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Using Existential-Humanistic Approaches in Counseling Adolescents With Inappropriate Sexual Behaviors

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Adolescent sexual acting out behaviors frequently occur in the context of comorbid issues, such as depression, trauma, behavioral disorders, and developmental deficits, thus rendering any single treatment modality less effective. Augmenting traditional treatment with an existential-humanistic perspective enables counselors to more effectively address a host of common co-occurring conditions.

Adolescents who exhibit inappropriate sexual behavior frequently have coexisting mental health problems that compound the decisions regarding selection of treatment approaches. The full extent of the client's emotional problems must be assessed. It is important to consider not only the sexually offending behaviors of the adolescent but also any associated mental health or emotional problems that may be present. Depression, trauma, behavioral disorders and developmental deficits occur on a fairly consistent basis in sexually acting out adolescents (Baker & White, 2002; Gerardin & Thibaud, 2004; Gray et al., 2003; Lambie & Seymour, 2006; Metz & Sawyer, 2004; Rich, 2003). A cognitive-behavioral approach has traditionally been used to treat inappropriate sexual behaviors, but the use of this approach alone may not adequately address common coexisting conditions (Rich, 2003). The addition of existential-humanistic (E-H) interventions may be helpful in treating the conditions that often accompany sexual acting out behaviors. Counselors should consider adopting a combination of therapeutic approaches to more effectively treat adolescents presenting with these problems.

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The purpose of this study is to review the literature and present adjuncts to existing treatment protocols for adolescents with inappropriate sexual

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behaviors using an E-H framework. Consideration is given to those components of the adolescent's development and environment that contribute to her or his acting out behaviors and existential anxieties (e.g., death, freedom, isolation, meaninglessness; Yalom, 1980).

COMMON CHARACTERISTICS OF ADOLESCENT SEX OFFENDERS

The literature recognizes two distinct types of adolescent sex offenders: (a) those who offend against peers or adults and (b) those who assault children. [AU3] The first type of offender predominantly assaults females and strangers and frequently operates in public areas (e.g., 15% of these cases in the United States occur in a school environment; Hunter, 2000). The latter group tends to be male offenders who prefer male victims (Rogers & Tremain, 1984). Most of these child-related offenses occur in the victim's home, particularly during child care activities, and in 90% of cases, the victim is known by the perpetrator (Ryan, 1991). The average age of the victim is 7 to 8 years old, and the majority of the victims are related to the offender (Ryan, 1991). Becker, Kaplan, and Cunningham-Rathner (1986) reported that almost half of sibling offenders demonstrate nonsibling paraphilic behavior. Adolescent sex offenders also generally have a history of nonsexual criminal offenses and a high incidence of antisocial behaviors and conduct disorders (Hunter, 2000).

Ninety percent of adolescent sex offenders are male and approximate the general population in terms of ethnicity, religious preference, and geographic location. The median age of reported offenders is between 14 and 15 years old (Utah Task Force of the Utah Network on Juveniles Offending Sexually, 1996).

The number of female sex offenders is increasing, and females who have experienced more severe victimization histories report that the age of onset of their sexual offending behavior is often even earlier than that of males [AU4] (Gray et al., 2003; Mathews, Hunter, & Vuz, 1997). There is evidence of sexual aggression in children as young as 3 and 4 years old, with the usual age of onset being between 6 and 9 years old for adolescent offenders in general (Araji, 1997).

There are a number of characteristics that are common to the adolescent sex offender population. The Appendix lists the common characteristics that appear regularly in the clinical records of adolescents who are in treatment for [AU5] sexually inappropriate behaviors. These characteristics are considered from three distinct, although interrelated, perspectives: (a) characteristic symptoms, (b) sociocultural characteristics, and (c) environmental characteristics.

Characteristic Symptoms

Becker et al. (1986) studied the incidence of depressive symptoms in adolescent sex offenders with a history of abuse (sexual, physical, or emotional).

They found that 42% of adolescent sex offenders experienced major depressive symptoms, as measured by the Beck Depression Inventory. The respondents' mean score was 2 times higher than that of a random sample of nonoffending adolescents.

Along the same lines, Millard and Hagan (1996) and Apsche, Evile, and Murphy (2004) found recurring themes of emotional disturbance in their study of adolescents in two sex offender treatment programs. These included diagnoses of post-traumatic stress disorder and personality disorders, including borderline personality disorder, narcissistic personality disorder, antisocial personality disorder, and histrionic personality disorder. Their study revealed that treatment participants consistently shared specific personality traits, life experiences and perceptions. Treatment participants reported their engagement in aggressive and self-destructive behaviors and additionally reported childhood experiences marked by physical and emotional abuse and neglect, which was often related to substance abuse in the family. Few of these participants reported exposure to positive male role models (Apsche et al., 2004). The victims of their aggression encompassed a broad spectrum, including family members, acquaintances, and strangers, and accounted for both genders and all ages (Millard & Hagan, 1996).

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Many adolescent sex offenders are also victims of sexual abuse, ranging from introduction to pornography and explicit sex acts at an early age to rape and sodomy (Gerardin & Thibaud, 2004; Gray et al., 2003; Rich, 2003). In these cases, counselors must help offenders work through their issues of victimization (Muster, 1992). Apsche et al. (2004) noted that 98% of the residents in one treatment program reported a prior history of victimization including sexual, physical, and/or emotional abuse(s). The authors also reported that there was a history of nonsexual delinquency and generalized antisocial tendencies found in the backgrounds of adolescents who engaged in aggressive sexual offending behaviors.

Sociocultural Characteristics

Thus far, more similarities among adolescent sex offenders have been documented than culturally derived differences. According to van Deurzen (1998), "All cultures are built around rules for sex, aggression, and affiliation" (p. 136). One factor that adolescent sex offenders of all racial and ethnic backgrounds have in common is that they have broken these rules. Further commonalities include a lack of assertiveness, poor social skills, and inadequate impulse control (Smith, Monastersky, & Deisher, 1987), all of which contribute to further isolation from their age-appropriate peers. Sloan and Schafer (2001) indicated that 22.6% of adolescent sex offenders lacked the knowledge and skills to choose prosocial behavior and demonstrated low levels of shame or guilt. In addition, they had cognitive and skill deficits related to anger management, empathy, sexuality, and clarification of appropriate gender roles.

This population is further characterized by "an undercurrent of misinformation and strange beliefs and attitudes" (Lakey, 1994, p. 757) contributing to the faulty logic and poor judgment underlying their inappropriate sexual behaviors. For example, Millard and Hagan's (1996) research noted that participants depersonalized their victims and viewed them as objects, not as human beings. Adolescent sex offenders rarely feel remorse for their actions, consistently deny their offenses, and tend to minimize the acts and the damage they inflict on their victims, their victims' families, and the community in general (Gerardin & Thibaud, 2004; Rich, 2003). More than 60% of adolescent sexual offenses involve some form of penetration entailing the use of power against the victim (Ryan, 1991). In a study of 1,600 adolescent sex offenders, Ryan and Miyoshi (1996) found that approximately 42% of the respondents perceived sex as a way to feel power and control, to hurt or punish, or even to dissipate their own anger.

The sociocultural factors described here are common to most adolescent sex offenders, regardless of cultural or ethnic identity. However, as with any individual or group receiving services, conceptualization and treatment should be grounded in the cultural context of the client (Lambie & Seymour, 2006; Liu & Clay, 2002; Wintersteen, Mensinger, & Diamond, 2005). The life experiences (e.g., family system) and worldview of these individuals certainly affect their developmental process and their behaviors.

Environmental Characteristics

A common and critical component of the adolescent sex offender's profile is the family system's influence. When young sex offenders were compared with nonoffending adolescents, the families of sex offenders were found to be more dysfunctional (with frequent interparental violence) and younger children evidenced significantly higher levels of social isolation and reported more stressful life events (Silovsky & Niec, 2002). Monastersky and Smith (1985) concluded that studies are virtually unanimous in their findings that the family is a crucial influence in the development and/or manifestation of the offending behaviors. The characteristics of the family environment of offenders have been described to include an unstable or rigid environment, sexual and depressive pathology within a parent, exposure to sexual interactions between parents or parental surrogates, family violence, and parental loss or separation (Gerardin & Thibaud, 2004; Gray et al., 2003; Monastersky & Smith, 1985; Rich, 2003).

A number of family influences have been identified as contributors to adolescent sex offending. Among them, and of particular importance, is exposure to aggressive role models; maltreatment experiences; exposure to pornography; and exposure to substance abuse, sexual abuse (Longo, 1982), and physical abuse (Johnson & Shrier, 1985). Several studies have reported significantly more marital discord in the family, parental rejection, physical discipline, negative family atmosphere, and general dissatisfaction

with family relationships in sibling-incest offenders (Fehrenbach, Smith, & Monastersky, 1986; Rich, 2004; Sloan & Schafer, 2001; Smith et al., 1987; Worling, 1995).

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TRADITIONAL TREATMENT APPROACHES

Early intervention is considered critical to avoid progression of sexual offending behaviors into the adulthood of the adolescent offender (Debelle, Ward, Burnham, Jamieson, & Ginty, 1993). The lack of early intervention has been hypothesized to result in the adolescent offender moving her or his deviant offending characteristics from their adolescent context into that of an adult offender (Knopp, 1985). This hypothesis has been supported through serial cross-sectional studies from adolescent to adult offenders and by retrospective studies that demonstrate that nearly 50% of adult offenders had deviant arousal patterns by the age of 15 years (Abel, Mittleman, & Becker, 1985).

Traditionally, a cognitive-behavioral approach to treatment has been the primary approach in treating adolescent sex offenders (Gerardin & Thibaud, 2004; Rich, 2003). Gerardin and Thibaud and Rich (2003) identified juvenile sexual offender treatment goals: (a) gain control over deviant sexual behavior, (b) teach impulse control, (c) correct distorted beliefs about normal sexual behavior, (d) develop relapse prevention strategies, and (e) increase appropriate social interactions for the adolescent. This is typically facilitated through a multidisciplinary treatment approach using cognitive-behavioral approaches via group, individual, and family counseling, as well as psychoeducational training, and when appropriate, pharmacological interventions (Becker & Hunter, 1997; Gerardin & Thibaud, 2004, Rich, 2003).

The first step in treatment is to break the denial and minimization and to help the adolescent accept responsibility for her or his behavior (Stevenson, Castillo, & Sefarbi, 1989). Other objectives include sex education, correction of cognitive distortions, reduction of deviant arousal, enhancement of impulse and anger control, improvement of victim empathy, development of individual motivation, and improvement of the knowledge of warning signals leading to offending behaviors. These adolescents must also be helped with the acquisition of communication skills and social competency (Becker & Hunter, 1997). Rich (2003), supported by Sloan and Schafer's (2001) research, pointed out that the sexual-offender-specific treatment strategies should include the following tasks:

> (1) understanding sexual motivation and cause; (2) acquisition of psychoeducational and cognitive-behavioral concepts; (3) development of self concept and personal identity; (4) disclosures of sexual offenses; (5) development of social skills; (6) provision of family therapy and resolution of family factors; (7) victim awareness and clarification; (8) relapse prevention planning; (9) diagnosis and resolution of comorbid conditions; (10) provision of psychopharmacology (where necessary); and (11) appropriate and adequate education. (pp. 253–254)

Rich (2003) also iterated that a multimodal approach is necessary in order to use a variety of interventions, including family systems therapy, that may address the diverse needs of the adolescent offender.

The family counseling component is a crucial but difficult component in the treatment of adolescent sex offenders, because family members often resist and prefer that treatment focuses only on the offending child. The goals of family treatment are to assess family dynamics, educate parents so that external controls on the child's behavior are provided, and to assure the safety of any other children in the home and the community (Elliot & Smiljanich, 1994). Family counseling should also promote positive parenting behaviors and assist in reintegrating the offender into the family (Davis & Leitenberg, 1987). Adequate family support has also been reported to reduce recidivism (Rasmussen, 1999; Worling & Curwen, 2000).

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RECOMMENDATIONS FOR USING E-H COUNSELING APPROACHES

On the basis of our review of the literature, the four co-occurring issues that are both more common and more relevant to the E-H approach are depression (Gerardin & Thibaud, 2004), trauma (Gerardin & Thibaud, 2004; Gray et al., 2003; Rich, 2003), development of relationships (Gerardin & Thibaud, 2004; Gray et al., 2003; Rich, 2003), and identity development (Fehrenbach et al., 1986; Metz & Sawyer, 2004; Sloan & Schafer, 2001; Smith et al., 1987). In accordance with Rich's (2003) recommendation to use multimodal approaches in treating co-occurring conditions, potential E-H approaches to these issues are discussed in the following sections.

Depression

Depression is a consistent diagnosis related to adolescents with inappropriate sexual behaviors (Becker & Hunter, 1997; Gerardin & Thibaud, 2004; Rich, 2003). Many adolescent sex offenders, especially those with victimization histories (Silovsky & Niec, 2002), show evidence of depression, deficits in self-esteem, and deficits in social competence (Myers, Burgess, & Nelson, 1998). Although depression is often described as the kind of problem that responds most effectively to medications and individual counseling, Maxman and Ward (1995) pointed out that family counselors should consistently approach treatment of depression holistically through adequate understanding of the family context of the presenting symptoms. This potentially includes many existential issues and is consistent with the general research consensus related to the family system's impact on the adolescent offender.

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From an existential perspective, depression is often a result of feeling that one cannot cope with what happens in one's life (Arnold-Baker, 2005). The person who is depressed "can see no future, and is confronted with a

[AU10] guilty past and a meaningless present" (Arnold-Baker, 2005, p. 192). Such a narrow, limited view of the world, and one's place in it, prevents one from becoming the person he or she has the potential to become. Jaspers (as cited in Arnold-Baker, 2005) used the phrase "disturbance of vital events" to describe the obstruction to development experienced by the depressed [AU11] person. According to Heidegger (as cited in Arnold-Baker, 2005), moods such as depression emerge out of one's interaction with the world. Therefore, one comes out of a depressed mood by interacting differently with the world. From a traditional cognitive-behavioral approach, the focus of treatment for depression is on faulty or illogical thoughts. Existentialists take a more holistic view of depression and encourage clients to take a look at the whole of their lives, examining how they live and how they have responded to events in their lives.

Trauma

With respect to co-occurring trauma, many adolescent sex offenders have experienced some form of traumatic experience within the family, contributing to their depressive symptoms (Gerardin & Thibaud, 2004; Gray et al., 2003; Rich, 2003). An exploration of spiritual issues, particularly in relationship to meaning making, may be a source of acceptance for those who feel traumatized and stigmatized and provides an avenue for existential healing. Spirituality is one component of existential development in which these adolescents can seek healing in the paradoxes of finding power in perceived powerlessness and strength in perceived weakness (Burke & Miller, 1996); thus, these individuals are allowed to pursue self-empowerment through awareness and acceptance of the traumatic experiences, [AU12] which may be an initiator to spiritual growth. Connecting the individual to the sources of the trauma, and the understanding that the trauma events were out of her or his control, provides a source of potential power over the effects of that trauma on the individual. The young offender struggles with numerous experiential issues (see the Appendix) that are perceived as beyond the control of the offender, thus initiating a level of helplessness and hopelessness. However, when her or his circumstances are analyzed, a clear picture of resilience evolves related to those functional strengths that the client possesses. These strengths, through the therapeutic relationship, become a vehicle connecting the individual to a source of power that has been previously unknown.

Relationship Development

With regard to development of relationships, Hanna, Hanna, and Keys (1999) discussed the crucial nature of developing a therapeutic relationship with the adolescent sex offender in order to effect beneficial change. The therapeutic relationship, including the development of empathy for

the adolescent, is a key intervention strategy that is consistent with E-H approaches to counseling. Yalom (1980) observed that healing comes from the relationship, and these adolescents tend to be deprived of appropriate role models who demonstrate healthy interactions and relationships with others (Hanna et al., 1999). Thus, a therapeutic approach that facilitates modeling of genuine and authentic relationships may benefit the adolescent in the development of empathy and social competence.

Self-absorption is a prominent theme of the oppositional-defiant adolescent, presenting the adolescent with confusion related to developing and maintaining appropriate, similar age relationships (Sherwood, 1990). Adolescent offenders are likely engaged in what Buber called the "I–It relationship" (Tantam & van Deurzen, 2005). Such relationships are by their nature exploitive and exist to serve the purpose of the "I" and at the expense of the objectified person, the "It." A side effect for the offender is that treating others as objects also results in becoming an object. The existential therapist's goal is to help the client develop relationships that Buber described as "I–Thou," in which both participants are genuine and equal and the relationship exists for mutual benefit. Many of the offending youth have themselves been the objectified It and subjugated to some other offender's need for immediate gratification. Learning to develop relationships in which they are neither the objects nor perpetrators of I–It relationships may occur within the context of the therapeutic relationship. The development of an appropriate therapeutic relationship, which necessarily includes genuine and unpretentious demonstration of deep respect toward the adolescent, provides a platform for establishing appropriate social boundaries typically lacking in the adolescent sex offender (Hanna et al., 1999). The relationship reinforces appropriate boundaries and the attributes of a healthy relationship, which can be experienced within the safe space of the therapeutic environment.

Identity Development

A struggle affecting both adolescent sex offenders and adolescents in general is identity formation. This is a critical part of adolescent development and is viewed as the interaction between the adolescent's psychological interior and her or his sociocultural environment (Bosma, Graafsma, Grotevant, & de Levita, 1994; Erikson, 1968). Adamson, Hartman, and Lyxell (1999) hypothesized that a person's existential questions are intrinsically linked to her or his identity and thus may be viewed as reflections of the identity formation process. Existential counseling focuses on authenticity, and this recognition of the true self is an important component of the identity search that is part of the adolescent journey. Kirby (2005) described the existential perspective on development articulated by Kierkegaard. In contrast to the traditional focus on linear stages of development, this focus is on three basic modes of existence including the aesthetic, the ethical, and the religious or

spiritual (Kirby, 2004). These modes are particularly relevant to the adolescent sex offender's struggle with identity formation and are described by Kirby (2004) as follows: The aesthetic mode includes an impulse toward immediate self-gratification, the ethical mode deals with deferred gratification, and the religious or spiritual mode offers a source of solace and direction in an unstable and insecure world. Persons living in the ethical and/or spiritual modes resist the impulse to act immediately to gratify their desires and instead make choices based on a commitment to a moral code of conduct. This is certainly a dilemma that the adolescent sex offender faces in confronting the discontinuation of her or his offending behaviors. This identity search, as highlighted in Hartman's (1986) research, demonstrates that an adolescent's existential journey is partially occupied with trying to control her or his behaviors and interactions with other people, which is a critical component of assisting the adolescent sex offender in adopting and maintaining appropriate sexual behaviors. Thus, identity development can be considered as a process balancing the intra- and interpersonal parts of the adolescent's "identity" and assisting in maintaining congruity between the self and others (Adamson et al., 1999).

[AU13]

Alcoholics Anonymous offered an example of the use of existential well-being to moderate psychological challenges and develop a healthy identity:

> When we experience positive spirituality, we tend to view ourselves as lovable, capable, and deserving. We allow others to enter and enrich our lives without feeling a need to manipulate, use, or abuse them. We find our world to be a largely safe place wherein we are able to develop toward our full potential. Life has positive meaning and purpose, and many of us find a loving God who guides our lives, shares our joys, and sustains us when we are in pain or in need. When positive spirituality dominates our lives, we have no need to alter our moods with addictive substances or behaviors. (as cited in Warfield & Goldstein, 1996, p. 199)

Warfield and Goldstein observed that the passage seems to offer an opportunity for individuals, with a sense of existential well-being, to steer their issues of betrayal, powerlessness, and stigmatization away from an internalization manifested as self-blame, alienation, shame, and aversion, toward developing a more positive identity.

Adolescent sex offenders consistently demonstrate cognitive distortions that are seen by counselors as thinking errors and distorted beliefs about normal sexual behavior and social interactions (Becker & Hunter, 1997; Gerardin & Thibaud, 2004; Rich, 2003). One of the first steps in treatment is to break down denial and minimization that result in a distorted concept of the outcome of adolescents' offending behaviors on others (Stevenson et al., 1989). Ultimately, this process is designed to promote an acceptance of responsibility by the adolescent for her or his behavior. The existentialist therapist would see this as an opportunity to investigate with the adolescent the source and nature of these distorted beliefs and thinking errors through an "in the moment" examination of the adolescent's experience

(e.g., exposure to family models who exhibit distorted beliefs) that brought her or him to those beliefs (see the Appendix).

With the acknowledged level of the family system influence on the adolescent's development, one existential approach to deal with environmental issues was noted by Viktor Frankl (1969) in his dimensional ontology concept. Frankl (1969) hypothesized that clinicians need to examine the existential family issues of the *must*, *can*, and *ought* levels in the treatment process that directly relate to "faulty thinking," which is common in adolescent sex offenders. In this dimensional ontology, Frankl (1969) referred to those patterns of family life that can be affected through will, freedom, responsibility, and choice and are reactive to learned patterns of family interaction that can be changed. In other words, the family system facilitates certain faulty patterns that the adolescent adopts and subsequently must be considered for clinical remediation. Such an existential journey can assist counselors and their clients in understanding how patterns of family living often result in the development of the presenting issues that the adolescent brings to treatment (Frankl, 1955, 1969).

DISCUSSION

The goal of E-H therapists is to increase the existential well-being of the client by focusing on increasing respect for the uniqueness of the individual and gaining a sense of commitment toward growth and a sense that there is meaning in their existence. When adolescents are able to explore their life experiences, including family roles, trauma experiences, beliefs, fears, needs, and defenses, and understand how these factors may have affected their life experiences, they have an opportunity to develop an identity along with healthy coping mechanisms and appropriate behaviors (Fehrenbach et al., 1986; Feinauer, Middleton, & Hilton, 2003; Metz & Sawyer, 2004; Sloan & Schafer, 2001; Smith et al., 1987).

In this review, we examined those symptomatic, sociocultural, and environmental components that have contributed to the course of the adolescent sex offender's journey. In addition, we reviewed traditional clinical approaches to working with this population in order to prevent future offending behaviors and allow the adolescent to develop a level of normalcy in her or his life. Because E-H processes do not naturally lend themselves to systematic quantitative analyses, the empirical support for the approaches we recommend is relatively modest (Mendelowitz & Schneider, 2008; Walsh & McElwain, 2002). However, Mendelowitz and Schneider noted that there is growing quantitative and qualitative support for the therapeutic effectiveness of existential principles. Support for our emphasis on factors including the therapeutic relationship and the client's self-reflective process of meaning making is reflected in "common factors" research (Hubble, Duncan, & Miller, 1999; Ottens & Klein, 2005). More specifically, Hubble et al. (1999) identified four common factors and their relative contribution to positive treatment outcomes: (a) client-extratherapeutic factors

(40%); (b) relationship factors (30%); (c) placebo, hope, and expectancy factors (15%); and (d) models and techniques factors (15%). The common factors model supports our contention that the therapeutic relationship and contributions from the client contribute a considerable amount to positive outcomes. In addition, there is ample support for the significant contribution of the therapeutic alliance (Beutler, Machado, & Neufeldt, 1994; Lambert, Orlinsky, Grawe, & Parks, 1994; Shapiro & Bergin, 1986; Wampold, 2001). [AU14]

Furthermore, qualitative research supports the therapeutic benefits of a self-reflective process of meaning making (Bohart & Tallman, 1999; Rennie, 1994; Watson & Rennie, 1994). Additional studies support the notion that exploring the client's existential guilt, as we recommended for treating depression, can lead to identity transformation through the reconstruction of meaning (Clarke, 1989; Fischer, 1989; Greenberg, Elliott, & Lietaer, 1994). Collectively, these findings support E-H counseling in general and support the belief that the client is a primary agent of change in the therapeutic alliance. We encourage counselors working with this adolescent population to adopt a scientist-practitioner model in order to empirically test the effectiveness of our recommended approaches.

CONCLUSION

The current article presents literature indicating that numerous factors play a part in the development of sexually inappropriate behaviors in adolescents and that not all of these factors can be adequately treated using a single approach to treatment. A combination of approaches is required to address the multiple problems inherent in this population (Rich, 2003). Each treatment approach must be suited to the age and social context of the adolescent. A critical component in this process will necessarily include both the adolescent's and family's acceptance of and engagement in the treatment process. Ideally, the treatment of adolescents and their families will include behavioral counseling, family counseling, and psychiatric and psychosocial interventions, while interjecting E-H approaches into those areas that more readily respond to aspects of relationship, identity development, personal responsibility, and self-concept.

Existentialist and humanistic therapies offer opportunities to approach many of the characteristic symptoms and sociocultural and environmental characteristics including depression, trauma, social competency, cognitive distortions, identity development, and developmental deficits related to the family environment. [AU15] These issues are approachable through existentialist and humanistic concepts that allow clients to investigate developing strategies to take control of their behaviors, search out the true foundations of their emotional disturbances, and to practice appropriate prosocial behaviors in the safe environment of the therapeutic relationship. This process of building a genuine therapeutic relationship opens the door for modeling of appropriate interactional activities with others, which is a consistent deficit with adolescent sex offenders. This same process offers the adoles-

cent a much needed bridge for healthy identity development. A necessary component of this bridging process is the inclusion of the consideration of cultural differences in assessing, treating, and relationship development. Liu and Clay (2002) offered five steps to guide decision making when working with diverse children:

1. Evaluate which, if any, cultural aspects are relevant.
2. Determine the level of skills and information necessary for competent *treatment* and possible referral.
3. Determine how much, when, and how to incorporate cultural issues.
4. Examine potential *treatments* and understand the cultural assumptions of each.
5. Implement the *treatment* using cultural strengths. (p. 178)

In summary, there are numerous treatment approaches available to counselors when working with any client with an emotional disorder. It is incumbent upon counselors to exhaust all available opportunities to provide effective therapeutic interventions to the client. As demonstrated through a review of current research literature, E-H approaches to counseling offer additional tools to counselors for assisting those presenting issues that may not fit neatly into a single modality intervention process.

[AU16]

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APPENDIX

Common Characteristics of Adolescent Sex Offenders

Characteristic Symptoms	Sociocultural Characteristics	Environmental Characteristics
Depression	Dysfunctional families	Aggressive role models
Deficits in self-esteem	Inter-parental violence	Maltreatment experiences
Learning disabilities	Stressful life events	Exposure to pornography
Lack of impulse control	Social incompetence	Exposure to substance abuse
Cognitive distortions	Lack of assertiveness	Use of drugs and alcohol
Faulty perceptions and	Lack of social skills	Negative family atmosphere: unstable rigid
Thinking errors	Absence of sex education (Fehrenbach, et al., 1986; Rich, 2004; Sloan, & Schafer, 2001; Smith et al., 1987)	Sexual pathology of parent
Oppositional defiant and conduct disorder	Lack of remorse	Exposure to sexual interactions by parents and partners
Assaultive behaviors	Denial and minimization of offenses and behaviors	Family violence
Feelings of resentment	Lack of empathy	Trauma
Victims of sexual and/or physical abuse (Becker and Hunter, 1997; Gerardin & Thibaud, 2004; Rich, 2003)	Social isolation (Gerardin & Thibaud, 2004; Rich, 2003)	Parental loss, separation and rejection
Deficit of personal identity		Marital discord
Deficit of spiritual identity		Dissatisfaction with family relationships (Gerardin & Thibaud, 2004; Gray, et al., 2003; Rich, 2003)
No deficit in general intelligence (Fehrenbach, et al., 1986; Metz, & Sawyer, 2004; Sloan, & Schafer, 2001; Smith et al., 1987)		

♦ ♦ ♦

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