FAS: Preventing and Treating Sexual Deviancy

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According to recent research (see chapter by Streissguth, Barr, Kogan, & Bookstein), inappropriate sexual behavior (ISB) is one of the most prevalent secondary disabilities of Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE). ISB is defined as any compulsive and problematic sexual behavior or any behavior that results in sentencing of an individual for sexual offender treatment. For children between the ages of six and eleven, ISB ranks second in prevalence among secondary disabilities after mental health problems. For adolescents between 12 and 20, ISB ranks fourth after mental health problems, disrupted school experience, and trouble with the law. For adults between the ages of 21 and 51, ISB ranks fifth, following confinement (i.e., imprisonment) in addition to the four secondary disabilities previously mentioned.

Evaluaters and treaters of individuals who have been charged with sexual crimes traditionally have not acknowledged the role of FAS or FAE in criminal behavior. Regardless of a person's ability to understand the nature of his/her actions and the consequences of that behavior, the sexual offender with FAS/FAE is not treated any differently than is an offender without such a diagnosis. The result of this lack of differentiation has been inaccurate assessment, improper treatment, and inappropriate incarceration. The following case study presents an illustration of how the approach to evaluation and treatment for sexual offenders with FAS can accommodate the special needs of these individuals. Following the case study is a separate section on how parents of children who are beginning to engage in inappropriate sexual touching can identify this problem and respond with techniques aimed at preventing criminal conduct.

Case Study

Joey* was 36 when I first met him. He had been referred by his attorney after being charged with two counts of Rape of a Child in

*Names and details have been changed to maintain client confidentiality.

the Third Degree. These charges stemmed from incidents in 1994 involving a young boy named Kevin who was 14 years old at the time. The two reportedly had known each other for about three years prior to the sexual abuse. They had met through mutual friends, who were about Kevin's age. Joey did not have any friends his own age; instead, he hung out with teenage boys, who accepted him in a peripheral way but also teased and taunted him because he was not very quick-witted. According to Joey, he and Kevin were "close friends." Joey would take Kevin to restaurants and buy him gifts. According to Kevin, who later gave a victim statement to police, he and Joey were "acquaintances," even though they saw each other almost every day.

Joey had worked in his father's successful recreational vehicle (RV) business for years as a detailer (i.e., he washed and cleaned RVs) but kept having difficulty getting along with some of his father's supervisors. As the son of the company's owner, Joey expected to be eventually promoted to a prestigious management position within the company and constantly was frustrated with his lack of progress. The supervisors, in turn, were frustrated with having to accommodate the son of the owner, who had to be told over and over how to do basic tasks that he had previously done many times. Joey occasionally would quit when he became frustrated with the "lack of respect" from these supervisors and find alternative work as a dishwasher or short-order cook. After a few days or weeks in another job, he would return to the dealership and begin detailing cars again.

On the day of the first incident of sexual molestation, Joey had quit working for his father's company and was planning to drive to another city to look for employment. He asked Kevin to accompany him, and the two drove off together. Once in a new city, Joey got them a room in a motel. According to Kevin, once in the room, Joey started becoming sexually aggressive with him. Joey tried several different sexual behaviors with Kevin, including anal intercourse. Kevin told police later that he kept resisting these advances. Finally, Joey fell asleep, and the two returned home the next day without any further incident.

Following this first incident of sexual abuse, there were two other occasions when Joey attempted to sexually molest Kevin. The third, and final, occasion took place in Joey's truck parked outside the home of Kevin's family. Kevin allowed Joey to sexually touch him this third time, and the two were engaged in sexual activity when Kevin's family came outside and discovered them together in the truck. Kevin's family phoned the police, and Joey was arrested and charged.

When I first met Joey for his psychosexual evaluation, he was in denial about what he had done and blamed Kevin for the sexual molestation. As we talked, he began to reveal details about his childhood that suggested he was likely fetal alcohol impaired. According to his report, his adoptive parents found out several years after he had been adopted that his biological mother had been an alcoholic and had been actively drinking throughout her pregnancy. The agency which had sponsored the adoption had not informed them of this at the time of the adoption.

The initial step in Joey's psychosexual evaluation was to obtain a complete history from him, including childhood experiences, relationship history, and sexual history. Joey talked easily about his childhood, and responded positively to my attention and interest in him. He revealed that his childhood was very difficult, and his adoptive parents, who did not know about FAS or about Joey's likely diagnosis, were overwhelmed by his problems. Joey told me, "I was not like a normal kid. I was slow. I still am in a way. I became scared of everyone because kids teased me. I got beat up by older boys every day at school. I learned you just had to do whatever they told you to do." Joey reported that his adoptive parents would fight over how to raise him. They could not figure out why he had so many behavioral problems (e.g., stealing, lying, truancy, aggressive behavior, inappropriate touching of other children), and why their younger son, who was also adopted, was relatively easy to raise.

Joey described his school experience in negative terms, "School was a joke. I was in 'special ed' (special education) in the first grade. I was stuck in this class with rowdy kids who did not care about learning. So, I never learned anything. To this day, I have not learned how to multiple or divide. I can read, but I can not spell. I spent all my elementary school years in special ed. The other kids called us Edders. No matter how much I asked, my mother would not get me out of special ed." Similarly to the way he blamed his victim for the sexual abuse, Joey had a tendency to blame his mother for his childhood problems. One of the characteristics I have observed in sexual offense clients with suspected fetal alcohol impairment is a diminished ability to take personal responsibility for their behavior. This makes it more difficult for them to become motivated in treatment to change their behavior.

The rest of Joey's history was similar. He got into drugs as an adolescent and acted out with his peers in order to be accepted. However, he never was accepted as part of the group and finally dropped out of school in the 11th grade to begin working full-time for his father's business. Socially, he was very shy with girls his own

age and reported no dating and very limited social involvement with same-age females throughout his teen and adult years. He had had his first sexual encounter at the age of 10 when he was molested by a boy two years older than he was. When he was 21, he had his first and only sexual experience with a young woman who was 19, whom he had met while talking on the CB radio. When he was in his 20's, he had two other experiences with women which did not result in sexual intimacy because the women quickly became disillusioned with him. As a result of his limited sexual experience, he felt inadequate with women his own age.

The evaluation process for this client conformed to the standards in Washington State, although more time than is usual was spent on his family history and childhood behavior in order to determine if he met criteria for FAS. He was interviewed extensively, and his adoptive parents also were interviewed. The latter typically is not done in sexual offense evaluations, but, in the case of a possible FAS diagnosis, which would affect the recommendations, this was considered essential. In addition to interviews, Joey was administered two personality tests and a sexual history questionnaire. He was given assistance in completing these tests, which revealed a passive-aggressive character, low self-esteem, need for attention, and tendency to act out impulsively. He also was administered an IQ test, which revealed an intellectual ability in the low average range.

Two physiological tests, the polygraph and plethysmograph, were included in the test battery that was administered to Joey. He passed the polygraph exam, which included questions that asked if he had ever sexually touched any other minor, male or female, other than Kevin. Joey responded, "No." The second physiological test was a penile plethysmograph. This test measures sexual arousal to a variety of slides, audio tapes, and videotapes that depict the full range of sexual behavior, including sexual behavior between adult males and young boys Kevin's age. Joey's results were interesting. His arousal to adult and minor females barely was significant. His arousal to adult males and males between the ages of 15 and 18 was insignificant. However, his arousal to boys between 12 and 14 was in the high moderate range. His arousal to boys between 8 and 11 was in the low moderate range. His arousal to boys between 4 and 7 was in the mild range. All this suggested a sexually deviant arousal pattern that would have to be addressed with arousal reconditioning techniques in treatment.

Finally, Joey was asked to comment on his victim's statements as they appeared in the police report. He began the evaluation by denying any responsibility for what had occurred. To him, Kevin was the

aggressor, and he was the victim. However, by the end of the evaluation, he was beginning to acknowledge that, as the adult, he was the one who was responsible. This enabled me to recommend treatment for this client. At sentencing, the judge was interested in Joey's possible diagnosis of FAS and his ability to learn and benefit from treatment given this diagnosis. I told him that individuals with FAS or developmental disabilities usually did very poorly in prison. They are quickly targeted as victims and often sexually abused themselves. They emerge from their prison experience with many more problems than they had going in, one of these problems being sexual behavior that is out of control.

Fortunately, Joey received treatment in lieu of a prison sentence and began a three year cognitive-behavioral program that was designed to teach clients how to control their behavior by controlling their thoughts and feelings. He is now in the process of learning about his sexual offense cycle. He is learning that negative core beliefs about himself and unhealthy ways of coping with stress contributed to his sexual acting out, as well as did what we call "impaired thinking." An example of impaired thinking for Joey was his tendency to think of Kevin as an equal in terms of responsibility for sexual behavior.

Joey is in his second year of treatment now and has just completed sexual arousal reconditioning, which pairs aversive stimuli with deviant sexual scenarios. This process is designed to eliminate deviant arousal. He has also been through an assignment that required him to put himself in the role of his victim and write his victim a letter of apology. This has been a particularly difficult assignment for Joey because he has a problem with concepts and abstract thinking. However, what was effective for him was bringing in an adult victim of childhood sexual abuse, who gave Joey's group a first-hand account of what it felt like to be molested as a young boy by an adult male. Currently, Joey is receiving anger management training and is about to begin a section on social skills development, which for him is very much needed and will support the process of building his self-esteem and self-confidence with adult women.

Joey has not reoffended since starting treatment, which is in part due to the support he is receiving from both his mother (with whom he currently lives) and from other members of his group. For the first time in his life, he feels accepted and a part of a group. He seems motivated to control his behavior, but the difficult time will come when treatment is finished, and he is on his own. Like other clients with fetal alcohol impairments and developmental disabilities, compliance with treatment — with all the structure we build into the

process — is relatively easy compared to life outside of treatment, where there are no rules, no restrictions, and no one watching over the client.

In order to prevent re-offense among offenders with FAS, some form of treatment aftercare and monitoring on a long-term basis is essential. Another critical need for such individuals is a structured, supportive living environment both during and after treatment. At present, there are few resources that offer such an environment. Group homes are one alternative, particularly for individuals who need 24-hour supervision. For individuals who are somewhat self-sufficient, independent living situations involving frequent and regular assistance from a skilled counselor or advisor may be appropriate. Without such ancillary resources, no matter how good the treatment program is or how motivated the client is while in treatment, prognosis is poor. Aftercare support must be available, perhaps for many years, in order to sustain the motivation and the positive behavior changes that have been made.

What is even more effective than a strong treatment and aftercare response, however, is preventive work. Joey's legal problems could have been avoided if his parents had known about his diagnosis from the beginning and been able to take steps to minimize the problems he was likely to have as a result of his impairments. In particular, had they known what to expect and look for in his behavior and how to address incipient problems before they had a chance to escalate into illegal behavior, Joey's life might have taken a more positive direction.

Advice to Parents

The challenge for parents of children with FAS/FAE who have begun to engage in inappropriate touching of other children is to stop the behaviors before they reach the level of becoming criminal offenses. Instruction for such children must be very basic and must clearly delineate consequences for failure to follow "rules" regarding social conduct. The objective is absolute clarity and understanding on the part of the child, who — despite difficulty with abstract thinking — must know key concepts that relate to ISB prevention and how these concepts relate to him or her personally.

The concept of "rules" is most important. In therapy, I ask the child if he has any rules at home or at school, and we begin by talking about those rules. I ask him what makes something a rule (e.g., expectation and requirements of parents and teachers), why it is good to follow the rules, what happens if you do not follow the

rules. I ask what would happen if there were no rules. For example, what would it be like to live in a house where there were no rules? What would it be like to go to a school where there were no rules? The conclusion we want the child to arrive at is that rules keep us safe.

Other key concepts include boundary (e.g., dividing line, physical space between people, where one leaves off and another begins), private places (e.g., genital areas, breasts, buttocks), sexual (e.g., people touching each other in private places, wanting to touch somebody who is attractive), physical (e.g., something to do with someone's body, something that can be seen/felt/touched), social (e.g., being with other people, talking and doing things with other people), and emotional (e.g., feelings such as anger, sadness, happiness, frustration, jealousy, love, attraction).

Once the child understands the meanings of the key words, we begin to work on using these words conceptually. We begin first with boundaries, or sets of rules about how to act with other people. Ask the child: How close do you get to someone else? When you are working near somebody, how close do you get? When do you touch somebody else? When is it not okay to touch somebody? How do you touch someone? What kinds of touching are okay in what situations? Once a child has a basic understanding of the concepts, we begin to differentiate different kinds of boundaries.

For example, with regard to physical boundaries, the objective is to have the child understand that he or she touches someone else *only with permission*. To teach the child this concept, ask the following questions:

Who can touch you and whom can you touch?
When is it okay for you to touch someone or for them to touch you?
How close do you sit or stand to people? (personal space)
When do you make eye contact?
How close do you get to people in elevators?
How close do you get to people while waiting in lines?

To teach a child that sexual touching is only allowed between grown-ups, ask the following questions:

Whom do you let touch you in a sexual way?
Whom is it okay for you to touch in a sexual way?
Who can see you with your clothes off?
When is it okay to touch somebody's private places?
What do you do if you want to touch someone's private places?

To protect the child from being victimized, ask the following questions:

With whom is it okay to talk?
Is it ever okay to talk to strangers?
What do you do when a stranger starts talking to you?
What do you do if a stranger touches you in a private place?
When is it okay to talk to others?
With whom do you do things/socialize?

Finally, in order to teach the child how to talk about his/her feelings with respect to sexual issues, ask the following questions:

Who controls your feelings?
How do you control your feelings?
Do you have a right to talk about your feelings?
When is it okay/not okay to talk about feelings?
With whom should you talk about your feelings?

Once the child understands the key words and the concepts, we begin to apply these ideas with vignettes and examples relevant to the child's experience:

Example 1

Kathy has very poor personal boundaries. Sometimes, she stares at people she does not know. Other times, she bumps into people in the lunch line at school. Kathy wants to be best friends with Sarah. She watches Sarah all the time at school. One day, at recess, she sees Sarah eating a snack on a bench in the play area. Kathy walks over to her and sits down very close. Sarah says "hi" to Kathy and moves farther away on the bench. Kathy is happy that Sarah said "hi." She watches Sarah eat for a minute and thinks that she is very pretty. She notices that Sarah's hair shines and sparkles in the sunlight. She reaches out her hand and touches Sarah's hair. Sarah jumps up, grabs her lunch, and walks away. *Ask the child: How did Kathy break the NO TOUCHING WITHOUT PERMISSION rule? What was Sarah probably thinking at the time? How should Kathy have behaved?*

Example 2

Michael is nine years old and is best friends with Danny, who is six. They play together all the time. Lately, Michael has begun to rough-house with Danny. He hides in Danny's closet when Danny leaves his room, and when Danny returns,

Michael jumps out and tackles him to the ground. One day, Michael tackles Danny, and the two are rolling around laughing on the floor. Michael starts tickling Danny on the side of his body. Then, he tickles him in his private area. Danny keeps laughing, so Michael thinks it is okay to keep tickling him in his private area. *How did Michael break the NO SEXUAL TOUCHING UNTIL YOU ARE GROWN UP rule? What was Danny probably thinking? What might Danny do after Michael touched him? Did Michael break any other rules?*

Parents of a fetal alcohol impaired child who has not yet begun to explore his or her sexuality have an advantage. The best way to prevent inappropriate sexual touching is to give the child guidelines and coping skills he or she can use when faced with a desire to make physical contact with another person. Contact the local school district or public library to obtain information used in the sex education curriculum and modify that information to make it more appropriate for the fetal alcohol-impaired child. The therapeutic approach described above also can be modified to fit the needs and learning ability of a child in question. Since children often begin sexual exploration by the age of nine or ten, parents should begin the process of in-home sex education while their child is in elementary school. In-home instruction should continue as the child reaches junior and senior high school, and parents can facilitate this process by remaining in contact with teaching personnel responsible for in-school sex education.

Parents of children with FAS/FAE who have already begun to engage in sexual touching should contact a therapist specialized in FAS/FAE, child psychology, or developmental psychology for assistance. Make sure that the therapists who are being considered have the appropriate training and experience to work with children on sexual issues. The preferred mode of treatment for such children is cognitive-behavioral therapy, which tends to be far more concrete and directive than other kinds of therapy. Other resources that might be helpful in such situations include local school districts (special education divisions, school counseling services), local and state agencies that deal with children's services and developmental disabilities, the National Council on Disability (202-272-2004), and the National Organization on Fetal Alcohol Syndrome (800-666-6327).

Novick, N. (1997) FAS: Preventing and Treating Sexual Deviancy. In: Streissguth, A.P. & Kanter J. (eds.) The Challenge of Fetal Alcohol Syndrome: Overcoming Secondary Disabilities (pp. 162–170). Seattle: University of Washington Press.