New York State Association for the Treatment of Sexual Abusers
and New York State Alliance of Sex Offender Service Providers

15th Annual Conference

Understanding and Treating Sexually Abusive Behavior in Children and Adolescents

Wednesday May 5, 2010

Presented by

Phil Rich, Ed.D., LICSW

Director of Clinical Program Development , Stetson School

(978/355-4541 x114)

www.stetsonschool.org

prich@stetsonschhol.org

phil.rich@comcast.net

– Blank Page –

Working With Sexually Abusive Youth

The Juvenile Sexual Offender and the JSO "Profile"

- Even though we can define some of the characteristics and behaviors typical to many juvenile sexual offenders, and draw a picture based on statistical and self-reported data, it's important to note that there is no such thing as a sexual offender "profile."
- Juveniles who commit sexual offenses do not all look alike and do not belong to an homogeneous group.
- The children and adolescents in this mixed group range widely in their psychological makeup, their behaviors and their history of sexual and non-sexual offenses, and in their personal histories.
- Despite characteristics which are both of concern and lend themselves to the possibility of sexual aggression in children and adolescents, there is no single factor or set of factors that clearly define the juvenile sexual offender.
- There is simply no way to responsibly describe a sex offender "profile."

Juvenile Sexual Offending and Heterogeneity

- The heterogeneity of sexually abusive youth is "one of the most resilient findings in the research on juvenile sexual offenders" (Caldwell, 2002, p. 296).
- Caldwell notes the importance of distinguishing between types of juvenile sexual offenders, lending support to the idea that not only are sexually abusive youth different from one another but they are not simply cut from the same cloth of "juvenile delinquency."
- One perspective is that juvenile sexually abusive behavior represents a special pathway that is subtly but nevertheless distinct from the pathway that leads to non-sexually abusive juvenile delinquency.
- This is true, even if juvenile sexual offenders and non-sexual juvenile offenders share similarities and even common roots.

Heterogeneity and the "Other" Juvenile Sexual Offenders

- Even as we recognize heterogeneity and different "types" of juvenile sexual offenders, it is important to also recognize that most of the research on sexual offenders has primarily been conducted with adult men, and secondarily with adolescent males, with IQs that typically fall somewhere between the low average to high average range of intellectual functioning.
- Therefore, as we discuss sexual offenders, as individuals or as types, whether adult or adolescent we are most typically exploring the behavior of average IQ male sexual offenders.

Working with Adolescent Sexual Offenders

- Working with adolescent sexual offenders and sexually reactive children is a substantially different proposition than work with adult offenders.
- This is primarily because sexually abusive behavior in both children and adolescents appears far more tied to developmental issues than sexual deviance, in terms of the emergence of personality, psychological development, response to the social environment and social messages, and the myriad of forces that shape and define the emotions, cognitions, relationships, and behavior of children and adolescents.

Our Understanding of Sexually Abusive Youth

- More specifically, it is both how we *understand* sexually reactive children and sexually abusive adolescents, compared to adult sexual offenders, that is different, as well as the way that we actually define and provide treatment for these different populations.
- Here, it's important to highlight that we are discussing, not two, but <u>three</u> populations.
- Although we tend to group children and adolescents who engage in sexually abusive behavior under the label of "juvenile sexual offenders," these are two distinct populations in their own right, with acute differences between them.

Adolescents, Children, and Other Juvenile Offenders

- Just as we conceptualize differences between adolescent and adult sexual offenders, we similarly conceptualize differences between sexually abusive post-pubescent adolescents and sexually abusive pre-pubescent children.
- Expanding this idea further, we also note other sub-populations included under the rubric of "juvenile sexual offender," including teenage (and pre-adolescent) girls, cognitively challenged children and adolescents, and other sub-populations that include adolescents from distinctly different cultures, for instance.

Heterogeneity among Sexually Abusive Youth

- If we fail to recognize and acknowledge these differences, we risk building a "one-size-fits-all" mentality which is not only unlikely to provide depth in understanding our clients and the roots of their behavior, but also limit specialization in treatment for different treatment groups.
- Further, as it's become a near tenet of current treatment that sexual offenders are not a homogeneous group, we risk failing to live up to our own stated beliefs that great heterogeneity exists, not simply <u>within</u> the larger group of "sexual offenders" but <u>across</u> different groups, by age, gender, cognitive and intellectual capacity, level of psychological/psychiatric functioning, and ethnic and cultural background.

Sub-Populations

- As we consider sex offender specific treatment, it is important to bear in mind that there are many sub-populations within the larger category of "sexual offender."
- Although this workshop focuses on male adolescent offenders, we recognize that we can apply some of the same ideas to other groups of young persons, including girls and young women, children, and cognitively impaired juveniles, but also that there significant differences among these sub-populations.

Distinguishing Between the Treatment of Adolescent and Adult Sexual Offenders

- In many substantial ways, work with juvenile sexual offenders is much like mental health and developmental work with any troubled child, involving:
  - Relationship building,
  - The exploration and development of attitudes, beliefs, and interests,
  - The emergence of empathy and social connectedness, and
  - The influence and context of the family.
- Compared to adult sexual offenders, sexually abusive youth are far less fixed, if fixed at all, in their social, emotional, attitudinal, behavioral and, in this case, sexual preferences and interests.
- Accordingly, they are far more amenable to treatment which, therefore, has the clear capacity to eliminate the problem of sexually abuse behavior by the time the child or adolescent reaches young adulthood.

The Developmental Process

- Regardless of their behavior, adolescents are still very much in the developmental process, have few fixed ideas or beliefs, are easily influenced and shaped by their social environment, and are still very experimental in their behaviors and attitudes as they try out and develop life scripts and personal identities.
- Rather than having the fixed ideas, interests, and motivations that characterize adults, adolescents are far more fluid in every aspect of their lives, and this is a normative aspect of the human developmental cycle.
- This is as true for juvenile sexual offenders as it is of any adolescent.
- In addition, adolescents are used and open to the educational and learning process as it permeates their lives in a way not true for most adults, and this aids in the process of treatment and change.
- Finally, with specific respect to sexual offending, juveniles experience far less deviancy in their sexual activities and arousal patterns and are far more motivated by experimentation, even if abusive and sometimes heinous in nature.

Desistance and Risk in Juvenile Sexual Offenders

- Although it likely that many adult sex offenders began their histories of sexually abusive behavior as adolescents, virtually every study, despite weaknesses in the research, tells us that many, if not most, treated juvenile sexual offenders will not become adult sexual offenders.
- Nevertheless, the possibility of emerging adult sexual offending speaks to its adolescent counterpart as an “at risk” condition.
- This highlights the importance of providing treatment to sexually abusive children and adolescents, and, given the relatively low incidence of the behavior persisting into adulthood, the strong possibility that intervention helps prevent the development of the fixed interests and behaviors that lead or contribute to later adult sexual offending.

Differences Between Adolescent and Adult Offenders

- Adolescents are not adults, even as they near that blurry line between late adolescence and adulthood.
- However, the things they do and their experience of life certainly shapes and influences not just their personality and behavior, but the sort of adults they’re likely to become.
- Not surprisingly, adolescent and adult sexual offender share many similar life experiences and resulting behaviors and characteristics.
- These experiences often include variants of disrupted and unstable childhood experiences, broken or unstable family environments, the presence of domestic violence, and abuse, neglect, and other forms of maltreatment, as well as insecurely developed attachment relationships to parents.

Patterns and Contexts of Sexually Abusive Behavior

- Nevertheless, despite these commonalities, it is important that we not confuse adult behaviors, motivations, and pathways to offending for those of adolescents, even if they appear similar.
- Adult patterns of and motivations for sexual offending behaviors differ from those of adolescents who engage in similar behaviors.
- Most often, juveniles engage in sexually abusive behavior for entirely different reasons than their adult counterparts, and travel along pathways that may or may not lead them further into sexual offending.
- In large part, this is because, despite seemingly common developmental pathways, the experience of each individual along that pathway is shaped by the context of that individual’s life. In the case of the sexually abusive youth, that context is adolescence.

The Adolescent World

- In fact, adolescents live in a very different world than that of adults, embedded as children within family and community systems and subject to a different set of rules, expectations, and obligations than adults.
- They are also substantially different in the development of their bodies, in their cognitive and personality development, in their formation of attitudes and acquisition of information, and in their emotional and behavioral maturity.
- Adolescents experience the world in ways that are significantly different than adults, and are stimulated, pleased, influenced, and motivated by different things, and are more experimental, with fewer fixed ideas than adults and fewer fixed personality characteristics.
- Their interests are still developing, and ideas, attitudes, emotions, and behaviors that may be considered outlandish, inappropriate, hostile, antisocial, or even deviant in adults, may not represent any of these things in adolescents.

Adolescent Neurology

- Adolescents are not adults. This is not just because they are at a different point in the development of their emotional lives, the gathering of life experience, and the experience of their daily lives.
- It is also because they are at a different point in the development of their neurological lives and cognitive skills.
- In addition to multiple behavioral, emotional, and social changes that occur during adolescence, Linda Spear (2000) describes significant and on-going physical, cognitive, and neurological development.
- Similarly, Jay Giedd (2002) describes continuing neural development beginning during early adolescence and continuing through until about age 16, involving a thickening of gray matter in the prefrontal cortex, or the further development of neural cells and their axons and dendrites.
- This development involves the extension of cognitive skills, including the capacity for increased abstraction, insight and judgment, attention and freedom from distractibility, and decision making skills, all functions involved in the development of executive functioning.

The Emotional Adolescent Brain

- Spear (2003) also describes greater emotionality in adolescents compared to adults, including a greater sensitivity to negative emotions and depressed mood.
- Deborah Yurgelun-Todd (2002) similarly reports that adolescents experience more emotional responses than adults, but have not yet developed the prefrontal capacity to accurately identify or process emotions.
- She writes also that adolescents are more susceptible than children or adults to neurological reward systems that drive and reward certain types of risk taking and exploratory behavior.
- In general, just as the adolescent is socially and physically in transition between childhood and adulthood, not surprisingly the adolescent brain in is transition also, described by Spear as differing anatomically and neurochemically from the adult brain.

Adolescent Neurological Decision Making

- In describing the capacity of adolescents to be held fully (or legally) responsible for their behavioral choices, Laurence Steinberg (2003), also describes the critical role of brain maturation, with a particular focus on regions of the prefrontal cortex implicated in planning and impulse control and the ability to both learn from experience and balance rewards against risks in decision-making.
- He asserts that it not a matter of whether adolescents can distinguish right from wrong, but the fact that they are distinguished from adults in their neural/cognitive capacity to form decisions that take into account the possible consequences of their behaviors, the way they weigh rewards against risks, their foresight and ability to plan ahead, and their ability to recognize and control impulses

A Foundation for the Treatment of Sexually Abusive Youth

Treatment Based on Case Formulation, not Formulaic Treatment

- Treatment must focus on the psychosocial and developmental histories and current treatment needs unique to each individual client.
- That is, as is true for any form of mental health treatment, treatment for sexually abusive youth must be comprehensive, individually driven, and based on case formulation, not formula.
- We are working with real people. The behavior of real people is complex, multi-faceted and multi-dimensional.
- Real people have multi-dimensional histories and multi-dimensional needs.
- Treatment must focus on the psychosocial and developmental histories and current treatment needs unique to each individual client.

Treatment as Rehabilitative and Re-Constructive

- Treatment of sexually abusive behavior is about rehabilitation, rather than "cure."
- The goal is to change direction and rehabilitate attitudes, ideas, and behaviors that may be generally ineffective or antisocial, self-destructive, or harmful to others.
- In treatment, we seek to understand the source and basis of problematic interactions and behaviors, and rehabilitate mental maps and cognitive schema that underlie and essentially responsible for such problems.

Treatment Is Integrated and Holistic

- The treatment of sexually abusive youth is moving away from simplistic and single-minded psychoeducational or cognitive-behavioral models of treatment.
- It is instead moving towards a more integrated and holistic view of sexually abusive behavior in children and adolescents, and accompanying treatment needs.
- This results in a shift in our thinking at every level, including how we assess risk and how and what we provide in treatment, including group, individual, and therapy.

The Complexity of Treatment

- Work with child and adolescent sexual offenders is complex as it deals with:
  - Developmental and cognitive issues,
  - Personality development,
  - Family and community systems,
  - The complex interplay between developing emotions and behaviors,
  - The line between normative sex play/experimentation and the development of sexually abusive behavior,
  - Psychiatric co-morbidity (co-existence),
  - Social learning, and often
  - The possibility of personal trauma in the juvenile offender.
- We are working with young people, troubled and troubling in behavior, still very much in the process of exploration, development, and maturation, and still very much influenced and directed by the messages embedded in the activities, relationships, social models, and larger social environment that surrounds them.

Treatment as Multi-Dimensional

- A comprehensive model of treatment includes multiple treatment components, wrapped into an integrated and multifaceted model.
- In order to meet disparate goals, treatment must be:
  - Multi-modal: not all treatment services can be provided through a single mode of treatment,
  - Multi-disciplinary: no one mental health or related discipline can provide the range of identified treatment services, and
  - Multi-theoretical: it is unlikely that a variety of goals can be accomplished through a single-theory model.

Sex Offender Specific Treatment Is Comprehensive, Integrated, and Holistic

- The multi-modal, multi-disciplinary, and multi-theoretical components of sex offender specific treatment are integrated and part of a larger treatment program, and not simply a loosely strung together bunch of treatments.
- This implies coordination among the parts, communication among the treatment team members who deliver each component, and a coherent vision that ensures each modality is a component within a larger model.
- A holistic treatment model treats the whole person, and not just abuse-specific behaviors.

Treatment Is Comprehensive and Broad

- Rather than limiting themselves to treatment aimed solely at sexually abusive behaviors, juvenile sexual offender treatment programs are increasingly moving towards the broader end of the treatment spectrum.
- Programs of treatment are more often including treatment in the affective/psychiatric domain, including psychotherapy, individual and group work that is psychodynamically oriented, and expressive treatments.
- This is a shift from the largely cognitive-behavioral approach adapted from substance abuse treatment models that focuses largely on cognitive distortions, relapse prevention planning, and skill development.
- Nevertheless, cognitive-behavioral treatment remains a mainstay of juvenile sexual offender treatment.

Treatment is Well Defined and Structured: Ten Stages of Treatment

1. Stabilization and Containment.
2. Engagement and Attachment.
3. Acceptance of Responsibility.
4. Learning New Language and Ideas.
5. Developing Awareness.
6. Applying New Ideas to Behavior.
7. Commitment to Change.
8. Development and Application of a Behavioral/Relapse Prevention Plan.
9. Discharge from Active Treatment.
10. Maintaining a Safe Life Style.

Treatment is Well Defined and Structured: Eleven Treatment Tasks

1. Understanding Sexual Motivation and Cause.
2. Acquisition of Psychoeducational/Cognitive-Behavioral Concepts.
3. Development of Self-Concept and Personal Identity.
4. Disclosures of Sexually Abusive Behavior.
5. Development of Social Skills.
6. Provision of Family Therapy and Resolution of Family Factors.
7. Victim Awareness and Clarification.
8. Relapse Prevention Planning.
9. Diagnosis and Resolution of Co-Morbid Conditions.
10. Provision of Psychopharmacology (where necessary).
11. Appropriate and Adequate Education.

Treatment is Well Defined and Structured: Twenty Goals of Treatment

- Treatment can aim at 20 primary goals which, if accomplished, leave the youth in a position to continue to grow in a pro-social direction.
- These goals provide a clear description of the ideal outcomes of sex offender specific treatment.

1. Appropriate Boundaries
2. Awareness of Others
3. Emotional Regulation
4. Engagement and Attachment
5. Enhanced Support Network
6. Healthy Sexual Development
7. Increased Responsibility
8. Improved Family Functioning
9. Impulse Deferment
10. Internalized Behavioral Control
11. Moral Development
12. Pro-Social Attitudes
13. Pro-Social Behaviors
14. Remission of Psychiatric Co-morbidity (co-existence)
15. Resolution of Sexual Deviancy
16. Retention and Transfer of Skills
17. Self-Esteem
18. Skill Enhancement
19. Social Competency
20. Tolerance for Emotional Distress

Treatment Treats the Whole Person

- Treatment of the whole child means viewing the problem of juvenile sexual offending from many angles, and attacking through treatment and rehabilitation as many of those problems as possible, or at least identifying them as significant factors to be addressed.
- Treating the whole child means treating different aspects of the pathology presented by the juvenile in treatment, but it also means recognizing the array of forces at play in the lives of each individual child or adolescent.
- In treating the "whole" person, we treat:
  - The sexual offenses that brought the youth into treatment in the first place.
  - Co-existing psychiatric conditions that may be affecting the youth.
  - Behavioral and relationship issues that shape and influence self-perception and interpersonal relationships.
  - Issues of developmental trauma and life changing experiences that may have a profound effect on the youth's development and current behavior.
  - Issues of self-identity, self-concept, and self-esteem.
  - Social skills and the experience of social mastery and personal competency.
  - Family, environmental, and other systemic issues that may affect and strongly influence thinking, behavior, and relationships.

The Dynamics of Sexually Abusive Behavior

Distinguishing Normative Sexual Behaviors from Sexually Inappropriate and Abusive Behaviors

- It is important to not consider all sexual behaviors, even inappropriate sexualized behaviors, as sexually abusive.
- Ryan (1999b) speaks of the distinction between sexual behaviors, sexual relationships, sexual experiments, and sexual abuse when she writes "it is not the sexual behavior that defines sexual abuse, but rather, it is the nature of the interaction and the relationship that give an accurate definition" (p. 424)
- The sexual behavior of children and adolescents develops over time, like other areas of growth. Many behaviors are healthy, and are normal for children at certain ages.
- Adolescents who initiate or participate in sexual activities, although we may not like or agree with the changing culture, are often following social norms, or helping to set the pace.
- Sometimes, these behaviors may seem, or in fact *are*, exploitive of others, but such behaviors are not necessarily criminally or sexually abusive, nor unusual during adolescence.

Distinguishing Normative Sexual Behaviors from Sexually Inappropriate and Abusive Behaviors

- Our job is to understand the behaviors, distinguish between normative and disturbed behaviors, and either help shape values and behavior or provide treatment interventions as appropriate, without over-stating or pathologizing normative adolescent behaviors, even though they may trouble us.
- Many children below the age of puberty who engage in sexual activities with other children their age or younger may not be engaged in sexual offending behaviors at all, or may not be intending to engage in sexually abusive behavior.
- Younger children may sometimes be engaging in mutual or otherwise non-abusive sexual play with others, and it is important to distinguish between sexual abuse and various forms of sexual play and sexual experimentation in this age range.

The Characteristics of Sexually Abusive Behavior: Consent, Inequality, and Coercion

- It is clear that in the assessment of risk for sexual re-offense it is sexually abusive behavior with which we are concerned, and not sexually inappropriate or appropriate behavior.
- A first step is to be sure that we understand the nature of sexually abusive behavior, as best as we can.
- The National Task Force on Juvenile Sexual Offending (1993) defines sexual abuse as behavior that occurs: (a) without consent, (b) without equality, or (c) as a result of coercion.
- The task force concluded that sexually abusive behavior is best represented by a continuum of behaviors, that contain all or some of these and related elements.
- These elements provide a useful platform upon which to understand the nature of sexual behavior that is truly *abusive* as opposed to inappropriate or appropriate but outlawed in some fashion, although not abusive.

Lack of Consent

- The strongest and clearest characteristic of sexual abuse is lack of consent, regardless of lack of equality or method of compliance. Here, sexual contact is unwanted to one degree or another, falling along a continuum.
- At one end it is experienced as a boundary violation that otherwise presents no great risk of harm. At the other, sexual contact represents an extreme violation of boundaries in which consent is neither given nor sought and the victim experiences great fear and harm.
- Both ends constitute sexual crimes, but it is in the latter case that consent is most clearly lacking.

Inequality

- Clear and unmistakable lack of consent eliminates the need to assess for the presence of inequality or coercion as factors that define a sexual behavior as abusive.
- However, in defining sexual behavior as abusive, even when consent appears to be given, we may also look to the nature of equality in the relationship.
- In seeking evidence that the behavior was abusive, we seek to understand the role played by the juvenile's physical size, authority or power, relationship, or mental capacity in gaining compliance and, perhaps as important, the juvenile's knowledge that he or she was in a more powerful position and could thus exert influence as a result.

Coercion

- Coercion is a close cousin to inequality as it implies power or control of some kind, and it is the level and type of coercion that helps point to a sexual behavior as abusive.
- Extreme forms of coercion such as threats, actual use of force, blackmail, and extortion make it clear that the behavior was unwanted and thus make it equally clear that there was no consent.
- Milder forms of coercion are commonplace in juvenile sexual offending and include promises or actual rewards of various kinds, or forms of manipulation or exploitation by which consent for sexual behavior was freely given, or at least implied.
- The elements of inequality and coercion are closely intertwined and sometimes overlap with the presence of consent. In some cases, consent is not freely given and is actually the result of a misuse of authority or prestige (inequality) or promises, rewards, intimidation, threats, or actual harm (coercion).

Consent, Inequality, and Coercion

- Even though we can point to sexual behavior as abusive in the absence of true consent and in the presence of inequality and coercion, it is also clear that it is the particular combination of circumstances and one or more of these elements that come together to produce abuse.

Sexual Behaviors in Children

- Children's sexual behavior develops over time, like other areas of growth.
- Many behaviors are healthy and are normal for children at certain ages.
- Whether parents and adults in general are comfortable or not, these are the normative behaviors of childhood and adolescence.
- However, there are other sexual behaviors with which we should be concerned.
- Children under age 12, including children as young as 3 years, can demonstrate clinically significant sexual behavior problems, including those involving intrusive acts against other children.
- Some childhood sexual behaviors are "worrisome" and should not be ignored or seen as child's play.
- Other behaviors are more serious and may be dangerous to the child and others.

Appropriate and Inappropriate Child and Adolescent Sexuality

- When a child engages in sexual behaviors, it can be difficult to decide when the behavior is natural and healthy and when it may reflect a problem or disturbance.
- That is, they become a special concern when sexual play or behaviors are not welcomed by both parties. This is the point at which sexually abusive behavior most closely and clearly hinges.
- The report of the ATSA Task Force on Children with Sexual Behavior Problems (Chaffin et al, 2006) describes the importance of distinguishing between childhood sexual behavior problems and normative childhood sexual play and exploration, which the task force describes as occurring spontaneously, intermittently, and non-coercively, and without causing emotional distress.
- The task force reports that although sometimes including sexual curiosity, interest in sexual body parts, and sexual stimulation, normative sexual behavior in children does not involve preoccupation or include advanced and adult-like sexual behaviors.
- In assessing whether the sexual behavior is inappropriate, the task force notes the importance of considering the behavior in the context of the child's developmental level and age, as well as the child's culture; the frequency, extent, and form of the sexual behavior, and the degree to which it has become a focal point for the child, and whether the child responds to adult direction to stop the behavior.
- With regard to childhood sexual behavior as potentially or actually harmful to others, the task force points to several distinguishing features, including:
  - age and developmental differences between the child and other children involved in the behavior,
  - emotional distress in other children,
  - problems in social functioning as result of the behavior, and
  - any use of force, intimidation, or coercion to gain compliance.

Nine Concerning Behaviors in Childhood Sexuality

Johnson (1999, 2001) has developed a checklist of sexual behaviors or attitudes in children that signal concerns, including the presence of sexually abusive behavior, which can be consolidated in nine points:

1. Sexual play should not be the only kind of play in which children engage.
2. Children should not sexualize relationships or see other children or adults as objects for sexual interactions.
3. Children should not be engaged in sexual play with children much younger or much older than themselves, or direct sexual behaviors toward adolescents or adults.
4. Children should not be preoccupied with and driven to engage in sexual play and behaviors, and stop when told to by an adult.

Continued

Nine Concerning Behaviors in Childhood Sexuality *(continued)*

5. Children should not have unusual or precocious knowledge of sex beyond their age, or behave in a sexual manner that is more like an adult than a child; children's sexual behaviors and interests should be similar to the sexual behaviors and interests of other same-age children, and should not become more intrusive and more noticeable over time.
6. Children's sexual behaviors should not lead to complaints from or have a negative effect on other children; should not be connected to bribery, threats, or manipulation; and should not cause physical or emotional pain or discomfort to themselves or others.
7. Children aged 4 and older should understand the rights and boundaries of other children in sexual play; children should not use distorted logic to justify their sexual play.
8. Children should not experience fear, shame, or guilt in their sexual play; sexual behaviors shouldn't follow or be followed by expressions of anger or other negative feelings.
9. Children should not engage in sexual relationships or activities with animals.

Pathways to Sexually Abusive Behavior in Children and Adolescents

The Development Of Adult Behavior

- We recognize, of course, that "adult" behavior doesn't simply pop into existence at age 18. It is developmental, which is precisely one of the reasons that it is important to understand that the roots of such behavior are established in adolescence, and sometimes in childhood, and recognize and treat the precursors to seriously troubled adult behavior before adulthood is reached.
- The DSM diagnosis of antisocial personality disorder, for example, cannot be made in individuals before age 18 but also requires that a diagnosis of conduct disorder has been carried for at least three years, with onset before age 15.
- However, recognizing than that the etiology of adult behavior is developmental, we must nevertheless be careful how we view troubled behavior in children and adolescents, and the conclusions we draw about implications for future behavior.

The Adultification of Adolescents

- Zimring (2004), for instance, warns us to take into account the developmental status of juvenile sexual offenders, with respect to the moral significance of their current behaviors, predictions of future behavior, and implications for treatment.
- Steinberg and Scott (2003) consider adolescents as developmentally immature when compared to adults, and in particular with respect to their decision making capacity, increased vulnerability to social circumstances, and still forming character and personality, as well as brain maturation and general psychological development.
- Steinberg (2005, p. 70) writes that is though "one is starting an engine without yet having a skilled driver behind the wheel."
- Additionally, Steinberg (2003) warns against the "adultification" of juvenile offenders, noting descriptions that sometimes label young offenders as "career criminals," "super predators," and "fledgling psychopaths."

The Impact of Early Developmental Experience

- Juvenile sexual offenders are a heterogeneous group who range in interests, self-image, identity formation, personal skills, social competencies, and behaviors. However, many juveniles who sexually offend do share common, and often predictable, features.
- Such commonalities can often (but not always) be found in family life, personal history, interpersonal connections, social competencies, academic functioning and motivation, and patterns of non-sexual behaviors.
- However, these same commonalities, life experiences, and life styles can be found in other children and adolescents who do not engage in sexually abusive behaviors. Indeed, sexually abusive juveniles take a different pathway than other kids who are similar in every respect, but who do not sexually offend.
- Consequently, there exists a belief that there is an *extra* pathology that has led them to sexual offending, and it is this missing extra element that marks the juvenile sexual offender.

Pathways to Sexually Abusive Behavior

- In the world of adolescent development there are clearly multiple pathways to sexually abusive behavior.
- These are driven by multiple motivations and influenced by multiple factors and variations in individual development that push different individuals along different passages through life.
- Nevertheless, it is reasonable to seek commonalities that allow us to spot danger signs for both the development of juvenile sexual offending and continued juvenile sexual offending in those instances where a sexual offense or sexually aggressive/abusive behavior has already occurred.

Developmental Pathways

- Developmental pathways can be thought of as channels through which children and adolescents pass en route to sexually abusive behavior, and by which their movements are directed along the journey.
- The developmental pathway model provides a means for recognizing starting points along a journey, a predictable end point (or result), and other mediating influences along the way.
- It can help us picture the sort of paths along which children and adolescents are channeled in their journey towards sexual offending, even though in real life situations many may not fit the mold.
- However, although there are many common features in the lives and development of juvenile sexual offenders, there are also countless permutations of markers, mediators, activators, dampeners, risk factors, and protective factors, all of which combine in unique ways to define the lives of different individuals.
- In their exploration of developmental pathways, Hunter, Figueredo, Malamuth, and Becker (2004) reported that: (i) childhood exposure to violence against women, and (ii) male-modeled antisocial behavior increases the risk of sexual aggression, and psychosocial deficits and egotistical-antagonistic masculinity plays an important shaping role in sexual offenses against children.
- They consider that these factors support the idea of social learning, in which boys internalize and mimic socially deviant behaviors in their social environment.
- Hunter et al. (2003) have written that “hostile masculinity” is a strong predictor of sexual aggression in boys.
- Similarly, Malamuth (2003) statistically links adult male sexual aggression to two primary developmental risk factors: (i) an early abusive home life that contributes to the development of impersonal and promiscuous sexuality and (ii) the presence of hostile masculinity.
- Knight and Sims-Knight (2003, 2004) also propose that sexual aggression in adult men can be statistically understood through the presence of three primary developmental elements: (i) early childhood sexual abuse, (ii) childhood onset aggressive antisocial behavior, and (iii) callous unemotionality.

Role of Personal Victimization and Maltreatment

- Among the 3,400 subjects studied in the U.S. National Health and Social Life Survey, Laumann (1996) reports that a strong relationship exists being touched sexually as a child and elevated rates of sexual activity, sexual dysfunction, and general sexual discomfort in adulthood.
- In fact, juvenile sexual offenders are more likely to have been sexually or physically abused than the general population of adolescents and children, which may represent a significant factor in the development of the juvenile sexual offender.
- Lee, Jackson, Pattison, and Ward (2002) assert that childhood sexual, physical, and childhood emotional abuse and family dysfunction are general developmental risk factors for later sexually abusive behaviors and, more specifically, they report that childhood sexual abuse is a predictor for pedophilia.
- This does not mean that all, or even most, juvenile sexual offenders have been victimized in such ways, or that such victimization is a necessary cause or inevitably leads to the development of sexual offending. On the contrary, such abuse does not appear to be directly related to the development of sexual offending nor is it always present.
- In itself, a history of abuse is neither an explanation for sexually abusive behavior nor a necessarily causative factor.
- In fact, most childhood victims of physical or sexual abuse do not go on to perpetrate abuse against others, nor do most physically or emotionally deprived children become abusive, aggressive, or neglectful.

Role of Personal Victimization and Maltreatment

- Nevertheless, Knight and Sims-Knight (2004) write that a history of physical abuse or witnessing domestic violence may contribute to the development of sexual violence in adolescents.
- Hunter, Figueredo, Malamuth and Becker (2004) also support the position that childhood exposure to violence, especially towards women, increases the risk of aggression and delinquency in juvenile sexual offenders.
- Addressing the fact that most victims do not later develop into perpetrators, Knight and Prentky (1993), Burton (2000), and Knight and Sims-Knight suggest that the connection between childhood abuse and later sexual offending may be linked to the victim-offender relationship, the frequency, type, and physical invasiveness of childhood abuse, and the developmental stage at which such abuse occurred in the life of the child.
- Hunter, Figueredo, Malamuth, and Becker (2003) similarly assert that the characteristics of an adolescent's own sexual victimization will define his characteristics as a perpetrator of sexual aggression. Likewise, Knight and Sims-Knight hypothesize that childhood sexual abuse directly or indirectly increases the risk for the development of aggressive sexual fantasies.
- Wyre (2000) asserts that "the type of relationship with the abuser will often determine the nature of the experience for the child and influence whether or not the child is likely to be predisposed to abusing children" (p. 65).

Cycles of Sexual Abuse

- The Office of the U.S. Surgeon General (U.S. Department of Health and Human Services, 2001) has reported that child abuse and neglect are weak predictors of violence, and that being the victim of sexual abuse does not predict violence.
- Glasser et al. (2001) write that few studies actually support the idea of a "cycle" of sexual abuse, in which perpetrators are somehow re-enacting or resolving their own abuse, and the U.S. General Accounting Office (1996) found no conclusive evidence to support the idea that childhood sexual abuse results in the development of adult sexual offenders.
- Similarly, Craissati, McGlurg, and Browne (2002) have written that "numerous questions remain unanswered regarding the nature of the relationship between sexual victimization in childhood and the subsequent perpetration of sexual assaults" (p. 225).
- Consequently, although histories of physical and sexual victimization are quite common in juvenile sexual offenders, the link between victimization and perpetration remains speculative.
- Although we recognize that a history of childhood sexual abuse is a risk factor, we also know that "the vast majority of sexual abuse victims do not become sexual abusers" (Ryan, 1999b, p. 134).
- Accordingly, such experiences alone are not adequate explanations for juvenile sexual offending, making clear that the issue of child maltreatment and its relationship to sexual aggression is far more complex.
- Consequently, we believe that childhood trauma, and in this case the experience of childhood sexual abuse, is only a single factor that combines with many others to produce sexually aggressive behavior.

History of Maltreatment

- Among both those juvenile sexual offenders who have been sexually or physically abused and those who have not, many have experienced a wider range of maltreatment that includes neglectful and generally inadequate parenting and child rearing practices, as well as negative and dysfunctional living and child-rearing environments.
- In her review of the literature of child maltreatment in the histories of juvenile sexual offenders, Way (2002) reported high rates of childhood sexual and physical abuse, family violence, and neglect, including maltreatment beginning at an early age and of long duration, perhaps disrupting multiple stages of personality and emotional development.
- Ryan (1999a) writes that when physical violence, sexual abuse, and parental neglect are included as maltreatment factors, "almost the whole population (of juvenile sexual offenders) can be seen to have experienced some type of maltreatment" (p. 134).
- In their wide ranging review of the professional literature on juvenile sexual offending literature, Righthand and Welch (2001) agree, suggesting that childhood experiences of physical abuse and family violence are both common and seem associated with sexual offending.

History of Maltreatment

- Bailey (2000) writes that "juvenile sexual offenders often come from disadvantaged backgrounds with a history of victimization" (p. 206).
- Similarly, Weinrott (1996) writes, "however flawed the measures of personal victimization, it seems pretty clear that juvenile sexual offenders are likely to have encountered some form of abuse or parental neglect" (p. 23).
- Lee et al. (2002) agree, stating that family dysfunction often goes hand in hand with childhood difficulties among sexual offenders, concluding that childhood sexual, physical, and childhood emotional abuse and family dysfunction are general developmental risk factors.

History of Domestic Violence

- The witnessing and experience of family violence serves as both an aspect of maltreatment and as a likely risk factor in the development of later sexual offending.
- Ryan et al. (1996) note that 63% of the 1,000 juveniles included in their study witnessed family violence.
- Bailey (2000) describes exposure to repetitive or extreme violence in the family environment as a risk factor for aggressiveness and violence.
- Skuse et al. (2000) report that male victims of sexual abuse are more likely to become sexual abusers if they have witnessed family violence, although they also write that "it may be more appropriate to view a climate of violence as conferring an <u>increased</u> risk, whether or not the boy is a direct victim of the physical abuse" (p.229).
- This is echoed by Bentovim (2002) who describes family violence as a distinguishing element found in juvenile sexual offenders who are also sexual abuse victims.
- Print and Morrison (2000) conclude that "adolescents who sexually abuse others often have major care deficits and frequently grow up in families in which they experience and/or witness violence, lack of empathy and a lack of sexual boundaries" (p. 296).

Troubled Attachments

- Pithers, Gray, Busconi, and Houchens (1998) suggest that an important link to the development of adolescent offending of all types may in part be due to the insecure and damaged attachment that develops between children and parents as a result of neglect and maltreatment.
- Bailey (2000) writes that physically abused and neglected infants typically develop insecure attachments with care givers.
- Although unable to discriminate between sexual and non-sexual offenders with respect to attachment style, there is support for the hypothesis that sexual offenders have troubled childhood experiences.
- Early childhood difficulties appear a general risk factor for later troubled, antisocial, and criminal behavior, rather than sexually abusive behavior in particular.
- Early insecure attachment experiences may place some individuals at risk for sexually abusive behavior in the context of other factors present in their lives, supporting insecure attachment as a general factor, potentiated by other life circumstances.

Theories Regarding Juvenile Sexual Offenders and Social Connection

- Miner and Crimmins (1997) report that although juvenile sexual offenders do not differ significantly than non-sexual juvenile delinquents in either attitude or behavior, they were significantly more isolated from family than non-delinquent youth and more socially isolated from peers than violent delinquents.
- Miner points to the importance of peer relationships in adolescent healthy and well adjusted behavior, the possibility that juvenile sexual offenders expect adult and peer rejection, and the centrality of attachment difficulties in the development of sexually abusive behavior.

Theories Regarding Juvenile Sexual Offenders and Social Connection

- Miner and Swinburne-Romine (2004) found that juvenile sexual offenders who molest children have fewer friends, feel more isolated, associate with younger children, and have more concerns about masculinity than other juvenile sexual offenders or non-sexual juvenile offenders.
- They do not consider juvenile sexual offenders to be more rejecting of social relationships than non-sexual juvenile delinquents, just less competent, and believe that there is a link between attachment, social isolation, and sexually abusive behavior.
- Juvenile sexual abuse appears driven by socially isolated, normless behaviors rather than by aggression, at least in those who molest children.
- This mirrors the conjecture of Hudson and Ward (2000) that sexually abusive behavior among adults is often more connected to the need for social connection and the acquisition of social goals than deviant sexuality.

Attachment, Juvenile Sexual Offenders, and Social Connectedness

- Miner points to the importance of peer relationships in adolescent healthy and well adjusted behavior, the possibility that juvenile sexual offenders expect adult and peer rejection, and the centrality of attachment difficulties in the development of sexually abusive behavior.

Attachment-Mediated Developmental Pathways

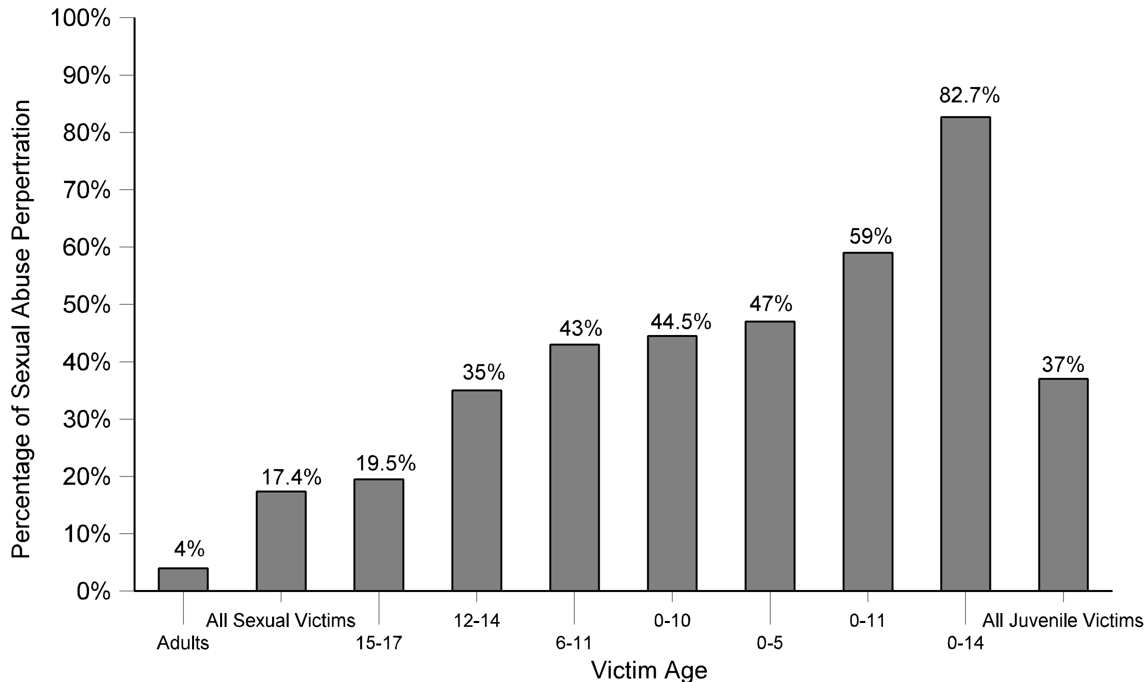
- Thus we see a developmental pathway that involves social relatedness and security in social relationships, social competence, emotional dysregulation in the form of anxiety that has resulted from earlier developmental experiences, and an interest and need to engage in social relationships, including sexual relationships, but deficits in the social and psychological mea ns to do so.
- Important in the model is the element of early maltreatment and especially early or premature exposure to sexual ideation, including the possibility of the juvenile's own sexual victimization.
- Daversa and Knight (2007) offer support for the elements of this developmental model, suggesting that adolescent sexual offenders struggle with the challenges of adolescent masculinity, are self-conscious about their physical appearance and appeal, and feel or are unable to compete with peers in the social world.
- They, too, conclude that adolescents who sexually abuse children experience social isolation and experience themselves as inadequate, are submissive, dependent, and socially isolated, experience feelings of sexual and social inadequacy, as well as anxiety and rejection.

Attachment-Mediated Developmental Pathways

- The on-going studies of Miner and colleagues further support this etiological model, at least for adolescents who sexually abuse children.
- Miner et al. hypothesize that juvenile sexual offenders:
  - Are insecurely attached to others.
  - Experience difficulty forming relationships.
  - Have fewer friends.
  - Feel more isolated.
  - Have more concerns about masculinity.
  - Feel socially inadequate,
  - Experience more social anxiety than other adolescents, including non-sexual juvenile offenders, although are not rejecting of social relationships even though not able to easily approach or build peer relationships.
- Miner conceptualizes these elements leading some juveniles, when catalyzed by still other factors, to sexually abusive relationships with children.

The Victims of Juvenile Sexual Offenders

- Data from various sources (Finkelhor et al., 2009; Gaudiosi, 2009; Snyder, 2000; Snyder & Sickmund, 2006; U.S. Department of Justice, 2009) shows sexual arrest data for juvenile sexual offenders through 2008.
- Juveniles are responsible for approximately 17% of all sexual assaults, and 37% of all sexual assaults against all minors (age 17 and younger).
- The graph, combining data from these sources, shows a clear pattern in which the largest proportion of juvenile sexual offenses involves victims 14 and younger, but a look at the graph clearly shows that is in the 0-11 age range that draws the greatest proportion of juvenile sexual offenses.
- On average, juvenile sexual offenders were responsible for 19% of sexual assaults against adolescents aged 15-17, and 35% against adolescents aged 12-14.
- However, juvenile sexual offenders were responsible for 43% of sexual assaults against children aged 6-11, and 47% of sexual assaults against children aged 0-5.



Multiple, Linked Causes

- The development of juvenile sexual offending is more likely linked to a combination of factors present in early development, childhood, and adolescence, including a history of childhood sexual or physical abuse, neglect, and/or broad maltreatment.
- Knight and Sims-Knight (2004) write that the experience and outcome of child maltreatment is likely determined by the interaction of many forces in the child's environment, as well as predisposing personality traits in the child.
- Skuse et al. (2000) conclude that a history of childhood sexual abuse is most likely to be a significant factor only when other risk factors, not directly related to the abuse, are also present.

Different Pathways to Sexually Abusive Behavior

- Many theories exist as to why juvenile sexual offenders are sexually aggressive, and the pathways that lead to such behavior. In fact, seemingly common developmental pathways, personal experiences, and risk factors seem to lead to different outcomes in different children.
- This is because sexually aggressive and assaultive behaviors develop, not in a vacuum, but in the context of the lives of individual children and adolescents and the internal and external influences and factors that shape emotion, thinking, social interactions and relationships, behavior, and personality.
- Addressing this point, Ryan (1997) and Calder (2001) both emphasize the need to recognize and understand human behavior in the context of individual development and life experiences, or with a phenomenological view in which we recognize that individual action is influenced by many factors, rather than single or universal causes.

Motivation for Sexually Abusive Behavior

- In the case of juvenile sexual offending, what idea or purpose is the sexually troubled juvenile attempting to accommodate when he or she engages in such behavior for the first time, and subsequent times if he or she continues to engage in sexually abusive behavior?
- Several years ago "power and domination" was considered the central reason for sexual offending; today, however, we recognize that sexual offending is a far more complex and multi-faceted behavior.

Motivation for Sexually Abusive Behavior

At a glance, we can see several avenues along which juvenile sexual offending and sexually aggressive behavior may lie:

- Power Seeking. Power is a primary motivator for the behavior of the sexual offender. Sexual gratification is viewed as a secondary gain that reinforces the primary behavior.
- Taking Charge. The "I-Take-What-I-Want" and "I-Have-the-Right" behavior and attitude of the sexual offender may indicate that the perpetrator has come to see the world in terms of "victims" and "victimizers."
- Thinking Error. The sexual offense is seen as just one example of criminal behavior, in which all criminal behavior is seen as the result of errors in thinking.
- Coping Mechanism. Sex is used in the service of non-sexual needs, as an "antidote" to a state of emotional turmoil in which the perpetrator feels helpless, frustrated, angry, powerless, or like a victim of society. In this scenario, sexual offending may be the only means by which the offender can fight off feelings of depression, anger, etc., and may be viewed as an antidote against feeling "bad."
- Frustration and Emotional Release. Engaging in sexual control or violence relieves and discharges emotions.
- Socially Learned. The offender has been exposed to, experienced, and/or learned a distorted and confused view of sexual relationships, and has incorporated these experiences and beliefs into his or her thinking, behavior, and interactions.
- Mental Illness or Cognitive Limitation. The offender is experiencing a mental illness or cognitive deficit that is significantly contributing to his or her perception, beliefs, interactions, and behaviors.
- Physical Compulsion. Here, the offender feels physically compelled to act out highly sexualized feelings and perhaps unable to control overwhelming physical (and mental) drives.
- Experimentation. In some cases, in younger or developmentally delayed offenders, sexually abusive behaviors are the result of curiosity, naivete, and classic "experimentation," in which case the offending behavior may be situational or the result of behavior that is not intended as an offense.
- Self-Reinforcing Cycle. The sexual behavior is the result of a repetitive and dysfunctional cycle, in which the personal history, triggering events, thoughts and feelings, thinking errors, and the sexual behavior itself serves as the preconditions for the very same set of thought, emotions, and behaviors to occur again, in a cycle of sexual abuse. This is a typical model used in the treatment of adult and juvenile sexual offenders, and is sometimes referred to as the "sexual assault cycle."

Driving Factors

Larger models and general perspectives aside, what are the factors that drive sexually abusive behavior among children and adolescents?

- Aggression (anger; power, control, and domination; revenge)
- Cognitive Impairment (cognitive/intellectual deficit)
- Coping Mechanism (emotional discharge, emotional satisfaction)
- Sexual Experimentation (curious, exploitive, naive)
- Sexually Opportunistic (impulsive, predatory, situational)
- Relationship Building (demonstrating or seeking affection or intimacy, avoiding loneliness)
- Sexual Deviance (deviant sexual fantasy, sexual fetish, sexual sadism/cruelty)
- Sexual Preoccupation (sexual obsession/compulsion, fantasy fulfilment, hyper-sexuality, pornography re-enactment)
- Social Environment (peer group encouragement, role modeling, social messages)
- Social Skills Deficit ("feel normal," social mastery, social expectations, sexual identity exploration)

The Developmental Course of Adolescent Sexual Offending

- Risk for sexually abusive behavior is "a complex interaction between psychological factors and an individual's history and current life transforming event circumstances" (Boer, McVilly, & Lambrick, 2007, p. 2).
- Psychological factors are usually the result of each individual's history and both are thus intertwined and often inseparable.
- Environmental risk factors and conditions are also essential elements in understanding risk.
- All risk is defined by this combination of history, psychological and environmental risk factors, and social environmental conditions.

The Developmental Course of Adolescent Sexual Offending

- This combination of history, psychological and environmental risk factors, and social environmental conditions is especially important for the child or adolescent in the midst of formative cognitive, psychological, and social development, and very much caught up in and influenced by the social environment in which development and learning is occurring.
- With respect to development, we understand that juveniles are very different than adults, not only at the psycho-socio-emotional level, but the neurological level as well. The emotions, relationships, attitudes and ideas, cognitive capacities, place and role in society and behaviors of adolescents are driven and motivated by very different experiences, forces, and factors than those of adults.
- Even though adults and juveniles who sexually offend share behaviors and some characteristics, the pathways that lead to such behaviors should not be assumed to be the same nor each confused for the other. Juveniles who engage in sexually abusive behavior typically do so for entirely different reasons than their adult counterparts.
- Furthermore, based on relatively low recidivism rates for juvenile sexual offenders, the developmental pathways of sexually abusive youth do not necessarily lead juvenile sexual offenders into patterns of adult sexual offending.

Sexual Recidivism in Juvenile Sexual Offenders

- The most recent Practice Standards and Guidelines of the Association for the Treatment of Sexual Abusers (ATSA, 2005) specifically distinguish between adult and juvenile sexual offenders.
- ATSA (2001) is not only clear that there are important differences between juvenile and adult sexual offenders but also asserts that "many juveniles who sexually abuse will cease this behavior by the time they reach adulthood, especially if they are provided with specialized treatment and supervision."

Recidivism in Juvenile Sexual Offenders

- With regard to recidivism, or continued engagement in sexually abusive behavior after apprehension (and usually treatment), statistics strongly suggest that relatively few adolescent sexual offenders develop into adult sexual offenders.
- Although rates have been reported as low as 0% and as high as 30% (Nisbett, Wilson, & Smallbone, 2004; Worling & Långström, 2003), and 41% in one study of 22 youths (Rodríguez-Labarca & O'Connell, 2001), post-treatment recidivism is typically reported as somewhere between 5-14% (for instance, Caldwell, 2007; Kemper & Kistner, 2007; Hunter, 2000; Parks & Bard, 2006; Waite et al., 2005; Weinrott, 1996; Worling & Curwen, 2000), with 12-13% representing the most recently robustly reported recidivism rates.
- In their recent meta-analysis that included 2986 juvenile sexual offenders, Reitzel and Carbonell (2006) found recidivism rates of 12.5% for sexual crimes.
- Epperson, Ralston, Fowers, Dewitt, and Gore (2006) reported a 13.2% rate for sexual recidivism in one study of 636 juveniles, and 12.8% in a second study of 538 juvenile sexual offenders (Epperson, 2007).
- The fact that juvenile sexual offending does not necessarily result in adult sexually abusive behavior tells us either that apprehension and treatment for sexually abusive youth is very effective or that sexually abusive youth are not on a path that necessarily leads to adult sexually abusive behavior, or both.

Sexual and Non-Sexual Criminal Recidivism

- It is widely reported that recidivism for adult and juvenile sexual offenders is significantly higher for non-sexual offenses than criminal offenses. Although varying from study to study, the rate of various forms of non-sexual criminal recidivism for adult sexual offenders always falls higher than their rate of sexual recidivism.
- Similarly, the idea that juvenile sexual offenders are at greater risk for re-engaging in non-sexual criminal behavior than a sexual offense is commonly noted (Caldwell, 2002, 2007; Fortune & Lambie, 2006; Hagan & Gust-Brey, 1999; Reitzel & Carbonell, 2006; Waite et al., 2005; Weinrott, 1996).
- This finding is reported by Letourneau and Miner (2005) as consistent across nearly all studies of juvenile sexual offender recidivism.
- Caldwell (2007) noted that the juvenile sexual offenders were nearly ten times more likely to recidivate non-sexually than sexually. Nevertheless, when comparing non-sexual recidivism, he found that the sexual offenders were significantly less likely to be charged with a non-sexual offense than the non-sexual offenders.

Juvenile Sexual Offenders and Juvenile Non-Sexual Delinquents

- A number of studies yield data to support the perspective that juvenile sexual offenders are not only different from one another, but as a group are generally different from non-sexual juvenile delinquents.
- These studies reach similar conclusions in which general non-sexual antisocial behavior is prevalent among juvenile sexual offenders, but is more commonly found – and more intense and broad in nature – among juveniles who sexually assault peers or adults compared to those who sexually assault children.
- These adolescents more closely resemble non-sexual juvenile offenders in this regard. They more typically engage in a range of antisocial or criminal behaviors, not only in addition to their sexually abusive behavior but also in or connected to the commission of sexual offenses.
- Beyond this, however, there are generally clear differences in the type and intensity of antisocial behaviors these juvenile sexual offenders display, which is often of a less criminal nature than the antisocial behaviors exhibited by non-sexual juvenile delinquents.
- Even among juvenile peer and adult offenders who engage in more intense conduct disordered behaviors than child molesters, there are differences that distinguish them from non-sexual juvenile offenders.
- In general, there are clear differences between juvenile sexual offenders and non-sexual juvenile offenders, not only in terms of the type of non-sexual antisocial behavior, but also in personality traits, social skill development, and social connection and experience.

An Ecological Approach to Treatment

Juvenile Assessment Is Contextual

- The process of evaluation for youthful sexual offenders requires a developmental approach to understanding and interpreting information.
- This is not only true about the sexually abusive behavior, but also of the juvenile sexual offender him or herself.
- In juvenile assessment, we must understand the youth in the context of his or her whole life, rather than just the circumstances of the sexually abusive behavior.
- In part, the assessment of juveniles focuses on understanding the systems within which children and adolescents live, learn, and function, and upon which they depend for structure, guidance, and nurturance.
- Assessments of juveniles take into account the still developing nature of the child/adolescent, and recognize that juveniles are far closer than adults to both positive and negative developmental influences, social learning and experimentation, and early childhood experiences.

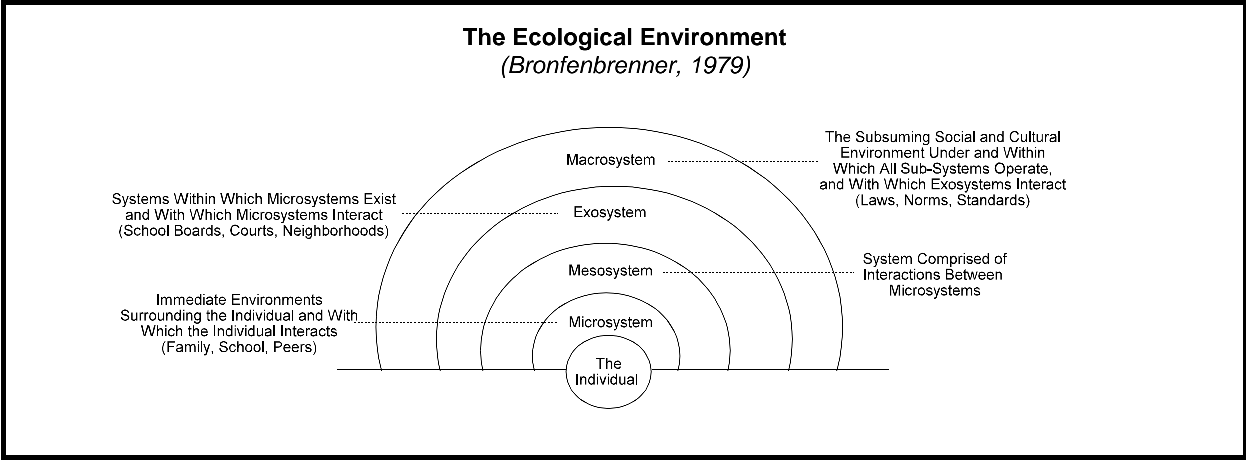
The Ecology of The Whole Person

- In the real world, the developmental pathway of each individual cannot be separated from the social environment into which it is woven.
- An “ecological” perspective from this point of view relates to the interconnection between and the mutual influence of each part of the environment.
- With regard to the contextual nature of treatment, in the non-forensic mental health field we have long accepted that individuals and their behavior must be understood in the context of their lives, or the larger social systems to which they belong and within which they operate.
- To a great degree these systems influence and define identity, role, attitudes, and behavior.
- Just as we have seen changes in our understanding of and work with juvenile sexual offenders in general, the field is also beginning to recognize and accept that sexually abusive youth and their behaviors are part of and influenced by these larger systems.
- This introduces an ecological approach to understanding sexually abusive youth *in situ*, in which we recognize that these children and adolescents interact with and are influenced by systems within systems and, to a great degree, are the products of these nested and mutually interacting systems.

The Ecological Environment

- In the ecological environment described by Bronfenbrenner (1979), systems are contained within still larger systems, and interaction and communication occurs not only within systems but *across* systems as well.
- Without reference to the larger ecological system that surrounds the individual, it impossible to fully understand human behavior or interaction.
- Elliot et al.(1998) describe the ecological-developmental approach as a framework by which human development is understood as a product of interactive social contexts which influence and shapes behavior.
- Human development thus occurs within a complex and multiply nested, multiply interacting, and mutually transactional environment. Our ability to understand human development and behavior thus requires an understanding of the individual affected by all levels of the ecological system.
- To a great degree, this becomes part of a guiding model in risk assessment for sexually abusive youth, in which we understand risk in children and adolescents in the contexts of both their neurological and psychological development and their social learning environment.

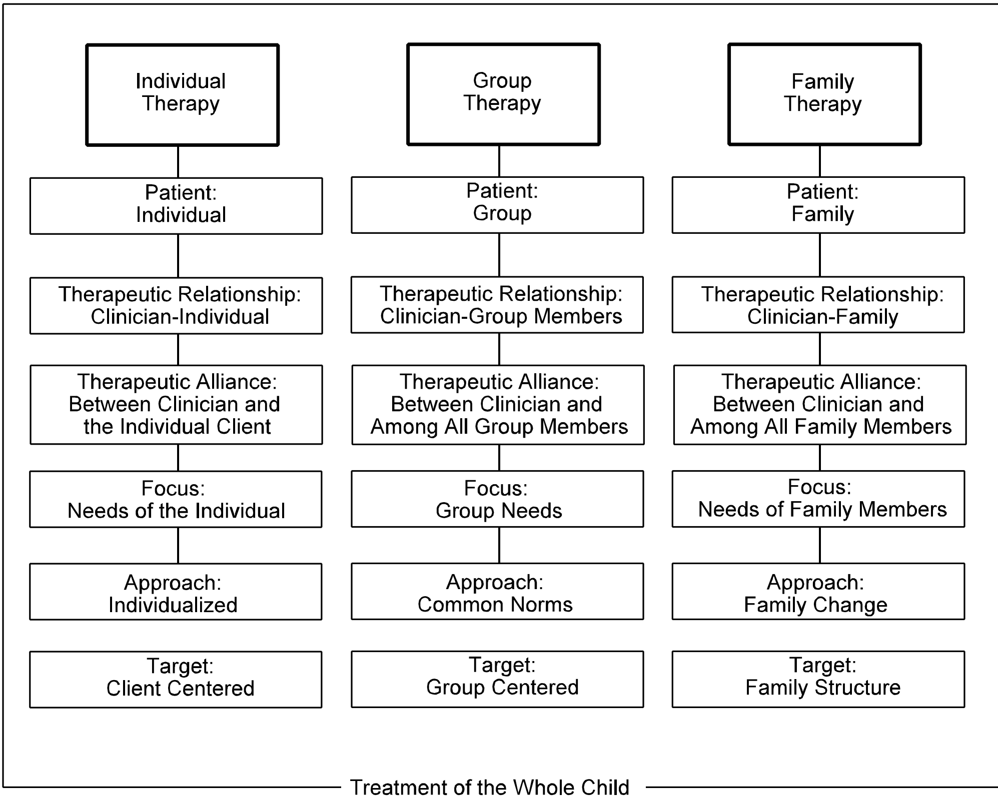
The Ecological Environment
(Bronfenbrenner, 1979)



Modes of Juvenile Sexual Offender Treatment

Multi-Modal: Individual, Group, and Family Therapy

- The three most central therapies in work with troubled youths in general, as well as juvenile sexual offenders, are group, individual, and family, utilizing both psychodynamic and cognitive-behavioral approaches.
- In an integrated treatment model, especially a model aimed at treating adolescents and children, each of these modes will be woven into treatment.
- Together, these therapies treat the whole child as: (1) an individual, (2) an interactional member of a peer group and the social environment, and (3) a member of a family in which the youth represents the identified patient.
- In employing all three treatment modes, strengths and weaknesses will become apparent and clues and directions will emerge that will shape the individualized and comprehensive treatment required in the rehabilitation of the juvenile sexual offender.



Individual Therapy

- Individual therapy for juvenile sexual offenders is best utilized and constructed as part of multi-modal treatment, serving a distinct role that cannot be filled by any other form of therapy.
- On its own, individual therapy is too weak of a model to adequately rehabilitate the juvenile sexual offender.
- The same is true, however, of both group and family therapy.
- Nevertheless, individual therapy fills a role that simply cannot be filled by any other form of treatment.
- It provides an intimate treatment environment that consists of therapist and patient.
- Through individual therapy, the therapeutic alliance is built and extended, and the role of the therapist strengthened as a central agent of hope and change.
- Individual therapy is both important in its own right, and also supplements and helps bring together different modes of therapy in a blended and integrated multi-modal treatment.

Group Treatment

- Group treatment is utilized in the treatment of all types of mental disorders, including the treatment of sexually abusive youth.
- Both in terms of financial costs and the application of treatment to many clients at the same time, group treatment has many attractive qualities.
- However, the reason for providing group theory is not because of its economy in terms of either cost or scale.
- Group treatment lies at the heart of juvenile sexual offender treatment, and is often a preferred and predominant mode, based on the belief that group treatment is an effective means for delivering treatment messages; developing new ideas, behaviors, and skills; and generally bringing about change in participants.

Family Therapy: The Least Used Approach

- Contrasted to individual and group therapy, family therapy is the least often provided treatment approach often.
- This is sometimes due to a lack of resources, in terms of time or cost, and sometimes because clinicians are not trained in or comfortable with family therapy. As a result, family therapy falls by the wayside in many cases.
- In other cases, families are unwilling to engage in family therapy for a variety of reasons. These include anger at the youth, a belief that the problem belongs to the youth and not the rest of the family, denial of the problem, disinterest in treatment, or practical reasons such as not being able to take time off from work in order to attend sessions or distance from home if the juvenile is receiving treatment far from home.
- In some cases, the juvenile has no family or, in the clinician's opinion, the family is not ready for treatment or treatment may be otherwise be counter-productive. In still other cases, clinicians may not recognize the importance of family therapy or are untrained in the method.
- In addition, family treatment is provided by clinicians inexperienced or untrained in family therapy and in some cases it is provided in the form of family psychoeducation or family meetings, which are important extensions of treatment, but not family therapy.

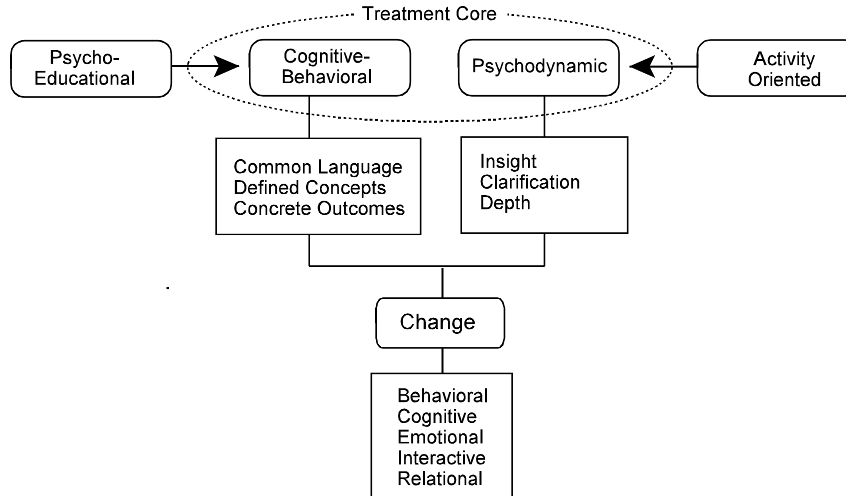
Building Integrated and Holistic Treatment

Modes of Treatment: Two Forms of Therapy

- Therapy is described by the American Psychiatric Association (1996) as fundamental to the practice of psychiatry, and essential in the treatment of mental disorders.
- Recognizing several major forms of therapy, APA describes the two most practiced versions as psychodynamic therapy (derived from psychoanalytic theory) and cognitive therapy (derived from learning theory).

Integrating Cognitive-Behavioral and Psychodynamic Therapy

- In a broad-based treatment model for the treatment of sexually abusive behavior, cognitive-behavioral therapy serves a central role, providing clear and well-defined language, concepts, and expected outcomes for treatment.
- Whereas cognitive-behavioral therapy is often oriented towards the psychoeducational end of the treatment spectrum, relationally based or psychodynamic therapy is focused on a more insightful, exploratory, and deeper area of psychological functioning. However, the two modalities are not incompatible.
- On the contrary, they appear to represent different views of the same phenomena that approach and treat the same problems in different ways – that is, psychological experience and behavioral functioning.
- By combining them and allowing psychoeducational and activity treatments to serve as additional feeds, we can define a model of change that results from integrating both approaches.



Building Holistic Treatment Programs

- If we understand the depth and complexity of the issues and factors that drive sexually abusive and other antisocial and self-destructive behavior, then we start to see sexually abusive youth as “whole” people in need of layers of treatment, rather than a unidimensional and narrow model of “sex offender specific” treatment.
- This requires not just the development of clinical skills in the practitioner, but the development of treatment programs able to recognize and treat multiple factors.
- Such treatment programs will recognize and treat the youth as a whole person, vulnerable and at risk in many ways but also carrying personal strengths and capacities that can be built upon and developed in treatment.

Holistic and Comprehensive Treatment

- What does a holistic model look like?
- First, it must into account the nature of each client as an individual whose emotions, cognitions, behaviors, and relationships are driven by multiple factors, many of which are unique to that individual.
- The first step, then, is learning about that client.
- Regardless of the intention and outcome of risk assessment, in which the primary goal is to predict the possibility or likelihood of a future sexual offense, we learn about the youth through a careful, thorough, and comprehensive psychosocial assessment in which the primary purpose is to develop an understanding of the youth.

Holistic Treatment

- A holistic model of treatment is “holistic” for two primary reasons.
- Perhaps first and foremost, it is holistic because it recognizes and responds to the client as a whole person, rather than defining, measuring, and responding to clients by some of their behaviors alone (for example, sexually abusive behavior).
- Second, a holistic approach recognizes that sexually abusive youth bring into treatment with them all of the myriad developmental experiences that have shaped them and the personal characteristics which define them, some or many of which will need to be addressed and become targets for treatment.

Holistic Treatment is Multi-Dimensional

- Driven by this belief in the “whole” child and recognition of a range of treatment issues, holistic treatment is thus multi-dimensional, bringing together many elements of treatment.
- It is aimed at multiple treatment targets.
- It is multi-modal, providing different forms of treatment and types of treatment interventions (such as individual, group, family, and experiential therapy, as well as psychiatry).
- And it is pantheoretical, weaving together ideas from different theoretical backgrounds, and most notably cognitive-behavioral and psychodynamic therapy, but increasingly ideas from neurology.

Holistic Treatment is Integrated

- However, the use of the term “holistic” is more of an expression about how the treatment program recognizes and responds to the nature of the client.
- With regard to approach, programs like this can be thought of as integrated models of treatment that bring together disparate, multiple, and complex elements of treatment, including assessment and re-assessment over time, as well as interweaving different theoretical approaches to treatment into a single model.
- Because of their awareness and use of multiple models and approaches to treatment, integrated programs are able to both customize treatment for individual clients and be flexible with respect to the “what, when, and how” of treatment, and with respect to what treatment interventions are provided, and when and how they are provided, in each case reflecting the pacing of treatment and geared to the needs of each client.

Integrated Models of Treatment

- Integrative therapies bring together elements from single tradition therapeutic modalities in an organized and systematic way. In an integrated model, the shape of treatment is defined by the treatment needs of each individual client, as well as general treatment needs that apply to all juvenile sexual offenders.
- Together, individualized and general treatment requirements influence and direct the actual treatment interventions selected. In an integrated model of treatment, we recognize that “one-size-fits-all” models of treatment, driven largely by psychoeducational technique and practice, are not likely to meet the complex needs of individuals, nor necessarily recognize those needs.
- One size fits all treatment models often use psychoeducation as a primary means to instruct clients and deliver treatment, concentrate on simplistic cognitive-behavioral techniques and ideas, and are driven by relapse prevention models. These models are limited and don’t truly reflect the dynamic factors at play for individual clients, and have been partially dependent on workbook-style materials and exercises for the delivery and completion of treatment.
- As Longo and Prescott (2006) write, “our new century finds growing support for (this) holistic/integrated model of treatment” (p. 37).

Integrated Models as Pantheoretical

- Integrated treatment programs incorporate a range of treatment techniques, including aspects of the psychoeducationally-driven program. By blending different treatments we create a multifaceted model of treatment in which no single theory predominates.
- These programs consolidate elements from single theory models of treatment, weaving together strands of different therapies into a new and coherent whole, as opposed to eclecticism which can be idiosyncratic and without theory (Holmes & Bateman, 2002).

Elements of the Integrated Treatment Program

- Cognitive-behavioral therapy to re-structure thinking and related behaviors that contribute to sexually abusive behavior.
- Psychodynamic therapy to build relationships and develop insights that help clients link current behaviors, attitudes, relationships, and emotional experiences with root causes and psychological needs.
- Family therapy by which to explore and re-construct family relationships and support systems.
- Expressive and experiential therapies to allow for non-verbal learning and expression.
- Psychoeducation provides an effective means by which to deliver ideas and teach concepts common to all clients in treatment, and helps build a common language that can be spoken and understood by clinicians and other treatment staff, clients, parents, and other related parties, such as probation officers and social service workers.
- Relapse prevention planning serves, not as the pinnacle of treatment, but a means by which we help teach sexually abusive youth and their family about triggers and risks that contribute to sexualized and antisocial behavior. It helps establish a means for self-monitoring, help-seeking, and harm avoidance.
- Through the use of individual, group, and family therapy, as well as psychopharmacology and psychoeducation, we utilize multiple methods for delivering treatment.

The Nature and Role of the Treatment Environment

Understanding the Client

- Unless we simply wish to treat the sexually abusive behavior apart from the totality of the youth engaging in those behaviors, or believe we can treat those behaviors in isolation from the youth’s other experiences of self and others, we must find ways to treat the whole child.
- This means recognizing the personal and social needs of each adolescent and the context of that adolescent’s life, within which the sexually abusive behavior developed and occurred.
- Most of all, we hope to change the trajectory along which the sexually abusive youth may be heading.

The Treatment Environment

- In the facilitative climate, treatment growth is recognized, partially at least, as a product of the environment itself and the therapeutic relationship that exists within it.
- However, we must always recognize those elements brought into the environment by the client, *independent* of treatment.
- For sexually abusive youth and other troubled adolescents and children, these personal elements often include attachment needs and difficulties, deficits in a range of critical social skills, poor self-regulation, a poorly-developed base for the development of either empathy or moral decision making, and other experiences of self and others related to early and on-going childhood development.

Treatment and Social Skills Development

- An integrated model of treatment operates within a treatment environment that focuses on the development of important social skills, recognizes the therapeutic relationship, and fosters social connection and the development of attached relationships.
- In an environment informed by ideas about attachment and social relatedness, treatment occurs in a caring and supportive manner, in which relationships are genuine, respectful, and supportive, while at the same time being structured and challenging, and in which the message that comes through is one of care, concern, understanding, and attunement.
- This sort of environment may be especially important in the treatment of sexually abusive youth, who have been described by Michael Miner (Miner & Crimmins, 1997; Miner & Munns, 2005) as frequently more socially isolated and normless than other adolescents (including non-sexual juvenile delinquents), possibly expecting adult and peer rejection.

Treatment as individualized and Wide Ranging

- In this treatment environment, sexually abusive youth are recognized and treated as individuals, rather than "sexual offenders" who all share the same backgrounds and behaviors.
- Despite commonalities, the needs of each client are assessed and interpreted on an individual basis, through the process of formulating each case.
- Now conventional and well developed psychoeducational/cognitive-behavioral elements of sex offender specific treatment are provided in this treatment environment, including a focus on dysfunctional behavioral cycles, thinking errors, cognitive restructuring, and relapse prevention plans.
- However, it is recognized that these are but elements of treatment among a larger array of treatment services that individualize treatment and avoid the one-size-fits-all model of sex offender specific treatment for sexually abusive youth.

The Responsive Treatment Environment

- All treatment components are thus embedded within and delivered through a treatment environment that is attuned to and responsive to clients, and in which they are recognized and understood.
- In this environment, opportunities are available for taking responsibility, realizing potential, and experiencing success, and thus building self-efficacy, self-regulation, and self-agency, while also building social skills that include perspective taking, values clarification and moral decision making, social connection, and relationship building.

The Treatment Environment as Complex and Multi-Dimensional

- We can teach simplistic concepts and methods to our clients, which has represented a good part of the sex offender specific model until recently.
- However, this is unlikely to engender the changes we seek or transmit ideas about social connection and relatedness.
- It is through a multi-dimensional and multi-theoretical approach that we are more likely to accomplish goals of social skill development, social competence, and social rehabilitation.
- The qualities that we wish to effectuate in sexually abusive youth, not only of behavioral restraint, appropriate social and sexual boundaries, and belongingness, but also empathy and concern for and the valuing of others, are exactly those qualities that juvenile sexual offenders must themselves experience from others in their environment, including those who provide treatment.

Treatment as Relational

- Through the warmth, concern, support, safety, and structure provided in the empathic and attuned treatment environment, sexually abusive youth are experienced as children with many complex needs, including the need to be recognized and understood by others.
- Perhaps more to the point, they must experience themselves as being seen and understood by others.
- Through this experience, they are enabled to see and explore themselves in a different light; in turn, they are able to see and experience other people in a different light.
- Through therapy and the therapeutic relationship, these are the changes for which we aim.

Treatment as Connective and Rehabilitative

- In the words of Urie Bronfenbrenner, “human development occurs in the context of an escalating ping-pong game between two people,” in which the child experiences someone caring about him or her (1979, p. 31).
- Despite the label of juvenile sexual offender, our clients are first children and adolescents with the need to feel good about themselves, cared about, and engaged in social relationships.
- The changes in sexual attitude and behavior we want come *after* these experiences.

Our Changing Ideas About and Approach to Treatment

Our Underlying View of Clients

- As more clinicians recognize the complex needs of their clients and apply critical thinking to their work, uni-dimensional models that consider treatment to be essentially psychoeducational have been increasingly replaced by more clinically sophisticated models that recognize the wholeness and complexity of clients and their needs, and the need for multi-dimensional treatment.

Our Underlying View of Clients

- Treatment with sexually abusive youth is not simply about psychoeducational and cognitive-behavioral modes of instruction and treatment.
- It is also, and perhaps more critically, about our view of our clients and how we conceptualize treatment.
- Our view as clinicians influences our work in three broad categories, each of which build upon and interact with one another:
  1. The way we think about and understand our patients or clients, and what they need in treatment.
  2. Our ability to think about and plan our treatment interventions.
  3. The way that we interact with and relate to the people we are seeking to help.

Our Approach to Treatment and the Therapeutic Relationship

- In our work with sexual offenders, we have recognized the need to change our approach to treatment.
- For example, in work with adult sexual offenders Beech and Hamilton-Giachritsis (2005) note a change in treatment technique from a direct and confrontational style, which they write is likely to lead to increased resistance rather than change. Instead, the movement is towards the development of a supportive and emotionally responsive treatment relationship.
- In our work with youthful sexual offenders, the same is true. Longo and Prescott (2006) write that the use of hostile, confrontational, and harsh treatment styles are ineffective with sexually abusive youth, and they instead stress the value of a warm, empathic, and rewarding approach in working with offenders.

Our Approach to Treatment and the Therapeutic Relationship

- These relatively new ideas in sexual offender treatment – that we need to build therapeutic alliances with our clients, help instill hope in them, and help them grow, rather than simply confront, challenge, and judge them –
- are welcome.
- They bring the treatment of juvenile and adult sexual offenders closer to therapeutic principles and processes already found in mainstream psychotherapy.
- These elements of therapeutic relationship and the pursuit of positive goals are clearly emerging in our work with both sexually abusive youth and adult sexual offenders.

Positive Psychology and the Good Lives Model

- Promising to further enhance the treatment process is the recognition of the centrality of the therapeutic relationship and its treatment alliance, as well as the introduction of elements of "positive psychology."
- Here, we recognize that people have strengths upon which they can build in making improvements in their life and are motivated, not just to avoid recidivism (an "avoidance" goal), but to accomplish desired and valued outcomes ("approach" goals).
- The "Good Lives" model, which is designed to work with adult sexual offenders but also finding a place in work with sexually abusive youth, shifts treatment in focus from a containment and control model to a model of positive psychology.
- In this model, treatment works towards recognizing the identity, values, and beliefs with which the offender identifies so that he or she can work towards personal fulfillment and the development of pro-social social skills.
- The focus is not solely upon risk reduction, but also on enhancing the capacity of the offender to improve his or her life.

Good Lives and the Acquisition of Human Goods

- With respect to the Good Lives model, Thakker, Ward and Tidmarsh (2006) write "we propose that the key theoretical perspective that guides treatment should be that of human well-being (i.e., good lives), rather than risk management, or relapse prevention" (p. 324).
- They assert that the focus of treatment should be on identifying obstacles to accomplishing "human goods" and the acquisition of the capacities and competencies required to achieve human goods in ways that are socially acceptable and personally satisfying.

Good Lives and the Therapeutic Alliance

- Yates (2005) notes that the aim in treatment is not to change the goal of social success, but to target the means the individual uses to achieve this goal.
- Hence, Ward and Stewart (2003) assert that the focus on a "good life," rather than risk containment and harm reduction, will contribute to the reduction of risk and the protection of society.
- Further, the expectation is that a focus on the acquisition of social skills and a personally fulfilling life will increase the offender's motivation to engage in treatment, and enhance the ability of clinician and offender to work together as partners, thus strengthening the treatment alliance.

The Nature of the Therapeutic Alliance and the Therapeutic Relationship

- Furthermore, no matter the style or technique, whether cognitive-behavioral or psychodynamic, individual therapy is administered through the relationship between the clinician and the client, and in modern application both therapy types contain elements of the other.
- In both cases also, effective therapy requires the active participation of the client and many have suggested that, more than any other factor, such participation is the primary key to therapeutic success.
- In addition, many, if not most, believe that a critical and essential factor in therapy is the client-clinician relationship, or the therapeutic alliance.

The Therapeutic Relationship

- Treatment alliance is key.
- Blanchard (1998) has described the therapist as the primary tool for initiating change in sexual offenders, writing also that “when the fundamentals of relationship-building are not applied to sexual offenders, little movement or growth will take place” (p.32).
- More than just the relationship that exists between the juvenile in treatment and the clinician, the therapeutic alliance is inclusive of the qualities brought into treatment by the therapist and the juvenile, as well as other factors that structure, frame, and define the content of the relationship.

The Therapeutic Relationship as Agent of Change

- Norcross (2000) and Blanchard (1998) have described the therapist as a central agent of change.
- Bachelor and Horvath (1999) have written that the important therapeutic relationship is formed early in therapy, established through the climate of trust and safety fostered by the clinician through responsiveness, listening, and the communication of understanding, regard, and respect.
- Contrary to ideas that juveniles are bullied, coerced, or confronted into getting better, the therapeutic alliance provides the environment through which the juvenile is able to willingly enter and engage in treatment.

The Facilitative Treatment Relationship

- In fact, many of the tasks of therapy can only be accomplished through the development of a meaningful relationship between the clinician and youth.
- An enriching therapeutic relationship can foster a climate that will allow youths to explore difficult areas in their lives, and express themselves more fully and more openly.
- Treatment ideas, techniques, and interventions are used to build and support the relationship which, in turn, is used to address treatment issues and goals identified along the way.
- Such relationships can only be built over time, and are a key to the pacing of treatment and what can be accomplished during any given period in the therapeutic relationship.

Treatment Through Social Connection and the Development of Social Skills

- The fact that most children raised under adverse conditions don’t become seriously antisocial makes it clear that there are many factors that influence developmental pathways, probably too individualized for us to ever fully recognize or understand.
- One of these factors, however, is likely to be personal connection to an important attachment or other adult security figure.
- For instance, in their long-term study of high risk children (in Kauai, beginning in 1955), Werner and Smith (1992, 2001) found that the presence of even one supportive person in the child’s life throughout childhood and adolescence increased the chances of personal success despite high risk life circumstances.

Attachment and Social Relatedness as Targets of Treatment

- In our treatment of sexually abusive youth, attachment experiences and related social relatedness and social competency should be targets for assessment and treatment.
- In terms of treatment, the focus is on rehabilitating the mental model that results from the accumulation of poor attachment experiences and their impact on a developing sense of self, others, and self-efficacy.
- It also includes developing the youth’s capacity to acquire and engage in meaningful and satisfying social interactions and relationships (“human goods”).

Treating Deficits in Social Skills

- The goal of teaching sexually abusive youth psychoeducational concepts, such as dysfunctional behavioral cycles and thinking errors that contribute or lead to sexually abusive behavior, has been and remains an important element in sex offender specific treatment.
- However, this work must be embedded into a larger and more complete treatment that also, and perhaps more significantly, addresses deficits in attachment, social relatedness, and social skills.
- Such deficits include a limited ability to form meaningful and satisfying relationships, experience empathy and concern for others, and engage in the behaviors, interactions, and relationships that are the backbone of appropriate social connection.
- These deficits further include a poorly developed capacity to recognize and understand one's own mental state and the mental state of others (metacognition), an under-developed sense of moral decision making and behavior, and inadequate self-regulation, or the ability to recognize and manage one's own emotional state.

The Task for the Clinician

- All of this speaks to the need for clinicians to engage clients in the treatment process and build a working relationship so that the client is an active participant in, and not simply the object of, the treatment process.
- Here, the client – in our case, sexually abusive youth – feels valued by and experiences empathy and warmth from the clinician, engages in a working alliance with the clinician, and experiences a genuine relationship with a genuine person, rather than sterile treatment with a treatment "technician."
- This is the heart of the therapeutic relationship, as true for work with sexually abusive youth as any other population.

The Clinician as Skilled Practitioner

- We arrive at a model of treatment that builds basic and important psychoeducational ideas and cognitive-behavioral principles into an larger, integrated model of treatment that recognizes the uniqueness of individual developmental pathways that lead to sexually abusive behavior, and the individuality of each sexually abusive youth who enters treatment.
- This model recognizes the wholeness of the client, and also the holistic nature of treatment itself.
- It incorporates and blends together different elements into a larger multi-faceted, multi-dimensional, and integrated whole.
- It also recognizes the central role of the clinician, including the attributes and approach of the clinician and the nature of the therapeutic relationship itself.
- This model goes far beyond single minded and less complex models of treatment.
- It is a far more complex, demanding, and intensive treatment process, requiring more skills from the clinician, as well as the clinician's ability to recognize, value, and empathize with the client, regardless of the behaviors that brought the client into treatment.

The Facilitative Therapist

- The therapist is highly interactive and engaged with the juvenile, involved in the discovery and exploration of practical ideas that can help the juvenile accomplish the goals of sex offender specific and general treatment.

Facilitative Use of Individual Therapy

- Recognize the juvenile's cognitive framework.
- Provide meaning and clarification.
- Understand how the juvenile relates to others.
- Give explicit advice and direction.
- Understand the juvenile's personal experience.
- Re-frame the juvenile's experiences and events in his or her life.
- Instruct the juvenile in new ideas and skills.
- Understand and process emotional experiences.
- Develop insight or new understanding.
- Understand/explore cognitive themes, ideas, and beliefs.
- Discuss/process current and recent experiences.
- Encourage the juvenile to try or adopt new behaviors.
- Facilitate the juvenile's ability to openly communicate.
- Learn about and overcome psychological defensiveness.
- Explore recurrent themes in the juvenile's experience.
- Form connections between current and past experiences.
- Ensure that the juvenile is committed to the work.
- Ensure that the juvenile understands what is expected.

Base Treatment on Case Formulation, not Formulaic Treatment

- Treatment must focus on the psychosocial and developmental histories and current treatment needs unique to each individual client.
- In the real world, treatment for sexually abusive youth must be comprehensive, individually driven, and based on case formulation, not formula.

What Makes Treatment Work? A Therapy of Engagement.

- How do we best engage sexually abusive youth in treatment?
- The first answer is that, as clinicians, on the twin levels of the therapeutic relationship and case formulation, we don't treat them any differently than we would any child or adolescent whom we are treating.
- In terms of our treatment of them, not the application and provision of psychoeducational ideas, we build the same sort of therapeutic relationship as we would with any client.
- This kind of therapy is far more difficult and energy consuming than a therapy guided by treatment protocols or workbooks, and requires good training and supervision.
- This is a therapy of engagement, in which the clinician is a significant conduit for self-realization and change in the client, and in which the therapeutic relationship becomes a crucible in which growth is fermented and from which change emerges.

Sixteen Tips for Clinical Facilitation

- Formulate the case. Learn about your client and his or her developmental pathway, and the factors that have contributed to whom the child is today and what motivated or led to his or her behaviors, including sexually abusive behavior. Develop a theory about what makes your client tick, and under what circumstances.
- Recognize wholeness. Your clients are more than simply, or only, sexually abusive youth. They are complete people, who are much more than their behavior alone. Many life issues and developmental forces come together to produce each individual and the behavior of each individual. Accordingly, recognize the totality, or the wholeness of your clients, and make sure that they recognize that you see and value them.
- Build relationships. Most of the work is about relationships and rehabilitation, not teaching concepts about sexually abusive behavior, although this is an essential part of the work.
- Work from strengths. Discover for yourself and help your clients find their strengths, working to build upon these.
- Be respectful. No matter how assertive, forceful, challenging, or confrontive, clinicians do not own their clients and do not have the right to treat them with disrespect. Under any circumstances, disrespect is unlikely to meet the goals of a positive therapeutic relationship or the rehabilitation or the juvenile, and is antithetical to the treatment alliance.
- Use appropriate techniques. Apply the correct technique to each client and each treatment situation. Therapists limited to single approaches will miss the opportunity to help many clients who don't fit their approach. The technique should fit the client, rather than squeezing the client to fit the approach. Under such circumstances, failure is seen as client failure, rather than the failure of the technique, and this cannot serve the outcome of helping the child.
- Like your clients. This goes hand in hand with working from your client's strengths. It is not only important to not judge, dismiss, or disrespect clients, but more to the point it is important to actively *like* them. Right to the point, the child psychiatrist Uri Bronfenbrenner commented that all children want someone to be crazy about them.
- Authenticity. Be genuine in your relationships with your clients.
- Demonstrate genuine interest. Therapists not really interested in their clients, and especially when the clients are kids who can almost sense authenticity in adults, are not likely to do well with their clients. Kids – including juvenile sexual offenders – are really very interesting people with interesting lives, ideas, and experiences, even if very troubled. Therapists are advised to become genuinely interested in their clients – it is part and parcel of building and using the therapeutic relationship.
- Unlock and demonstrate empathy. Experience the world that your client lives within, and the way that he or she experiences that world. Your capacity to be empathically attuned to your client may help your client learn to recognize the experiences of and experience empathy for others.
- Start where the client is at. Recognize the developmental, cognitive, and emotional capacities of each client, as well their individual needs, and start treatment at that point. This means designing and employing interventions that match each client's current level.
- See the world through the eyes of the client. This is about the "phenomenology" of the juvenile, and also about empathy and connection. Clinicians must be able to understand the world of the client in the way that each client experiences it.
- Maintain the right emotional distance. Recognize and respond to each client's attachment needs and style. Some clients need to get closer to you, some need to remain more distant. Maintaining appropriate boundaries will help you to set the "right" emotional distance, based on the individual needs and styles of each client.
- Pace treatment. Remember that some things happen later in treatment rather than earlier. Don't expect too much too soon, and think about a logical progression in treatment for each client. In some cases, recognize that the things you want to get at may not emerge until much later in treatment, if at all, such as the "truth" behind the nature or extent of the sexually abusive behavior.
- Expect regression. This is the phenomenon of one step forward, two steps back. At different times and under different circumstances, clients will move forward and then appear to fall back in treatment. They usually haven't really fallen back, but have just stepped off to one side or taken a dead end road. They may not be able to move forward, but they almost certainly haven't lost all of the gains previously made.
- Recognize that change comes slowly. Recognize that changing means giving up prior ways of behaving that were, more likely than not, adaptive in some way, and that change not only means finding new ways to adapt but comes slowly.

Integrating Complex Treatment

"The use of a unified framework demands much of the psychotherapist, as multiple domains of knowledge need to be absorbed and organized. This requires more than technical skills alone; a deep understanding of complex systems and their domains in necessary" *(Magnavita, 2006, p. 890).*

References

American Psychiatric Association. (1996, November 30). *Committee on the Practice of Psychotherapy: Resource document on medical psychotherapy.* Washington, DC: Author.

Association for the Treatment of Sexual Abusers. (1997). *Ethical standards and principles for the management of sexual abusers*. Beaverton, OR: Author.

Association for the Treatment of Sexual Abusers. (2000, March). *The Effective Legal Management of Juvenile Sexual Offenders.* (Position paper). Beaverton, OR: Author.

Association for the Treatment of Sexual Abusers. (2005). *Practice standards and guidelines for members of the Association for the Treatment of Sexual Abusers for the evaluation, treatment, and management of adult male sexual abusers.* Beaverton, OR: Author.

Association for the Treatment of Sexual Abusers. (2001). *Practice standards and guidelines for members of the Association for the Treatment of Sexual Abusers.* Beaverton, OR: Author.

Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.). *The heart and soul of change: What works in therapy* (133-178). Washington, DC: American Psychological Association.

Bailey, S. (2000). Sadistic, sexual and violent acts in the young. (2000). In C. Itzen (Ed.), *Home truths about child sexual abuse: Influencing policy and practice* (pp 200-221). London: Routledge.

Beech, A. R., & Hamilton-Giachritsis, C. E. (2005). Relationship between therapeutic climate and treatment outcome in group-based sex offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment, 17,* 127-140.

Bentovim, A. (2002). Research on the development of sexually abusive behaviour in sexually abuse males: The implications for clinical practice. In M. C. Calder (Ed.), *Young people who sexually abuse: Building the evidence base for your practice* (pp. 345-354). Dorset, England: Russell House Publishing.

Blanchard, G. T. (1998). *The difficult connection: The therapeutic relationship in sexual offender treatment.* Brandon, VT: Safer Society Press.

Boer, D. P., McVilly, K. R., & Lambrick , F. (2007). Contextualizing risk in the assessment of intellectually disabled individuals. *Sexual Offender Treatment, 2* (2). Retrieved December 2007, from http://www.sexual_offender_treatment.org/index.php?id=59&type=123

Bronfenbrenner, U. (1979). Discovering what families do. In D. Blankenhorn, S. Bayme, & J. B. Elshtain (Eds), *Rebuilding the nest: A new commitment to the American family* (pp. 27-38). Milwaukee, WI: Family Servcie America.

Bronfenbrenner, U. (1990). *Rebuilding the nest: A new commitment to the American family.* Milwaukee, WI: Family Service America.

Burton, D. L. (2000). Were adolescent sexual offenders children with sexual behavior problems? *Sexual Abuse: A Journal of Research and Treatment, 12,* 37-48.

Calder, M. C. (2001). *Juveniles and children who sexually abuse: Frameworks for assessment* (3rd ed.). Dorset, England: Russell House Publishing.

Caldwell, M. F. (2002). What we do not know about juvenile sexual reoffense risk. *Child Maltreatment,7,* 291-302.

Caldwell, M. F. (2007). Sexual offense adjudication and sexual recidivism among juvenile offenders. *Sexual Abuse: A Journal of Research and Treatment, 19,* 107-113.

Chaffin, M., Berliner, L., Block, R., Johnson, T. C., Friedrich, W., Louis, D., Lyon, T. D., Page, J., Prescott, D., & Silovsky, J.F. (2006). A*ssociation for the Treatment of Sexual Abusers Task Force Report on Children with Sexual Behavior Problems*. Beaverton, OR: ATSA

Craissati, J. McGlurg, G., & Browne, K. (2002).Characteristics of perpetrators of child sexual abuse who have been sexually victimized as children. *Sexual Abuse: A Journal of Research and Treatment, 14,* 225-239.

Daversa, M., & Knight, R. A. (2007). A structural examination of the predictors of sexual coercion against children in adolescent sexual offenders. *Criminal Justice and Behavior, 34,* 1313-1333.

Elliot, D. S., Williams, K. R., & Hamburg, B. (1998). An integrated approach to violence prevention. In D. S. Elliot, B. A. Hamburg., & K. R. Williams (Eds.), *Violence in American schools: A new perspective* (pp. 379-386). Cambridge, England: Cambridge University Press.

Epperson, D. L. (2007, October). *Development, reliability, validity, and scoring of the JSORRAT-II.* Workshop presented at the 26th Annual Conference of the Association for the Treatment of Sexual Abusers, San Diego, CA.

Epperson, D. L., & Ralston, R. A. (2005, February 7). *Optimal predictors of juvenile sexual recidivism in a large scale study of utah adolescents who have offended sexually.* Seminar presented at the 20th Annual Conference of the National Adolescent Perpetration Network, Denver, CO.

Epperson, D. L., Ralston, C. A., Fowers, D., Dewitt, J., & Gore, K. S. (2006). Actuarial risk assessment with juveniles who sexually offend: Development of the Juvenile Sexual Offense Recidivism Risk Assessment Tool-II (JSORRAT-II-II). In D. S. Prescott (Ed.). *Risk assessment of youth who have sexually abused* (pp 118-169). Oklahoma City, OK: Wood & Barnes.

Finkelhor, D., Turner, H., Ormrod, R., Hamby, S., & Kracke, K. (2009, October).Children's exposure to violence: comprehensive national survey. *OJJDP Juvenile Justice Bulletin.* Washington, DC: U.S. Department of Justice, Office of Justice Programs.

Fortune, C., Lambie, I. (2006). Sexually abusive youth: A review of recidivism studies and methodological issues for future research. *Clinical Psychology Review, 26,* 1078-1095.

Gaudiosi, J. A. (2009). *Child maltreatment 2007.* Washington, DC: U.S. Department of Health & Human Services, Administration on Children, Youth and Families.

Giedd J. N. (2002). *Inside the Teenage Brain.* Retrieved. December, 2004, from http://www.pbs.org/wgbh/pages/frontline/shows/teenbrain/interviews/

Glasser, M., Kolvin, I., Campbell, D., Glasser, A., Leitch, I., & Farrelly, S. (2001). Cycle of child sexual abuse: Links between being a victim and becoming a perpetrator.

Hagan, M. P., & Gust_Brey, K. L. (1999). A Ten-year longitudinal study of adolescent rapists upon return to the community. *International Journal of Offender Therapy and Comparative Criminology, 43*, 448-458.

Holmes, J. & Bateman, A. (Eds.). (2002). *Integration in psychotherapy: Models and methods.* Oxford, England: Oxford University Press.

Hunter, J. A. (2000). Understanding juvenile offenders: Research findings & guidelines for effective management & treatment. *Juvenile Justice Fact Sheet.* Charlottesville, VA: Institute of Law, Psychiatry, & Public Policy, University of Virginia.

Hunter, J. A., Figueredo, A. J., Malamuth, N. M., & Becker, J. V. (2004). Developmental pathways in youth sexual aggression and delinquency: Risk factors and mediators. *Journal of Family Violence, 19,* 233-242.

Hunter, J. A., Figueredo, A. J., Malamuth, N. M., & Becker, J. V. (2003). Juvenile sex offenders: Toward the development of a typology. *Sexual Abuse: A Journal of Research and Treatment, 15,* 27–48.

Johnson, T. C. (1999). *Understanding your child's sexual behavior: What's natural and healthy.* Oakland, CA: New Harbinger Publications

Johnson, T. C. (2000, October/November). Sexualized children and children who molest. *Siecus Report, 29* (1), 35-39.

Johnson, T. C. (2001, August). Understanding the sexual behaviours of children - II. *CYC-Online, Issue 31.* Retrieved February, 2008, from www.cyc-net.org/cyc-online/cycol-0801-toni2.html

Kemper, T. S., & Kistner, J. A. (2007). Offense history and recidivism in three victim-age-based groups of juvenile sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 19,* 409-427.\

Knight, R. A., & Prentky, R. A. (1993). Exploring characteristics for classifying juvenile sexual offenders. In H. E. Barbaree, W. L. Marshall, & S. M. Hudson (Eds.), *The juvenile sex offender* (pp. 45-83). New York: Guilford.

Knight, R. A., & Sims-Knight, J. (2004). Testing an etiological model for male juvenile sexual offending against females. In R. Geffner, K. C. Franey., T. G. Arnold, & R. Falconer (Eds.). *Identifying and treating youth who sexually offend: Current approaches, techniques, and research* (pp. 33-55). Binghampton, NY: Haworth Press.

Knight, R. A., & Sims-Knight, J. E. (2003). The developmental antecedents of sexual coercion against women: Testing alternative hypotheses with structural equation modeling. In R. A. Prentky, E. S. Janus., & M. C. Seto (Eds.), *Sexually coercive behavior: Understanding and management: Vol. 989. Annals of the New York Academy of Sciences* (pp. 72-85). New York: The New York Academy of Sciences.

Laumann, E. O. (1996). *Early sexual experiences: How voluntary? How violent?* Menlo Park, CA: The Henry J. Kaiser Family Foundation.

Lee, J. K. P., Jackson, H. J., Pattison, P., & Ward, T. (2002). Developmental risk factors for sexual offending. *Child Abuse & Neglect, 26,* 73-92.

Letourneau, E. J. & Miner, M. H. (2005). Juvenile sex offenders: A case against the legal and clinical status quo. *Sexual Abuse: A Journal of Research and Treatment, 17,* 293-312.

Longo, R. E., & Prescott, D. S. (2006). *Current perspectives: Working with sexually aggressive youth and youth with sexual behavior problems.* Holyoke, MA: NEARI Press.

Magnavita, J. J. (2006). In search of the unifying principles of psychotherapy: Conceptual, empirical, and clinical convergence. *American Psychologist, 61,* 882-892.

Malamuth, N. M. (2003). Criminal and noncriminal sexual aggressors: Integrating psychopathy into a hierarchical-mediational confluence model. In R. A. Prentky, E. S. Janus., & M. C. Seto (Eds.), *Sexually coercive behavior:*

Understanding and management: Vol. 989. Annals of the New York Academy of Sciences (pp. 33-58). New York: The New York Academy of Sciences.

Miner, M. H. (2004). *Risk for sexual abuse: A study of adolescent offenders*. Grant R49 CE000265 (project period, 8/1/04-7/31/07). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, GA.

Miner, M. H., & Crimmins, C. L. S. (1997). Adolescent sex offenders: Issues of etiology and risk factors. In B. K. Schwartz & H. R. Cellini (Eds.) *The sex offender: Corrections, treatment and legal practice* (pp. 9.1-9.15). Kingston, NJ: Civic Research Institute.

Miner, M. H., & Munns, R. (2005). Isolation and normlessness: Attitudinal comparisons of adolescent sex offenders, juvenile offenders, and non delinquents. *International Journal of Offender Therapy and Comparative Criminology, 49,* 491-504.

Miner, M. H., & Swinburne-Romine, J. (2004, October). *Understanding child molesting in adolescence: testing attachment-based hypotheses.* Presentation at the 8th International Conference of the International Association for the Treatment of Sexual Offenders, Athens, Greece.

National Task Force on Juvenile Sexual Offending. (1993). The Revised Report on Juvenile Sexual Offending, 1993 of the National Adolescent Perpetration Network. *Juvenile & Family Court Journal, 44,* 1-120.

Norcross, J. C. (2000). Toward the delineation of empirically based principles in psychotherapy: Commentary on Beutler (2000). *Prevention & Treatment, 3,* Article 28. Retrieved July, 2002, from http://www.journals.apa.org/prevention/volume3/pre0030028c.html.

Parks, G. A., & Bard, D. E. (2006).Risk factors for adolescent sexual offender recidivism: Evaluation of predictive factors and comparison of three groups based on victim type. *Sexual Abuse: A Journal of Research and Treatment, 18,* 319-342.

Pithers, W. D., Gray, A., Busconi, A., & Houchens, P. (1998). Children with sexual behavior problems: Identification of five distinct child types and related treatment considerations. *Child Maltreatment, 3,* 384-406.

Print, B., & Morrison, T. (2000). Treating adolescents who sexually abuse others. In C. Itzen (Ed.), *Home truths about child sexual abuse: Influencing policy and practice* (pp 290-312). London: Routledge.

Reitzel, L. R., & Carbonell, J. L. (2006). The effectiveness of sexual offender treatment for juveniles as measured by recidivism: A meta-analysis. *Sexual Abuse: A Journal of Research and Treatment, 18,* 401-421.

Righthand S., & Welch, C. (2001, March). *Juveniles who have sexually offended: A review of the professional literature.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention, U. S. Department of Justice.

Rodríguez-Labarca, J. & O'Connell, J. P. (2001, September). *Recidivism of Delaware juvenile sex offenders.* State of Delaware, Office Management and Budget Statistical Analysis Center. Document Number: 100208-070603.

Ryan, G. (1997). Phenomenology: A developmental-contextual view. In G. Ryan & S. Lane (Eds.), *Juvenile sexual offending: Causes, consequences, and correction* (new and rev. ed.) (pp. 122-135). San Francisco, CA: Jossey-Bass.

Ryan, G. (1999a). Recent develops and conclusions. In G. Ryan and Associates, *Web of meaning: A developmental-contextual approach in sexual abuse treatment* (pp. 133-151). Brandon, VT: Safer Society Press.

Ryan, G. (1999b). Treatment of sexually abusive youth: The evolving consensus. *Journal of Interpersonal Violence, 14*, 422-436.

Ryan, G., Miyoshi, T. J., Metzner, J. L., Krugman, R. D., & Fryer, G. E. (1996). Trends in a national sample of sexually abusive youths. *Journal of the American Academy of Child and Adolescent Psychiatry, 35,* 17-25.

Skuse, D., Bentovim, A., Hodges, J., Stevenson, J., Andreou, C., Lanyado, M., New, M., Williams, B., & McMillan, D. (2000). Risk factors for development of sexually abusive behavior in sexually victimized adolescent boys. In C. Itzen (Ed.), *Home truths about child sexual abuse: Influencing policy and practice* (pp 222-231). London: Routledge.

Snyder, H. N. (2000, July). *Sexual assault of young children as reported to law enforcement: Victim, incident, and offender characteristics.* (NCJ 182990). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Snyder, H. N., & Sickmund, M. (2006). *Juvenile offenders and victims: 2006 national report.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Smallbone, S.W., & Wortley, R.K. (2004). Onset, persistence and versatility of offending among adult males convicted of sexual offenses against children. *Sexual Abuse: A Journal of Research and Treatment, 16,* 285-298.

Spear, L. P. (2000). The adolescent brain and age-related behavioral manifestations. *Neuroscience and Biobehavioral Reviews , 24,* 417-463.

Spear, L. P. (2003). *The psychobiology of adolescence.* (Working Paper 76-11). New York: Institute for American Values.

Steinberg, L. (2003, April 26). *Less guilty by reason of adolescence: A developmental perspective on adolescence and the law*. Invited Master Lecture, biennial meetings of the Society for Research in Child, Development, Tampa, FL.

Steinberg, L. (2005). Cognitive and affective development in adolescence. *Trends in Cognitive Sciences, 9,* 69-74

Steinberg, L., & Scott, E. S. (2003). Less guilty by reason of adolescence. *American Psychologist, 58,* 1009-1018.

Stierlin, H. (1974). Family theory: An introduction. In A. Burton (Ed.). *Operational theories of personality* (278-307). NY: Bruner/Mazel.

Thakker, J., Ward, T., & Tidmarsh, R. (2006). A reevalaution of relapse prevention with adolescents who sexually offend: A Good-Lives model. In H. E. Barbaree & W. L. Marshall (Eds.), *The Juvenile sexual offender* (2nd ed., pp. 313-335). New York: Guilford.

U.S. Department of Health and Human Services (2001). *Youth Violence: A report of the Surgeon General.* Rockville, MD: Author.

U.S. General Accounting Office. (1996, September). *Cycle of sexual abuse: Research inconclusive about whether child victims become adult abusers.* (GAO/GGD-96-178). Washington, DC: Author.

U.S. Department of Justice. (2009). *Crime in the United States 2008.* Washington, DC: Author.

Waite, D., Keller, A., McGarvey, E. L., Wieckowski, E., Pinkerton, R., & Brown, G. L. (2005). Juvenile sex offender re-arrest rates for sexual, violent nonsexual and property crimes: A 10-year follow-up. *Sexual Abuse: A Journal of Research and Treatment, 17,* 313-331.

Warner, M. S. (1997). Does empathy cure? A theoretical consideration of empathy, processing, and personal narrative. In A. C. Bohart & L. S. Greenberg (Eds.) *Empathy reconsidered: New directions in psychotherapy* (pp. 125-140). Washington, DC: American Psychological Association.

Way, I. (2002). Childhood maltreatment histories of male adolescents with sexual offending behaviors: A review of the literature. In M. C. Calder (Ed.), *Young people who sexually abuse: Building the evidence base for your practice* (pp. 26-55). Dorset, England: Russell House Publishing.

Weinrott, M. R. (1996, June). *Juvenile sexual aggression: A critical review* (Center Paper 005). Boulder, CO: University of Colorado, Center for the Study and Prevention of Violence.

Werner, E. E., & Smith, R. S. (1992). *Overcoming the odds: High risk children from birth to adulthood.* Ithaca, NY: Cornell University Press.

Werner, E. E., & Smith, R. S. (2001). *Journeys from childhood to midlife: Risk, resilience, and recovery.* Ithaca, NY: Cornell University Press.

Worling, J. R., & Curwen, T. (2000). Adolescent sexual offender recidivism: Success of specialized treatment and implications for risk prediction. *Child Abuse & Neglect, 24,* 965-982.

Worling, J. R., & Långström, N. (2003). Assessment of criminal recidivism risk with adolescents who have offended sexually. *Trauma, Violence, and Abuse, 4,* 341-362.

Wyre, R. (2000). Paedophile characteristics and patterns of behaviour. In C. Itzen (Ed.), *Home truths about child sexual abuse: Influencing policy and practice* (pp 49-69). London: Routledge.

Yates, P. M. (2005, Summer). Pathways to the treatment of sexual offenders: Rethinking intervention. The Forum, XVII (3).

Yurgelun-Todd, D. (2002). *Inside the Teenage Brain.* Retrieved. December, 2004, from http://www.pbs.org/wgbh/pages/frontline/shows/teenbrain/interviews/

Zimring, F. E. (2004). *An American travesty: legal responses to adolescent sexual offending.* Chicago, IL: University of Chicago Press.