. If “No,” please describe how or why no techniques can help

8. Are there any techniques in Cognitive Behavioral Therapy that can help male adolescent sexual offenders to accept responsibility of their sexual crimes?

   If Yes, describe some techniques and explain how they help male adolescent sexual offender to accept responsibility of their sexual crimes?

   If No, explain why there are no techniques that can help male adolescent sexual offender to accept responsibility of their sexual crimes?

9. Often in the counseling, when male adolescent sexual offenders are confronted about their sexual crime, they may minimize or deny their part in sexual crime. As a counselor,
are there any techniques in Cognitive Behavioral Therapy that can help you to change the way male adolescent sexual offenders minimize or deny their part in sexual crime?

If Yes, please explain. If No, please explain.

10. Are there any techniques in Cognitive Behavioral Therapy that can help change “thinking errors” among male adolescent sexual offenders?

If Yes, please explain how Cognitive Behavioral Therapy can help change thinking errors?

If No, please explain why Cognitive Behavioral Therapy cannot help change thinking errors of male adolescent sexual offenders?

11. Do you feel Cognitive Behavioral Therapy can help improve low self-esteem in adolescent male sex offenders?

If Yes, please explain how. If No, please explain why it cannot.

12. As a counselor, do you feel Cognitive Behavioral Therapy would effectively help male adolescent sexual offender clients with the ability to recognize and explore emotions of their sexual victims?

If Yes, please explain. If No, please explain.

13. Do you feel Cognitive Behavioral Therapy would effectively help male adolescent sexual offenders to develop empathy towards their victims?

If Yes, please explain how it can help. If No, please explain why it cannot.

14. Do you feel Cognitive Behavioral Therapy would effectively help male adolescent sexual offenders to develop empathy towards other people?

If Yes, please explain how it can help. If No, please explain why it cannot.

15. Do you feel Cognitive Behavioral Therapy would effectively help male adolescent sexual offenders to change sexual deviant thoughts?

If Yes, please explain how it can help. If No, please explain why it cannot.

16. Do you feel Cognitive Behavioral Therapy would effectively help male adolescent sexual offenders to address sexual deviant behaviors?
If Yes, please explain how it can help. If No, please explain why it cannot.
APPENDIX B

Consent Form
Consent Form to Participate in a Research Study

TITLE: Perceptions on the Use of Cognitive Behavioral Therapy In Treating Adolescent Sex Offender

INVESTIGATOR: Neng Her, MSW II Social Work Student

Purpose: To evaluate the perceptions social work clinicians have on the effectiveness of using Cognitive Behavioral Therapy in treating sexual and deviant behaviors. This research will be conducted by Neng Her, a second year Master of Social Work student at Sacramento State University.

I want to let you know that your participation in this research study is completely voluntarily. Please note that due to volunteering, you may decline participation in this study at any time during this process without any consequences.

Your participation in this study includes completing the attached questionnaire, which would take approximately 15-20 minutes of your time. The questions are constructed in a way to assure no discomfort or risks other than what you might experience in a day-to-day experience of completing a survey. You do not have to answer any question that you do not feel comfortable answering.

All the information collected through the survey will be kept confidential at all times except for the reporting of thematic content that will result from the compiled findings of the study without any reference to any identifying information.

Benefits: There are no direct personal benefits from participating in this study. No inducement of any kind will be offered to participants. It is hoped that the findings of this studied will be used to make future recommendations to better improve services to address the needs of male adolescent sex offenders who undergoes sexual offending treatment and services.

Risks: It is believe that this research project has no risk for you. However if any of the questions in this survey or evoke any discomfort, contact Psychological Counseling Service at Sacramento State University, (916) 278-6416, located on the second floor of the Student Health Center, located on the second floor of the Student Health Center, 6000 J Street, Sacramento, CA 95819-6034.

If you have any further questions about this research, you may contact me at (209) 373-7047 or by email: neng-her@hotmail.com or my Thesis Advisor, Dr. Serge Lee at (916) 278-5820 or by email: leesc@csus.edu

Your signature below indicates that you have read this informed consent document and agreed to participate in this study.

________________________ Signature    ______________ Date
APPENDIX C

Human Subject Approval Letter
TO:  NengHer  
FROM: Committee for the Protection of Human Subjects

RE: YOUR RECENT HUMAN SUBJECTS APPLICATION

We are writing on behalf of the Committee for the Protection of Human Subjects from the Division of Social Work. Your proposed study, "Perceptions on the Use of Cognitive Behavioral Therapy in Treating Adolescent Sex Offenders."

_X_ approved as _____ EXEMPT  _X_ NORISK  _____ MINIMAL RISK.

Your human subjects approval number is: 09-10-039. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Professors: Teiahsha Bankhead, Chrys Barranti, Andy Bein, Joyce Burris, Maria Dinis, Susan Eggman, Serge Lee, Kisun Nam, Sue Taylor
REFERENCES


