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Perspectives of young adult males who displayed harmful sexual behaviour during adolescence on motive and treatment

Cecilia Kjellgren

Department of Social Work, Linnaeus University, Växjö, Sweden

ABSTRACT

Few studies have examined the subjective experiences of young people following interventions for sexually abusive behaviour. To learn more about how this population experienced these interventions and how these interventions affect their adult life, 22 adult males (m = 22 years) who were assessed as teenagers (m = 15 years) for sexually abusing children or peers were interviewed, on average six years after the assessment of their offence. Three main themes were identified: something sexual happened (recalling memories of the sexual acts and motives of the behaviour), societal actions (interventions offered), and life has been affected (memories and feelings associated with the abuse still being present). Seven respondents (32%), who all had a cognitive disability, had sexually reoffended by follow-up. If the respondents received interventions that focused on their abusive behaviour, they were likely to find the interventions helpful. Interventions that did not address abusive behaviour, were perceived as less helpful for dealing with their behaviour, and the short- and long-term consequences associated with this behaviour. Respondents reported feelings of sadness and guilt associated with their sexually abusive behaviour and these feelings remained into adulthood. These findings suggest that interventions for this population need to address the individual needs of the adolescent as well as sexual behaviour problems. In addition, interventions should include opportunities for follow-up.

ARTICLE HISTORY

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KEYWORDS

Adolescents; sexually abusive behaviour; follow-up; young adults; interventions; cognitive disabilities

Introduction

According to recent prevalence studies of sexual victimisation experiences among adolescents, young people account for a large proportion of all sexual offenses. In a Swedish study of high school students (n = 3,432) (Priebe & Svedin, 2012), 25% of 18-year-old students reported that they had been sexually abused, half of them by an adolescent. In a Swiss national representative sample of 15-year-olds (n = 6,787), Mohler-Kuo et al. (2014) found that 40% of girls and 17% of boys had been victims of sexual abuse. More than half of the victims reported being abused by a juvenile. Pereda, Abad, and Guiller (2016) identified similar results for a Spanish adolescent population with a majority reporting being abused by juveniles. Finkelhor, Shattuck, Turner, and Hamby (2014) reported similar results in a prevalence study of sexual abuse and assault among 15-, 16-, and 17-year-olds in the US and juveniles committed half of the offenses. The rising awareness of sexual abuse committed by young people emphasises the importance of exploring how professionals interact with this population and the effectiveness of the interventions received.
Different risk factors associated with a harmful sexual behaviour have been suggested. Using meta-analysis, Seto and Lalumière (2010) compared adolescents who had history of non-sexual offences with adolescents who had a history of sexually abusive behaviour to identify risk factors specific to sexually abusive behaviours. The factors with the strongest association included atypical sexual interests and a sexual abuse history. Similarly, using a Swedish school-based population survey, Kjellgren, Priebe, Svedin, and Långström (2010) compared adolescents who had non-sexual conduct problems with adolescents who had a history of sexually coercive behaviour and identified sexually-related risk factors for the latter group including pro-rape cognitions and sexual preoccupation. In both these studies, sexual abuse history was prevalent among adolescents who had a history of harmful sexual behaviour. Although several studies have identified a link between being sexually abused and being sexually abusive among adolescents (Aebi et al., 2015; DeLisi, Kosloski, Vaughn, Caudill, & Trulson, 2014; Seto et al., 2010), few studies have explored the views of adolescents regarding their motives related to their sexually abusive behaviour.

A limited number of studies have evaluated the outcomes of interventions for young people who have sexually abused others. In an eight-year follow-up study, Borduin, Schaeffer, and Heilblum (2009) reported juveniles who received Multisystemic Therapy (MST) had a sexual abuse recidivism rate lower than juveniles who were required to participate in usual community service. Similarly, Worling, Littlejohn, and Bookalam (2010) in a 20-year follow-up study reported that adolescents who had committed sexual abuse were significantly less likely than comparisons to reoffend if they received specialised treatment, including themes like accountability for the offending, prevention plans, awareness of victim impact, and improving social relationships.

In a study that examined how sexually abusive adolescents experienced treatment programmes, Geary, Lambie, and Seymour (2011) found that these adolescents and their caregivers desired a client-centric treatment that included good pre-entry information, a quality client-therapist relationship, family involvement, and post-treatment support. In a study that focused on the post-treatment of adolescents exhibiting sexually harmful behaviours, Lambie and Price (2015) found that these adolescents would benefit from follow-up that included mentors and role models as these adolescents had a difficult time asking for help and ultimately transitioning back into their communities. Similarly, Slattery, Cherry, Swift, Tallon, and Doyle (2012) found that post-release changes in Irish juveniles sentenced for sexual offences were better maintained if interventions targeted criminogenic factors and sexual risk factors by providing follow-up monitoring that included families/partners and agencies. In a study of young male adults who had sexually abused others during adolescence, Ingevaldson, Goulding, and Tidefors (2016) found that these men struggled with intimacy, sexuality, and trust and used self-protective strategies to conceal their identification as sexual offenders in part because they felt ashamed of their past behaviours.

Different concepts of the life course perspective may be applied when the trajectory from adolescence to young adulthood is explored. Moffitt (1993) suggested that the anti-social behaviour can be adolescent-limited or life course persistent. Lussier, van den Berg, Bijleveld, and Hendriks (2012) identified two trajectories of juvenile sexual offending – adolescent-limited and high-rate slow desisters – in a retrospective and prospective longitudinal study that followed a sample of juveniles who had sexually offended (n = 498) from late childhood to adulthood. The majority (89.6%) of the sample was associated with an adolescent-limited trajectory where sexual offending was confined to the stage of adolescence. In follow-up studies, desistance from sexually abusive behaviour is the most likely path when adolescents become adults (e.g., Zimring, Piquero, & Jennings, 2007). Within the theoretical approach of life course (Elder, 1998), different concepts such as life events, transitions, and turning points may help illuminate how troubled adolescents change over time. Laub and Sampson (2001) referred to the concept of turning points as a potential event that could result in long-term changes in the direction of a pathway or trajectory. According to Sampson and Laub (2005), the mechanisms of desistance are consistent with the general idea of social control and they describe that turning points involve the following:
(1) a new situation that “knife off” the past from the present;
(2) new situations that provide both supervision and monitoring as well as new opportunities of social support and growth;
(3) new situations that change and structure routine activities; and
(4) new situations that provide the opportunity for identity transformation.

According to Sampson and Laub (1997), a turning point is not a single event but rather a process that unfolds over time. Furthermore, a turning point may be positive or negative because it represents an opportunity when life trajectories may be directed to more adaptive or maladaptive paths. These frameworks may be useful for understanding the transition points that might be experienced through the intervention process, and into young adulthood for adolescents who sexually abuse.

The present study

Research involving young adults who displayed harmful sexual behaviour during adolescence may inform practice as well as research on different perspectives on their further development and the service received, as some follow-up studies previously have demonstrated (e.g., Lambie & Price, 2015; Slattery et al., 2012). After the transition from adolescence into adulthood, individuals may reflect on a previous phase with increased maturity. A former client who displayed harmful behaviour probably has an ability to evaluate what components of treatment were helpful as well as perspectives that were overlooked in the service delivered. Additional knowledge on long-term effects in the lives of young adults can also be identified. This information cannot be identified without listening to the former clients.

This study explores how young adults remember their sexually abusive behaviour they engaged in during their adolescence, how this behaviour was disclosed, and how they experienced interventions. In addition, this study examines whether these young adults were experiencing any consequences for the sexually abusive behaviour they exhibited as adolescents. That is, this study aims to answer four questions:

1. How do these young adults remember the sexually abusive behaviour they engaged in during their adolescence?
2. How do these young adults describe the motives of their sexually abusive behaviour?
3. How did these young adults experience interventions designed to treat their sexual abusive behaviour?
4. How do the memories of their sexual abusive behaviour affect their adult life?

Method

This follow-up study invited a clinical sample of young adult males who had sexually abused others during their adolescence. At the time of offending all the adolescents were referred for clinical assessment that focused on risk of sexual reoffending and treatment needs, by social services or youth assessment units. The assessments were carried out by two senior social workers specialised in the assessment of adolescents with sexually abusive behaviour (the author is one).

The interventions

The interventions that followed the assessment varied. Eleven adolescents received specialised residential or out-patient treatment that focused on the sexual abusive behaviour. The individual and group treatment sessions typically focused on responsibility of the abuse, precursors of the
abusive behaviour, victim empathy, healthy sexual behaviours, and abuse prevention strategies. Some of the units also focused on reducing the impact of potential traumatic events. Eight adolescents received residential or out-patient treatment designed to generally target adolescents with antisocial behaviour typically involving themes such as changing antisocial attitudes, implementing social skills, and reducing aggression through aggression replacement therapy. Three adolescents did not receive any intervention.

**The Swedish context**

In Sweden, criminal behaviours of adolescents are handled differently than in some other European and non-European countries. The age of criminal responsibility in Sweden is 15. Social welfare is fully responsible for offenders under 15. Adolescents over 15 but under 18 are dealt with in regular courts. Special policies are applied to adolescents, including waivers of prosecution and transference of jurisdiction to the local social welfare services (Janson, 2004). When the sexual harmful behaviour of the adolescents in the current study was identified the further interventions were under the jurisdiction of the social welfare services.

**Participants (Main study)**

An invitation letter for participating was sent to 78 young adult males who were previously assessed for sexually abusive behaviour. Of these, 13 actively declined to participate and 26 did not reply after one initial letter and three reminders. The 39 who accepted participation were individually interviewed and 38 agreed to have their interview recorded. Interviews were conducted, and assessment protocols, self-report questionnaires, and criminal records were collected to gather information about past as well as current life situations. No significant differences were identified when comparing the 39 participants with the 39 non-participants by age at potential follow-up, victim target, or whether the participant was assessed to be at high risk for sexual reoffending.

**Present sample**

For this study, a sub-sample of respondents was used. The decision to include or exclude respondents was guided by the quality of the interviews in relevant areas. For example, participants who were willing to talk about both their abusive behaviour and experiences with intervention were included to obtain the richest data for the study. Saturation of the data was achieved with the interviews of 22 respondents. On average, the respondents were 15 years old at the initial assessment and were interviewed on average six years (range: 4–8 years) after assessment when they were on average 22 years old (range: 17–26 years). Half of the respondents (n = 11) reported having a cognitive disability (defined as having an intellectual disability or a functional cognitive disability such as Attention Deficit Hyperactivity Disorder (ADHD)). Before the initial assessment, 16 participants had abused a child under the age of 12, eleven had received some type of offense specific intervention (either out-patient treatment or institutional treatment), and seven (32%) sexually reoffended one or more times after the initial assessment (according to self-reports or criminal records) (Table 1). Among the seven respondents who sexually reoffended, two reoffended the same year as the risk assessment was carried out and five respondents reoffended one to three years after the risk assessment. Six respondents (27%) other than those who sexually reoffended were convicted of a non-sexual offence by the time of the follow up interview according to criminal records (theft, possession of drugs, or non-sexual assault) after assessment. One respondent was serving a prison sentence when interviewed convicted of a sexual crime.

The assessment and the interview revealed no significant differences between mean age of respondents and the 16 non-included young adults. Furthermore, no significant differences were identified comparing the groups with respect to child victims and the proportion who received offence specific treatment. The respondents were more likely to have sexually reoffended by follow-up (32% vs. 6%) although this did not reach statistical significance.
Procedures

Interview

The semi-structured interviews focused on the sexually abusive behaviour, disclosure of the sexual abuse, interventions received, and the current life. The interviews were conducted at the university, at social welfare offices, or in the participant’s home. The data were collected in 2008 and 2009.

Coding and analysis

The interviews were transcribed verbatim. The texts were analysed using qualitative content analysis. This method is used both for organising transcripts and for gaining knowledge about a specific topic (Downe-Wambold, 1992). The qualitative content analysis is a method for identifying, coding, and categorising data and for identifying patterns (Krippendorff, 2004). All transcribed interviews were read several times to obtain an overall sense of the content. Guided by the research questions, we divided the text into meaning units. The meaning units were coded and categorized in accordance with previously suggested procedures (Graneheim & Lundman, 2004). Finally, subthemes and themes were identified. In addition, a PhD student independently read and reread the transcripts. Agreement on themes and subthemes was achieved and the final analysis was validated. Three themes were identified: something sexual happened, societal actions, and life has been affected (Table 2).

Extracts from the transcribed interviews are presented in italics. When additional information is needed for understanding, it is inserted in regular font within brackets. The respondents are numbered 1–22 and the respondent's number is indicated (e.g., Respondent 1).

Table 1. Characteristics of participating respondents.

<table>
<thead>
<tr>
<th>Respondent number</th>
<th>Age by assessment</th>
<th>Age by follow up</th>
<th>Child victim</th>
<th>Any offense specific intervention</th>
<th>Sexually reoffended</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>18</td>
<td>24</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>15</td>
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<td>15</td>
<td>20</td>
<td>1</td>
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<tr>
<td>Total</td>
<td>Mean (SD)</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>15.2 (1.8)</td>
<td>21.8 (2.0)</td>
<td>16 (73)</td>
<td>11 (50)</td>
<td>7 (32)</td>
</tr>
</tbody>
</table>

*Sexually abused child/children (<12 years) by referral to the clinical assessment.
*Received any treatment (out- or in-patient) where the sexual abusive behaviour was addressed.
*Any sexual reoffending after the clinical assessment until research interview according to self-report or criminal record.

Table 2. Themes and subthemes.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
<th>Subthemes</th>
<th>Subthemes</th>
<th>Subthemes</th>
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</thead>
<tbody>
<tr>
<td>Something sexual happened</td>
<td>The abusive behaviour</td>
<td>The motive</td>
<td>Moment of disclosure</td>
<td></td>
</tr>
<tr>
<td>Societal actions</td>
<td>Talking about the problem</td>
<td>Nothing about sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life has been affected</td>
<td>Still present</td>
<td></td>
<td>No interventions</td>
<td></td>
</tr>
</tbody>
</table>

JOURNAL OF SEXUAL AGGRESSION 5
**Ethical approval**
The Regional Ethical Review Board in Lund approved the study (2004/443). Respondents received 40 £ (500 Swedish crowns) as compensation for the time spent participating in the study.

**Results**
The life circumstances of participants, at the time of interviews, showed diverse, yet mostly positive experiences. The majority \( (n = 16, 73\%) \) were employed or studied and about the same proportion \( (n = 15, 68\%) \) reported having a close relationship with their family of origin and frequent contact with friends. One-third of the respondents \( (n = 7, 32\%) \) were in a relationship, and three \( (14\%) \) were parents. However, almost half \( (n = 9, 41\%) \) were engaged with some form of professional counselling during the past year, including justice agencies, psychiatric and addiction services.

The stories of the respondents revealed three main themes – something sexual happened, societal actions, and life has been affected – and subthemes (Table 2).

**Something sexual happened**
The theme *something sexual happened* presents the respondents’ memories of the sexually abusive behaviour, their views on why the sexual behaviour occurred, and their reactions upon disclosure. In this theme, three subthemes were identified: the abusive behaviour, the motive, and moment of disclosure. The subtheme the abusive behaviour indicated the way respondents recalled and described the sexually abusive behaviour that resulted in a report to social welfare. To various degrees, the respondents talked about their abusive behaviour. Some respondents were more comfortable talking about the events:

*I was in a special class and we took a trip [...] I asked the girl in my class if she wanted to go with me somewhere else, so we went [...] then she asked what we were doing here, and I started to paw her and unbutton her pants, and she just said no, no, and don’t want to, but I still kept going with her. Finally, the teacher came and asked, “What the hell are you doing?” Then she told him, “Yes, he tried to rape me”*. (Respondent 4)

*It started with my little sister, and it started at dad’s house. One time it happened when we moved in with the foster family and now I remember that the foster parents weren’t home, so someone else was there to watch us. She noticed, and yes, she understood that it wasn’t a good thing to do*. (Respondent 13)

*I had sexual intercourse with a minor. It was a member of my family, my sister. She was six years old at the time*. (Respondent 6)

Some of the respondents had difficulty remembering the sexually abusive behaviour or were less likely to talk about it:

*There were accusations [...] of sexual abuse. Against a younger boy in the foster family [...] I don’t really remember at all. [...] He kind of brought something up [...] I had to move out of there [...] he was like five, six years old*. (Respondent 20)

*I don’t know how it came out, I don’t know. But I was accused because I had been with a little boy, our neighbour boy*. (Respondent 3)

*I got this foster family. The foster family had a four-year-old daughter who I tried to play sex games with. It was an accident that I would rather not talk about*. (Respondent 16)

Some respondents seemed to minimise the details of the actual sexual abuse. For example, some minimised the importance of the age difference if the respondent was a teenager when the abuse took place:

*It’s a rather sad story from the beginning. What I remember is that I wasn’t very old myself. My sister in the foster family had a baby daughter and I was attached to her rather soon; we spent time together and played, and she got older and...*
Respondents recalled the reason for the sexually abusive behaviour, which is presented under the subtheme the motive. Taking revenge or fighting back because of being a victim of abuse or neglect was identified as one motive in the narratives:

I did it pretty much because I was feeling really bad and then, yes it’s like you wanted to get revenge almost; you wanted to expose someone else. I also thought at the same time that it would make me feel better, but that wasn’t the case; it just made it worse. I was totally wrong there. Then I abused the second one because I felt like shit myself. I’m really sad that it happened. (Respondent 8)

Some respondents identified sexual components associated with sexually abusive behaviour as a motive:

I have a strong sexual drive; I like to explore and such. I’m so drawn to it; it almost feels like I’m a nymphomaniac, sometimes [. . .] I don’t know why it got like this. (Respondent 14)

Deep inside I’m very emotional, but I can easily shut that down, too. [. . .] I didn’t think about her, my sister; I just thought about my own sex drive. (Respondent 15)

Some respondents mentioned that anger played a role when the abuse was taking place:

I remember that I threw her onto the ground and then she screamed [. . .] I was angry about something she said, I was angry and then I threw her. Then she screamed. [. . .] I was caught for attempted rape, though that wasn’t my intention. (Respondent 10)

Many respondents talked about not understanding how the sexual abuse could occur, that it just happened:

I was so little, I didn’t understand; I thought you could do that. I didn’t know what was right or wrong. I guess my foster parents were shocked. I don’t remember anything else. (Respondent 13)

We were close all the time; we did a lot together, we played and [. . .] we did everything. I didn’t think at all and I really don’t know why it happened. It just went wrong. (Respondent 6)

How respondents recalled the moment when someone found out about their abusive behaviour is presented as the subtheme moments of disclosure. Most the respondents clearly recalled the episodes associated with disclosure of their sexually abusive behaviour. Some respondents revealed that the moment of disclosure was a crisis, with details that remained clear several years later:

I was really cold, like everything stopped; everything was just completely silent. I knew it was serious. But in a way, I was pleased. I do not know [. . .] because I had been discovered. (Respondent 6)

It was dinnertime, six o’clock. I got home and then my sister was sitting and crying on my mum’s lap and my dad sat and stared at me, and then I just knew [. . .] yes [. . .] I remember it so clearly. It’s a situation you never forget. Then everything broke inside, I admitted everything from the start to finish, what had happened. (Respondent 15)

About two weeks after my mum found out about it, so within that period I had moved in with my grandma, and one morning the police came, in the morning . . . to my grandma’s house. The time was seventeen minutes to seven. They were two of them. Civilian-dressed police officers. They asked me to follow them down to the station. And so, I did. (Respondent 6)

In the middle of the night the doorbell rang and it was the police, and it was because I had raped her. (Respondent 9)

One respondent recalled strong mixed feelings of disdain and relief associated with the moment of disclosure:

In a way, I’m happy and it’s good that they found out, because then I could finally get help. On the other hand, there’s another part of me that’s spitting, hitting and kicking myself, that really hates myself for what I’ve done. So, it was really there, this thought of damn how disgusting you are [. . .]. (Respondent 6)

One respondent recalled the moment of disclosure, when his mother interrupted him while he was sexually abusing a sibling, but did not take any actions:
My mother finally revealed me... we were in a caravan out in the yard. She did not report it, she kept it to herself. That’s how it’s been in the family, if something happens within the family, it’s within the family and then it’s not meant to be told. (Respondent 19)

**Societal actions**

Within the theme *Societal actions*, respondents talked about a variety of experiences of interventions organised by social welfare in connection with the disclosure of the sexually abusive behaviour. After disclosure and assessment, respondents were referred by social welfare offices to inpatient residential units run by private sector, or locked security units run by a government agency, as well as outpatient services run by public and private treatment providers. Some respondents did not receive any interventions. None of the respondents participated in the decision concerning interventions.

Three subthemes were identified: *talking about the problem*, *nothing about sex*, and *no interventions*. Those who received treatment that among other topics focused on the sexually abusive behaviour were identified in the subtheme *talking about the problem*. They recalled overall positive experiences:

*I had to learn from my mistakes while learning to live with this problem, both by talking about it and by confiding in adults so that they know.* (Respondent 19)

*Yes, I feel like I’ve gotten help. Otherwise I would have continued doing that stuff over and over again. I got the most help from my therapist. And she was also in touch with them, the foster parents. They worked together so that when I stayed with them, they checked in with me and taught me what I could and couldn’t do.* (Respondent 13)

*What’s helped me the most [...] that’s probably the treatment, with sexuality, at least starting to think and above all to know that they wanted to get rid of this burden for me. They’ve helped me with it a lot. My train of thought is completely different. Anyway, they’ve worked hard.* (Respondent 7)

Some respondents received treatment with no focus on their sexually abusive behaviour. The sub-theme *nothing about sex* reflects the experiences of respondents who received more or less extensive interventions with no focus on the sexual behaviour. Many respondents mentioned that they knew that they had to deal with the sexual behaviour problems and the consequences of the behaviour. However, therapists and other staff members at the residential care unit or the outpatient unit did not initiate themes associated with the sexual abusive behaviour that had occurred:

*They mostly talked about how things were at home and tons of stuff like that [...] and almost never about the event, actually [...] I would have liked to talk to someone about my problems.* (Respondent 4)

*The thing about getting help, so to speak – but you never really talked about it either; they never brought it up. Instead it was more about doing fun stuff, watching TV and eating the best food ever. I’ve never had food that good.* (Respondent 9)

*At the residential unit [...] actually there was nothing bad about it, except for that they should have brought up this thing that happened like it was something that was wrong. That’s not what it was like [...] rather, we’re putting you there; stay there until the time is up and then go back home, and then everything was fine.* (Respondent 9)

Reflecting on being referred by the court to a psychologist at an outpatient service because of sexual and violent assaults during adolescence, one respondent stated that the therapist never addressed the sexually abusive behaviour during the ten sessions:

*She [the therapist] didn’t help me with the sexual things; she just helped me with the physical assault. We didn’t even bring it up. Really weird, right? [...] In fact, I was kind of relieved [laughing] [...] but now as an adult [...] I have my own thoughts.* (Respondent 21)

The silence around the sexually abusive behaviour among staff at a residential unit was interpreted by one respondent as a strategy that allowed them to observe the adolescents, observations that they could share with the team.

*Some [staff members at the residential unit] were closer and you could talk and joke with them and stuff. But the subject of what had happened was never brought up, never [...] more like they were keeping an eye on you and such.*
They actually didn’t talk with me, but they definitely talked to each other to keep an eye on me, but never with me.
(Respondent 16)

Another respondent expressed disappointment that staff did not help him deal with the consequences of the sexually abusive behaviour:

Help with this […], no; I still can’t say that even today. […] While staying at the residential unit, staff also talked, but they didn’t really focus on that particular problem. So, it just slipped through the cracks, I think. But I’ve had to live with it, because I was convicted. (Respondent 17)

Some respondents noted they were not invited to talk about their sexual abuse and the consequences of their behaviour during treatment. Some of these respondents mentioned other sources of support:

The greatest support I’ve received, in my opinion, is that from my parents. We have talked about sex before this, so this talking about sex was nothing new. (Respondent 9)

The third subtheme includes experiences of respondents who did not receive any support, identified as no interventions. Some respondents who were not referred to any treatment were asked as teenagers by the social worker if they wanted to receive any treatment. As one respondent describes it, this was presented as a suggestion rather than a real opportunity:

They might have offered […], but I said I didn’t need to, I don’t have any problems. (Respondent 3)

The seven respondents that had sexually reoffended by the follow-up interview, all had a cognitive disability. Three of them received specialised treatment, two non-specialised treatment, and two no treatment. In the interviews respondents of this subgroup expressed their views on treatment. The quotes of two respondents who did not receive specialised treatment reflect on their need of treatment targeting their sexual behaviour, as teenagers.

The social worker said that I didn’t need any specialized treatment, like for those who sexually abuse. He said I didn’t need that help, it costed too much. He didn’t care what others thought. (Respondent 10)

They should have talked with me and told me it was wrong to do things like that and then talked with me a lot about it, over and over again. (Respondent 4)

Some of the respondents reoffended during the initial phase of treatment, others later during treatment, or after treatment. When the reoffences were acknowledged, some of the respondents were referred to prolonged treatment.

First I went home from the residential treatment and then I had to return back … We did therapy and everything like that. They thought they were done with me and said I could go home, that I had learnt everything and that I would not do it again. Then it happened, it happened again. It was a day when I skipped school and stole a porn movie and followed a couple of girls. They felt insecure and didn’t want me there … I wanted a girl and was kind of desperate … Then I had to go back. (Respondent 13)

Two respondents with experiences of prolonged treatment reflect on their experiences of treatment

In treatment we talked about what I did and what I had been exposed to. What I learned was that you need to be two, about the same age, then it’s ok. They showed me that it’s not ok to be one big and one small, it does not go well together. (Respondent 13)

You cannot do the treatment work too fast, it takes time. They have do it slow. I believe you have to do it in a way so one can learn from it. To be able to really understand … (Respondent 8)

Life has been affected

In the theme life has been affected the consequences raised by respondents on the sexually abusive behaviour are expressed. In the subtheme still present, long-term consequences were identified. For some respondents, memories of their sexual abusive behaviour and the aftermath were still with
them. Some mentioned that others still remember the event. For example, one respondent was still living in the city where he attempted to rape a girl when he was 15. The memories of the rape attempt were still alive among his cohort:

There have been a lot of rumours about this. Like “He’s the one who raped that girl”, I’ve heard. My girlfriend’s friends talked about me when we started dating, before she came over to my place the first time. The guys didn’t like me and were talking about what I had done. But she said, “I still want to see him and get my own picture.” (Respondent 9)

Feelings of guilt were experienced on a regular basis for some of the respondents:

I don’t know; I can’t get rid of the thought. I don’t understand why I did it. And that’s probably why I’m stuck, because I can’t get any real answers. But I’ve moved on in my life in general; it’s not like I think about it every day, but sometimes when I see my sister and talk to her, I’m reminded. (Respondent 2)

It’s hard to know that you’ve done something like that, that you’ve actually hurt another person this way. (Respondent 7)

Two respondents mentioned they had suicidal thoughts associated with the abusive behaviour during their youth:

I regret it so deeply that sometimes I just want to kill myself. It’s the most cowardly thing to do, but sometimes I’ve just felt that way; I’ve felt so bad about what I’ve done. (Respondent 15)

Some said they avoided bringing up the topic with the former victim within the family to prevent the negative feelings:

We don’t even talk about it. We both know about it, but we never talk about it. […] If you bring it up, you will feel bad again. (Respondent 2)

Some respondents stated that they still had concerns about their sexual behaviour such as having deviant sexual interests and being sexually preoccupied:

So, my entire sexual image, it’s skewed. […] I’m not free. I’ve become a control freak because of it; I have to be in control of this; I can’t let my sexuality be free, because then it will all go to hell, frankly. (Respondent 14)

Some respondents express a need to deal with the present concerns about the abusive behaviour. Some respondents who previously did not receive treatment focused on the sexual abusive behaviour and others felt they were too immature to benefit from the treatment received during adolescence:

Needed to talk with someone […] it never happened, not that I remember anyway […] I also think it sounds strange but that’s the way it is […] yes I still think so today. I would have liked to talk to someone about my problems. (Respondent 2)

During that treatment, you’re too young for it, you don’t understand. Had it been now, it would have been completely different. Sometimes I feel like I need to relieve the pressure, and then I hesitate. I don’t want to talk about it. But at the same time, I want to. It would have probably helped me to answer some questions, to have someone to talk to. (Respondent 15)

Discussion

This study examined what 22 young adults recalled or were willing to remember about committing sexual abuse during their adolescence, how society responded to their behaviours, and how these events affected their adult lives. The study presents different findings and four main perspectives will be discussed: memories of abuse and reflections around the motives, interventions received, disclosure as a potential turning point, and the long-term consequences.

The respondents recalled their sexually abusive behaviours to different degrees. Some respondents who received long-term treatment were more likely to talk about their behaviour and to take responsibility for their behaviour. Some had more difficulties recalling the event or had less
desire to talk about it. Some minimised what they actually understood of their sexual acts when they committed the abuse as teenagers; that is, rather than talking about the abuse in detail, respondents reflected on the motives of the abuse. A range of explanations were suggested including a sexual motivation, anger, or confusion. Sexual motivation and preoccupation with sexual thoughts were presented motives by some respondents, confirming previous findings on more sexual preoccupation among adolescents with a harmful sexual behaviour than among controls (Kjellgren et al., 2010). In one previous study on rape by adolescents (Williams & McCarthy, 2014), low sexual self-control and high self-esteem were associated with having perpetrated rape, factors also present among some of the respondents of this study. A few respondents talked about revenge or fighting back. The link between having been sexually abused and sexually abusing behaviour among adolescents has been suggested in previous population-based research (Aebi et al., 2015; DeLisi et al., 2014; Seto et al., 2010), but was not identified in this study by participants themselves except for one respondent: “You wanted to get revenge almost; you wanted to expose someone else”.

The differences in interventions the adolescents received are noteworthy. In Sweden, local social welfare authorities have the main responsibility to organise the interventions for adolescents. The sexual behaviour problem was acknowledged by the local social welfare services as all the respondents were referred by social welfare for a risk assessment that focused on risk for sexual reoffending and treatment needs. However, only half of respondents received treatment that focused on the sexual abusive behaviour. In total, half of the respondents were referred to residential care, which typically lasted for a year or more. Some of the care providers offered treatment focused on the sexually abusive behaviour, but some did not. Some of the respondents who were referred to a secure residential care organised by the governmental agency (The Swedish National Board of Institutional Care) did not receive treatment focused on their sexually abusive behaviour. Decisions to refer adolescents to no interventions or to interventions with no focus on the sexual abusive behaviour did not reflect a less serious abuse or low risk for sexual reoffending as identified in the risk assessment protocol. Worling and Langton (2012) argue that treatment for adolescents who have sexually abused must be tailored to the unique strengths, risks, and needs of the adolescent. Residential settings that offer specialised treatment group-based work should focus on issues such as healthy sexual attitudes, interpersonal intimacy, family relationships, and general offense prevention strategies. Individual therapy is a more appropriate context for bringing up details of past sexual offenses and for addressing deviant sexual interests (Worling & Langton, 2012).

Adolescents rarely initiate that they need to talk about their sexually abusive behaviour. Consequently, in this study, respondents revealed that they did not raise the topic with staff. However, at the follow-up, respondents who did not receive specialised treatment highlighted the lack of focus on their sexual behaviour in treatment and the consequences of not receiving specialised treatment, an understanding that they developed only after they had matured. The most essential treatment components, for those who received specialised treatment, were talking about the sexual behaviour and receiving support to improve sexual health. This group of respondents highlighted the value of seeing empathic and persistent therapists. Those who received an intervention not focused on the sexually abusive behaviour reported other kinds of experiences. They had met staff who ignored their history of abusive behaviour and had further experienced staff who were distanced from the adolescent. Despite the shortcomings in treatment, however, the majority of those respondents did not sexually reoffend. Some of the respondents mentioned support from families as particularly helpful in dealing with the behaviour.

Of the seven respondents who sexually reoffended, three received specialised treatment. Some of these were in an early stage of specialised treatment, so the reoffending was dealt with during treatment, which could be prolonged. Other respondents reoffended after treatment. The participants who abused a child were more likely to sexually reoffend (6/16) compared to those who abused a peer (1/6). These findings are consistent with previous research on risk factors for sexual reoffending (e.g., Worling & Långström, 2003). All who reoffended had a cognitive disability, six had a learning disability, and one had a neuropsychiatric disorder. Previous research has identified higher rates of
sexual reoffending among a learning-disabled population than among their non-learning-disabled counterparts (Craig & Hutchinson, 2005). Insufficient interventions to prevent sexual reoffending have to be understood in light of the special needs among this group of adolescents. As previous research has pointed out, the treatment that serves adolescents with cognitive impairments needs to be adapted (Almond & Giles, 2008; Malovic, Rossiter, & Murphy, 2018; Wiggins, Hepburn, & Rossiter, 2013). Among learning disabled respondents in this sample, specialised treatment providers sometimes required extended treatment, but they had to finish the original treatment before assessing that the treatment was completed. This provision was required by social welfare services, the entity responsible for paying for the interventions.

The moment of disclosure was recalled not only as a clear moment of horror but also as a moment of relief. Some respondents were not only afraid of disclosing their abuse but also were relieved that the disclosure gave them the opportunity to receive assistance for various problems. Disclosure could be considered as a potential turning point when respondents are able to separate or “knife-off” the past negative behaviours from the present (Sampson & Laub, 2005). The opportunities of supervision and monitoring, as described by Sampson and Laub, were immediately there for some respondents and their parents, who could initially deal with the crisis within the family and then look for further support. Some respondents did not experience reactions from their parents but rather experienced their parents ignoring the abuse. The further process of redirecting the path of the young person requires in addition to family members, professional supervision, monitoring, and social support. This population needs the involvement of social welfare to assess and plan interventions. Disclosure may serve as a start of a turning point process and transformation. However, the potential turning point by disclosure became less favourable for some of the respondents. Sampson and Laub (1997) describe a turning point as an opportunity when trajectories are directed to more adaptive or maladaptive paths.

For the majority of the sample, some positive findings concerning current life situation were identified. These findings included being employed and having a close relation with family and friends. Although some respondents had recently been involved in non-sexual criminal behaviours and drug use, no reported sexual reoffending occurred the year before the interview. These facts may indicate that the trajectory of sexual harmful behaviour may have turned into a more adaptive path. Additional follow-up data are needed to explore the continued path. However, as Lussier et al. (2012) concluded, the adolescence-limited trajectory is the most likely path for adolescents with a sexual harmful behaviour. Some of the respondents of the sample convicted for non-sexual crimes may follow another path.

Professionals sometimes tend to believe that young adults do not reflect on anti-social behaviours displayed in early adolescence and on the consequences of their behaviour. In this study, however, respondents still expressed anxiety and concerns about their past abusive behaviour. These anxieties were evident both in respondents who abused younger siblings as well as in those who raped or attempted to rape peer-aged victims. For those who had sexually abused a sister or brother, the long-term consequences included retained negative impact on the family, feelings of guilt, and concerns for the victim. Feelings of guilt and shame among adolescents who have sexually abused have not been scientifically explored (Epps & Fisher, 2004). When intrusive feelings of guilt remain six or seven years after the abusive behaviour occurred, the mental health of the young adult may be affected, a condition that requires attention. Some respondents shared in the interview their thoughts about still being considered a rapist or need for help with sexual behaviours. The respondents expressed a desire of additional counselling and support from adults. Previous research has identified the value of follow-up sessions for this population (Geary et al., 2011; Lambie & Price, 2015). Furthermore, Lambie and Price (2015) note that adolescents often have a difficult time asking for help because they consider this a sign of weakness. However, the participants of their study would have welcomed someone inviting them to talk about their struggles. When concerns about sexuality and other life issues remain as identified in this study, follow-up sessions could
have identified a need for further consultation or treatment to improve sexual health, prevent further problematic sexual behaviours, and improve mental health.

Mental health professionals, social workers, and researchers can improve their understanding of the effects of sexual abuse on the perpetrator by inviting young adults who displayed harmful sexual behaviour during adolescence to reflect on their experiences. In this study, the respondents offered rich descriptions and views concerning their experiences. Although many respondents had a number of adverse experiences, displaying sexual harmful behaviour was seen as exceptional. When former clients criticise previous treatment interventions received, they may be expressing a desire for better specialised treatment. That is, they may be expressing that there is a need to provide better training for social workers and other mental health care professionals, to adapt the treatment to individual needs, to increase the focus on healthy sexuality, and to provide follow-up sessions.

Limitations

It is acknowledged that the sample of 22 young adult males somewhat limits generalisability of findings. A sub-sample of respondents whose interviews offered rich data, was selected. However, respondents included in the study more frequently self-reported sexual reoffending than those excluded from the study. This difference may have been due to the fact that the included respondents were generally more likely to talk about their sexual behaviour problem and possibly more likely to talk about their sexual reoffending.

The respondents were assessed as adolescents because of sexually abusive behaviour in the early 2000s and the follow-up data were collected through 2008 and 2009. As the respondents received interventions about 15 years prior to the publication of this study, the findings may not reflect the present quality of service for adolescents with sexual behaviour problems in Sweden. However, the national professional network in the field of children and adolescents who display harmful sexual behaviours has expressed a need for improved interventions for this population. These concerns may indicate continuing shortcomings in the interventions offered to this group of adolescents. Despite these limitations, this study can contribute with individual perspectives on sexually abusive behaviour in a life course perspective that may be helpful in continued clinical work as well as research.

Conclusions

In this study, many respondents did not receive interventions designed to prevent further sexual abuse, to support emotional well-being, or to promote sexual health. The needs of the participant were neglected when social welfare failed to intervene through the encouragement of disclosure as dictated by good practice and failed to support the young person to use the disclosure as a turning point. The fact that all the reoffenders had a cognitive disability raises concerns about the special needs of this sub-group and the necessity for adaptive interventions to effectively address this behaviour. If this population is to receive effective interventions, social workers and other professionals will need training and support that addresses the specific needs of these individuals. The results of the study further illustrate persistent consequences of the sexual abusive behaviour during adolescence in young adults.

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References


