DEVELOPMENT AND INITIAL EVALUATION OF A HETEROSOCIAL SKILLS TRAINING GROUP FOR SEXUALLY ASSAULTIVE AND OTHER ADOLESCENT PSYCHIATRIC INPATIENTS

by Rosemary J. Esseks

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BY

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University of Nebraska-Lincoln, 2003

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The current study explored the development and initial evaluation of the Relationship Skills Group, a curriculum intended to increase the heterosocial skills and confidence of adolescents. The curriculum was designed to improve heterosocial functioning through a combination of instruction, discussion, modeling, and practice in a structured group setting. Skills addressed varied from basic interpersonal communications (e.g., making good eye contact, demonstrating active listening) to more complex, dating-specific issues (e.g., setting limits on sexual activity, discussing use of safer sexual practices). The treatment was provided to a population of adolescent psychiatric inpatients, most of whom were diagnosed with behavioral disorders, and many of whom were adjudicated for sexual offenses. Assessment instruments completed by these youth included the Survey of Heterosocial Interactions (SHI), the Assertion Inventory (AI), the AIDS-Risk Knowledge Test (ARKT), and the Structured Learning Skill Checklists Checklist (SLSC). Pre- and posttreatment data, consisting of these measures and videotaped role-play assessments, were collected on 32 youth who received the complete intervention. Pre-intervention analysis of data from 168 facility youth, including the treatment group, revealed that youth reporting lower heterosocial confidence were more likely than their

more socially confident peers to be assigned to participate in the group. The examination of differences between pre- and post-intervention assessments, as measured through the SHI and subjects' performance in the videotaped role-plays, indicated that the group was successful in increasing participants' heterosocial confidence. No statistical evidence was found to indicate that the group increased the participants' levels of heterosocial skill. The study was limited by its small sample size and apparent subject confusion with one of the measures. It is suggested that the observed capacity of the Relationship Skills Group to increase heterosocial confidence demonstrates its utility as a technique for assisting adolescents to pursue positive, consensual romantic relationships, and decrease the likelihood that they will fall back on abusive or otherwise unhealthy patterns of fulfilling sexual needs.

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Adolescent psychiatric inpatients commonly demonstrate deficits in social functioning. Adolescent sexual offenders by definition engage in behaviors that violate social norms and cause pain to their victims and virtually all those connected to the victims. For these reasons, it was hypothesized that training behaviorally-disordered adolescent psychiatric inpatients, including adolescent sexual offenders, in dating skills would improve their actual and perceived social competence, reduce their involvement in risky sexual behaviors, and thus improve post-hospital adjustment.

Adolescence is a critical period in the development of social skills, as youth become more closely aligned with peers in preparation for moving out of the family home, and, eventually forming a bond with a mate (Nangle & Hansen, 1993). Because of concerns about poor impulse control, unhealthy boundaries, and even histories of sexual perpetration among adolescent psychiatric patients, most treatment facilities place far greater restrictions on heterosocial contact than youth would encounter at home or in regular schools. Some facilities are single-gender, and most (if not all) discourage patients from involvement in dating relationships with other patients. In particular, facilities that treat sex offenders have an obligation to protect other patients from victimization. Youth with significant emotional problems may spend years in such institutions with limited to no contact with the opposite sex. Those peers with whom these youth do have contact are likely to be equally or more severely socially impaired, making it probable that any skill learning that does go on may not be healthy (Gordon,

1996). Although the concerns about youth with severe behavioral and emotional problems becoming involved in unhealthy relationships is understandable, it is worrisome to consider the possible negative effects of institutionalization on the heterosocial development of inpatient youth, particularly those who experience long hospitalizations.

A discussion of treatment of social skills deficits and poor sexual decision-making must begin with an examination of the social tasks facing adolescents, normal adolescent heterosocial development, and the current context in which adolescent social development takes place. Because a discussion of healthy adolescent sexuality must include attention to issues such as past abuse experiences, pregnancy prevention, STD and HIV risk, dating violence and other sexual offending, these problems as well as various intervention efforts aimed at reducing their frequency will be explored. The specific population included in this project, the challenges and benefits of conducting this type of intervention, and suggestions for improving interventions in the area of adolescent heterosocial competence will also be discussed. Finally, the format of the intervention will be detailed.

Salient Issues in the Area of Adolescent Heterosocial Interactions

Social Tasks of Adolescence

The major social tasks of adolescence include transitioning from the family as primary support, increasing reliance on peers, and then eventually forming a bond with a mate. Through this period, adolescents' social interactions are affected by changes in family functioning, involvement with new peers, and changes in social expectations as they become older and gain new skills, responsibilities, and privileges (Hansen, Watson-

Perczel, & Christopher, 1989).

In adolescence, as the peer group exerts a stronger influence, social skills become more important (Nangle & Hansen, 1993). As adolescents spend more time with the opposite sex, and place more importance on relationships with the opposite sex, heterosocial skills become crucial. Heterosocial skills are those social skills required to engage successfully in interactions with the opposite sex, not exclusively those involved in romantic relationships. Many of these skills are included in the basic category of social skills, such as starting conversations, reading others' social cues, maintaining appropriate nonverbal behavior (e.g., eye contact, interpersonal distance, facial expression), and listening (Gambrill & Richey, 1985). Heterosocial skills which are more specific to courtship include date initiation, or requesting the presence of someone else in a social activity, and dating, or interaction as a pair in a rewarding activity, which may lead to future interaction, commitment, or sexual activity (Hansen, Christopher, & Nangle, 1992). Also required for healthy courtship behavior would be communication skills, assertiveness skills, and problem-solving skills. As expressed by Nangle and Hansen (1993):

> These skills serve a variety of important functions for the adolescent, including (a) the promotion of interpersonal competence and adult-like social behavior; (b) recreation, including entertainment and sexual stimulation; (c) the enhancement of status within the peer group; (d) the development of independence assertion; (e) experimentation with sex-role behaviors and sexual activity; and (f) courtship and mate selection (p. 117).

Such heterosocial skills, like other skills, are learned through observing models engaging in heterosocial behaviors, participating in peer heterosocial activities, and experiencing the consequences of heterosocial behaviors. Various cognitive factors, such as beliefs and self-statements about heterosocial behaviors, affect skill learning and skill use as well (Nangle & Hansen, 1993).

The process of learning heterosocial skills presents a unique set of challenges to adolescents (Nangle & Hansen, 1993). Heterosocial skills are developed at a time during which the influence of parents is decreasing and the influence of peers is increasing. However, peers, confronted with the same issues of cognitive and social immaturity, may not serve as good skill models. Even if a youth has friends with healthy heterosocial skills, sexual interaction skills are usually exercised in private, which would limit a youth's opportunities to observe peer or other models. In this situation, there would also be less opportunity for an adolescent to receive feedback regarding his/her skills. Most skills can be learned by trial and error, but in the arena of sexual interactions the possibility exists of experiencing a significant error in just one trial (e.g., become pregnant, exposure to HIV). Although the positive consequences of sexual behaviors are immediate (e.g., physical gratification, social validation), the negative consequences may not emerge for some time (e.g., pregnancy or disease). Finally, adolescents could also fail to use heterosocial skills they do in fact possess due to social anxiety.

Despite the challenges involved in the development of heterosocial skills, neglecting to learn these skills is not a healthy option. An individual lacking in heterosocial skills would have difficulty forming intimate relationships with others.

Intimacy is necessary for healthy development, and seen as a basic human need, varying somewhat in importance according to an individual's personality and disposition. As expressed by Marshall (1989), "individuals with well developed intimate relationships seem resistant to all manner of problems" (p. 495). Such individuals tend to have better responses to stress, report more of a sense of meaning in life, and tend to experience less depression. On the other hand, "failure to achieve intimacy…produces loneliness, which leads to an aggressive disposition" (p. 491).

Influences on Adolescent Heterosocial Functioning

Obviously, the development of healthy or unhealthy adolescent heterosocial functioning has multiple determinants. Personal variables—gender, self-esteem, physical development, history of sexual abuse—influence skill development, but so also do parents, peers, and society at the local, national, and international levels. These individual variables interact with each other in a number of ways (e.g., relationship with parents affects self-esteem; physical development affects peer relationships), making it difficult to tease out the relative contributions of each to the overall quality of an individual adolescent's heterosocial skills. In addition to those factors affecting skill development, this section will also explore what may influence whether or not an adolescent chooses or is able to use these skills. For example, an adolescent who knows how to refuse a sexual advance may end up engaging in intercourse due to pressure from peers or incapacitation resulting from substance abuse.

Influence of parents. Miller, Norton, Fan, and Christopherson (1998) observed that, although adolescents tend on the whole to have more permissive attitudes about

sexuality than their parents, there is a link between parents' and adolescents' values. As stated by Marshall (1989):

> The growth of the capacity to form intimate attachments is seen as largely dependent upon adolescent experiences. Similarly, the transition from parental attachment to peer attachment, and the associated capacity for adult intimacy, is dependent upon adolescent experiences. In these formative experiences the parents play a vital role in providing a warm supportive attachment figure, in instilling self-confidence so that the transition to adult intimacy is facilitated, and in providing the skills necessary to act effectively on the need for intimacy (p. 493).

Disrupted attachment (Marshall, 1989), parent-adolescent communication patterns (De Gaston, Weed, & Jensen, 1996; Raffaelli, Bogenschneider, & Flood, 1998), parental monitoring of adolescent behavior (Meschke, Bartholomae, & Zentall, 2000; Miller et al., 1999; Rodgers, 1991; Smith, 1997), and parents' own sexual histories (most notably, parental early pregnancy) (Gordon, 1996; Quint, 1991; Smith, 1997) all have been shown to affect adolescents' sexual behavior.

However, as noted by Whitbeck and colleagues (1993), research regarding the effects of various parental behaviors on adolescent heterosocial skills and sexual decision-making is mixed. For example, the simple fact that an adolescent communicates with at least one parent about sex does not necessarily translate into a reduction in high-risk sexual behavior. Whitbeck and colleagues argue that the effects of parental behavior on adolescents are indirect. For example, their study of adolescent girls' relationships

with parents found a link between parental warmth, adolescent depression, and involvement with sexually active peers. Whitbeck and colleagues hypothesized that it is the quality of the relationship with her parents that affects a girl's emotional state, which in turn affects the decision to become sexually active.

Influence of peers. Although it is normal for peers to have increasing influence as adolescents attempt to individuate from the family, this influence is not always for the best (Gordon, 1996). De Gaston and colleagues (1996) noted adolescent males report the perception that their partners pressure them to engage in sex. Females in their study were more likely than males to see peers as less pressuring to engage in sex and more supportive of abstinence. However, several studies have found that associating with sexually active peers, or at least perceiving that peers are sexually active, is a primary influence on sexual activity for females (Gordon, 1996; Whitbeck, Conger, & Kao, 1993). Pistella and Bonati (1998), in their survey of 249 adolescent females, found that respondents were more likely to have discussed "reproductive health topics" with peers than with adults. This relationship may represent cause for concern, in that peers are not necessarily the best sources of information on such topics. DiBlasio and Benda (1994) noted that peers tend to reinforce the idea that the benefits of sex counterbalance the risks. In a study of youths seeking outpatient psychiatric services, Donenberg, Emerson, Bryant, Wilson, and Uber-Shifrin (2001) found that externalizing symptoms were related to peer influence, which was in turn strongly related to substance abuse, needle use, and unsafe sex. Donenberg points out that these behaviors all take place in a social context; "delinquent youths are influenced by peers who support risky behavior and that, at least

partly because of this support, they engage in risky behaviors" (p. 651).

However, it would stand to reason that not all adolescents are equally affected by peers, and peer influence does not always have to be unhealthy. Whitbeck and colleagues (1993) suggest that girls who feel less supported by their families would tend to be more susceptible to peer influences, whereas those with strong relationships with their parents may be better able to resist unhealthy peer influences. Conversely, an adolescent would likely benefit from associating with peers who hold healthy beliefs about sexual issues; attempting to affect individual behavior by changing the norms of the peer group is among the goals of some intervention programs (Donenberg et al., 2001). Indeed, perceiving that peers believe condom use is important has been found to increase frequency of condom use among youth (DiClemente, 1990).

Child and adolescent sexual abuse. The sexual abuse of children is a phenomenon that has been receiving increasing attention in recent years. Studies vary greatly in their estimates of the prevalence of sexual victimization of children, with rates of reported abuse ranging from 6% to 62% for females and 3% to 31% for males. Regardless of which set of numbers one chooses to accept, no one can deny that childhood sexual abuse is a problem meriting serious attention (Conte, 1990).

A study of inpatient adolescents found higher rates of violent behavior, impulsivity, suicidality, substance use problems, and tendencies towards dependent or borderline personality patterns amongst victims of CSA than amongst patients without such histories (Grilo, Sanislow, Fehon, Martino, & McGlashan, 1999). Adolescents with histories of CSA may also be more prone to engage in risky sexual behaviors (Paul,

Catania, Pollack, & Stall, 2001; Taylor-Seehafer & Rew, 2000). In a study of 116 sexually active adolescent psychiatric inpatients, Brown and collegues (2000) found that those who had been victims of CSA displayed deficits in impulse control, knowledge of HIV, and their perceived abilities to use condoms, were less likely to purchase condoms, and reported higher rates of sexually transmitted diseases than peers who had not been victims of CSA. As stated by Brown and colleagues:

> Adolescents with a history of sexual abuse may have particular difficulty being assertive in sexual situations. Sexual abuse may lead to low self-esteem, powerlessness, and difficulty maintaining appropriate sexual boundaries (p. 1415).

CSA likely affects adolescents' heterosocial interactions in part through impaired skill learning because of poor modeling of sexual and other interpersonal interactions. Victims of CSA tend to come from families with a variety of other problems, including domestic violence, drug and alcohol abuse, and neglect of basic needs (Webster, 2001). Often children who experience CSA are physically abused as well. Thus the long-term effects of CSA can be hard to tease apart from the effects of these other factors. Webster describes children who have been victims of CSA as showing a variety of reactions, including sexualized behavior, disturbed sleeping patterns, conduct problems, a tendency to perceive other's behavior as hostile, discomfort with conflict, edginess, pronounced distractibility, or overly compliant behavior. Some show few symptoms, but Webster notes this may indicate that the child is in denial or shock and may display symptoms later in life, which he describes as a "sleeper effect." As expressed by Webster:

> There is a great deal of consensus across many studies using a variety of samples and definitions of CSA indicating that the psychological, social, and emotional effects of CSA are serious, intense, and very complex. Even in the absence of immediate symptoms, one cannot assume that the survivor will go on to lead a normal and reasonably well-adjusted life style (p. 538).

Lifetime consequences of childhood sexual victimization can include anxiety, depression, somatic complaints, substance abuse, communication skills deficits, difficulties establishing and maintaining personal relationships, sexual dysfunction, Post-Traumatic Stress Disorder (Ryan, 1991b) and suicidal ideation and attempts (Ullman & Brecklin, 2002). Some victims of CSA become perpetrators of CSA in adolescence or adulthood (Crimmins, Cleary, Brownstein, Spunt, & Warley, 2000; Romano & De Luca, 1997). In their study of adult sexual offenders, Romano and De Luca determined that 75% of study participants had experienced sexual abuse in childhood. Romano and De Luca hypothesized that these perpetrators were in some ways acting out their own abuse experiences, as most of their sexual abuse experiences occurred when they were between six and ten years old, which was the age of the majority of their victims. In addition, those abused by females were likely to abuse female victims.

Substance abuse. As discussed previously, even those adolescents with strong heterosocial skills may be unable to use them under the influence of mind-altering substances such as alcohol and drugs of abuse. Fortenberry, in a 1995 review of the research, observed that use of drugs and/or alcohol and involvement in sexual activity were closely related for adolescents. Use of drugs and/or alcohol has been associated

with onset of sexual activity (Fortenberry, 1995), earlier age at first intercourse (Smith, 1997), decreased use of birth control (Fortenberry, 1995; Hou & Basen-Engquist, 1997), and increased incidence of pregnancy (McCullough & Scherman, 1991; Walton, Ackiss, & Smith, 1991). Adolescents often tend to use drugs and/or alcohol shortly before having sex (Downey & Landry, 1997). Substance abuse may not only impair judgment, leading an adolescent to engage in behaviors she would not otherwise select, but it may also impair her ability to use birth control devices correctly (Flanigan et al., 1990). In this situation as well, even those adolescents who understand and attempt to reduce the risks of their behavior may be unsuccessful in protecting themselves from STDs and pregnancy.

Although numerous studies have noted a link between substance abuse and sexual behavior, it is unclear whether this association represents a causal link, or whether both behaviors are elements of a general pattern of risk-taking/rebellion (Fortenberry, 1995). Fortenberry observed that in addition to the association with the onset of sexual activity, delinquent behavior also tends to follow closely on the heels of the onset of substance abuse. Doljanac and Zimmerman (1998) and Mitchell and Beals (1997) have found links between high-risk sexual behavior and antisocial behavior, school problems, and cigarette, drug, and alcohol use. Fortenberry (1995) noted that the relationship between sexual activity and substance use declines with age. Possibly as both behaviors become acceptable for adults, they no longer serve the purpose of rebellion.

However, a consistent picture of the "rebellious" adolescent who engages in a variety of rule-breaking behaviors does not always emerge from the research. Contrary to

their expectations, Mitchell and Beals (1997) did not find that the Native American adolescents in their study fit into categories of "good kids" who were engaged in positive/conventional behaviors or "bad kids" who engaged in a variety of problem/ unconventional behaviors, because engaging in one was not inversely related to engaging in the other.

Influence of recent social trends. As discussed above, adolescent heterosocial skill learning and sexual behavior take place in the social context of the larger community. In recent years, adolescents in the United States have become involved in sex at a younger age, exhibited high rates of teenage pregnancy, experienced greater exposure to information about sexuality and birth control, and, most frighteningly, have had to contend with the specter of HIV/AIDS.

In the past few decades, adolescents have begun to engage in intercourse at younger and younger ages (Meschke et al., 2000). In a group of youth involved with the Wisconsin juvenile justice system in 1986, Melchert and Burnett (1990) found the mean age at first intercourse to be 12.5 years. In more general populations, rates of initiation into sexual activity have been reported at 72% of boys and 46.7% of girls aged 15 (Smith, 1997), and 53% of both genders aged 16 (Downey & Landry, 1997).

As Smith (1997) observed, to a certain extent sexual exploration is a normal part of adolescence, but "a few year's difference in the age when teenagers begin having sexual intercourse can make a substantial difference in their ability to manage this complex behavior" (p. 341). Various studies have associated early onset of sexual activity with increased rates of STDs infection (Taylor-Seehafer & Rew, 2000),

pregnancy (Melchert & Burnett, 1990; Smith, 1997), involvement with multiple partners (Smith 1997), greater frequency of sexual activity (Smith, 1997), and lack of or incorrect use of contraception (Melchert & Burnett, 1990; Smith 1997). Miller and colleagues (1998) noted it is unclear whether early sexual activity causes these other problems, or whether both are reflections of an underlying pattern of poor adjustment or poor decision-making. Not surprisingly given these associations, subjects in Melchert and Burnett's study (1990) reported wishing they had waited an average of 1½ years longer to begin sexual activity. As Smith observed, younger teenagers are often not developmentally ready to make good choices about sexual behaviors. In addition, a younger person would be less likely to have had the opportunity to learn the skills necessary for acting on a decision to behave in a more sexually responsible manner.

Although teenage pregnancy rates are beginning to decline from a peak reached in 1991, the United States still has the highest teenage pregnancy rate in the developed world (Meschke et al., 2000). Rates of involvement in sexual activity for American adolescents are similar to those of adolescents in other developed countries, but rates of pregnancy resulting from that activity are much higher for American teenagers. The greatest differences between American pregnancy rates and those of other developed countries appear in the younger age brackets (Foster, 1986). For example, a fifteen-year-old in the United States is four times more likely to give birth than a fifteen-year-old in the developed country with the next highest adolescent pregnancy rate (Fielding & Williams, 1991). Roughly half of young women who become pregnant in the United States carry their fetuses to term and elect to raise the babies themselves (Foster, 1986).

Currently, most adolescents receive some education regarding reproduction in school, and much more information on sexual topics is available in the media than in years past, for better or worse. Existing sex-education programs seem to be successful in increasing teenagers' knowledge about birth control methods, but without necessarily changing adolescents' beliefs that the use of these practices is important to them (Fielding & Williams, 1991; Flanigan, Mc Lean, Hall, & Propp, 1990; Melchert & Burnett, 1990). An understanding of contraception may not imply an adequate understanding of conception. If adolescents do not comprehend *how* birth control methods work, they would not have a sufficient appreciation for why they are important, and thus would be less likely to use them (St. Lawrence, 1993). Even if an adolescent does have a thorough understanding of birth control, she may lack the skills to address this issue in an actual encounter with a partner.

By the 1990s, AIDS had become one of the most common causes of death for young adults (Miller et al., 1998). The Centers for Disease Control and Prevention (CDCP, 1998) estimate that 25% of the 40,000 new HIV infections reported each year are among people 21 and younger. Estimates of AIDS cases diagnosed in 1997 for all adolescents ages 13 to 24 were 1,824. Significantly more female adolescents are contracting AIDS now than in the recent past; by 1996 females represented 46% of adolescent AIDS cases, compared with 14% in 1987. Adolescent females are likely to be infected by an older partner who himself contracted HIV through sex or IV drug use. Minority adolescent gay and bisexual males are at particular risk for AIDS; the CDCP report that in 1997 5 to 9% of this group was infected. Homeless, runaway, delinquent,