

TDMHSAS BEST PRACTICE GUIDELINES

Adolescents Who Have Engaged In Sexually Abusive Behavior

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The guidelines presented here are to assist in the evaluation and treatment of adolescents who have engaged in sexually abusive behavior. The goal of these guidelines is to improve the care of adolescents who have engaged in sexually abusive behavior, which in turn increases community safety and decreases the victimization of others.

These guidelines are primarily intended for males who have engaged in sexually abusive behavior. Though some may apply to females there is insufficient research to develop guidelines for females who have engaged in sexually abusive behavior. Caution should also be taken in directly applying these to youth with significant developmental disabilities.

The document was written as “considerations” rather than “policy,” to avoid the unintended consequences of a policy too slavishly adhered to. It is intended for use in various areas of DCS: child protective services, juvenile justice, and foster care. It is also intended to be useful to courts and treatment providers.

I. Special Considerations for Informed Consent

Overall provisions of informed consent common to all mental health services apply also to adolescents who have engaged in sexually abusive behavior. For these adolescents, however, several additional considerations come into play:

Evaluation and treatment of adolescents who have engaged in sexually abusive behavior typically involve multiple systems, and depend on close coordination of these systems. Therefore, the limits of confidentiality and the importance of sharing information with professionals in other systems (court, probation, DCS) should be discussed as part of informed consent.

For adolescents who have engaged in sexually abusive behavior, evaluation and treatment may not be voluntary. The discussion of possible benefits, risks, and adverse effects of evaluation or

treatment should also include the potential legal consequences of consenting or not consenting to evaluation or treatment.

II. Definition of Adolescents Who Have Engaged in Sexually Abusive Behavior

The current revision of the guidelines utilizes the term “youth who have engaged in sexually abusive behavior” instead of adolescent sex offender which was used in the previous guidelines. This change, which is consistent with national trends, avoids labeling, clarifies that the youth has engaged in the behavior while negating a preconceived notion that he/she will continue the behavior and encompasses youth who are not involved in the legal system or adjudicated for an offense. Many youth who have engaged in sexually abusive behavior may not have adjudications or be involved in the legal system, but may be involved in a social services system (Prentky, Li, Righthand, Cavanaugh & Lee, 2010). In Tennessee youth who have engaged in sexually abusive behavior may also be addressed in a variety of ways including legal involvement, social services involvement, or other linkage to services.

Adolescents, for purposes of these guidelines, are defined as youth ages 13 through 17 years. Youth 12 and under who have engaged in problematic and/or abusive sexual behavior are considered children with sexual behavior problems and differ significantly from adolescents who have engaged in sexually abusive behavior and have very different treatment needs (Chaffin et al., 2008). Please refer the TDMHSAS Guidelines for CSBP for further information.

Defining adolescents who have engaged in sexually abusive behavior does not lend itself to use of the DSM-IV-TR. While some youth may have co-morbid psychiatric disorders, few will meet criteria for “Paraphilias” and many of the paraphilias require the youth to be 16 years of age and older. In addition, the current recommendations by the DSM-5 paraphilia work group would raise the age requirement to 18. More importantly, a “Paraphilia” diagnosis provides little information that assists in determining risk or treatment needs.

Some favor defining adolescents who have engaged in sexually abusive behavior by legal criteria, however, given that legal statutes can differ, for our purposes, it is more beneficial to use a clinical definition. The clinical definition includes the following factors (Murphy, Haynes, & Page, 1992): (1) age difference of at least four to five years between the victim and the offender; (2) use of verbal or physical force or a weapon; (3) power differences between the offender and victim (older sibling made responsible for younger siblings); (4) developmental differences between the victim and the offender (e.g., taking advantage of a peer with developmental disabilities); (5) differences in emotional stability (e.g., taking advantage of a peer with clear emotional disturbance); (6) engaging in such behaviors as exposing, voyeurism, and obscene phone calls to unsuspecting persons.

III. Prevalence

The actual incidence or prevalence of sexually abusive behavior by adolescents is difficult to determine. There are a number of estimates based on different data sources including criminal justice reports, victim surveys, and surveys of the general population. Criminal justice records suggest that adolescents are frequently identified for committing sexual offenses. In 2009, approximately 15,400 youth were seen in juvenile courts in the U. S. for a sexual offense

(Puzzanchera & Kang, 2012) and data from the FBI's Unified Crime Report indicated that about 17 percent of arrest for rapes or other sexual offenses were under age 18 (Puzzanchera, Adams, & Kang, 2007). Finkelhor, Ormrod, and Chaffin (2009) analyzed data from the 2004 National Incident Based Reporting System. The NIBRS is designed to replace the FBI crime reports and provides more case detail and covers a wider number of criminal offenses. They found that 25.8 percent of all sex offenses known to the police were committed by persons under age 18 and 35.6 percent of those offenses against juvenile victims were under 18. It should be noted that the 2004 NIBRS did not have complete coverage of all jurisdictions in the United States and therefore cannot be considered a representative sample of police data.

The National Incident Study of Missing, Abducted, Runaway and Thrownaway Children (NSMART-2) used telephone interviewing methods to collect information on a national probability sample of households (Finkelhor, Hammer, & Sedlak, 2008). Information on victimization was obtained through proxy interviews with caretakers of children under age 17 and through direct interviews with the victims themselves for children aged 10 to 17). Results indicated that 25 percent of the sexual victims indicated that the offender was under 18, with only 30 percent of these victims reporting these to the police.

There have also been attempts to determine the prevalence of sexual abuse among adolescents by studying representative nonclinical populations (Ageton, 1983; Borowski, Hogan, & Ireland, 1997; Casey, Beadnell, & Lindhorst, 2009). These studies suggest prevalence rates of between 2.4 percent and 5.6 percent. However, the behaviors being measured may not be similar to the populations seen in clinical programs and the screening questions used may not have captured the full range of sexually abusive behavior.

Existing data for Tennessee suggest a similar pattern. In 2009, DCS data indicates that there were 2,588 indicated perpetrators of child sexual abuse in the state of which 717 were youth between the ages of 13 and 17, representing approximately 28 percent for indicated cases. Juvenile Court data for 2008 indicated that there were 603 referrals to Juvenile Court for a sexual offense and 261 adjudications for a sexual offense. In 2011, based on the TN Incident Based reporting system, (available from the TBI website) there were 5,920 reports of sexual offenses by individuals identified as age 13 and over and 890 or 15 percent of these were ages 13-17.

IV. Adolescents Who Have Engaged In Sexually Abusive Behavior: What We Know

Data suggest that adolescents are responsible for a significant number of sexual offenses. While historically adolescents were viewed in similar ways as adult offenders, research has shown that they are not the same as adult offenders and, in fact, there are significant differences. Unfortunately, despite research to the contrary, adolescents have been subjected to adult sanctions (consequences) such as community notification and registration and viewed as needing long term treatment in restrictive environments.

Adolescence is a time of continued development and change with research showing that brain development continues into early adulthood (Steinberg, 2012). One example of the impact of brain development is the decrease in sensation seeking and impulsivity as the adolescent moves into adulthood. Adolescents also have less entrenched deviant sexual arousal patterns and less

entrenched antisocial attitudes than adult sex offenders. Adolescents who have engaged in sexually abusive behavior also appear to have more often experienced trauma than adult offenders. In addition, adolescents are much more influenced by family and interventions that involve the youth's family and social environment are an important aspect of treatment.

It also appears that adolescents have lower recidivism rates as compared to adult offenders. Two large meta-analyses have shown that sexual re-offense rates are between 7 percent -12 percent (Caldwell, 2010; Reitzel & Carbonell, 2006). Adolescents also appear to be much more responsive to interventions.

In addition to research distinguishing adolescents who have engaged in sexually abusive behavior from adult sex offenders, research has also demonstrated that this group of youth is quite heterogeneous. These youth may vary on a number of factors including: cognitive and learning skills, social competence, family functioning, personal victimization, co-morbid diagnosis and delinquency. Family and environmental strengths and assets as well as individual strengths and assets may differ as may the youth's ability and willingness to engage in interventions. The youth's risk to reoffend, both sexually and non-sexually, will vary which impacts treatment and supervision.

Hunter (2006) based on his and colleagues' research describes three developmental pathways for youth who have engaged in sexually abusive behavior. This includes: 1) an Adolescent-Onset Paraphilic group which is at most risk for repeat sex offending without intervention; but only represents a very small proportion of adolescents who have engaged in sexually abusive behavior, 2) a Life Style Persistent pathway in which youth are more at risk for general offending, but are less at risk for continued sexual offending, and 3) an Adolescent-Onset Non-Paraphilic group whose offending is transitory. This may represent the most frequent group of youth who have engaged in sexually abusive behavior.

V. Core Foundations

The research findings previously highlighted, and other current research, suggest that adolescents who have engaged in sexually abusive behavior are a very heterogeneous group with only a small number at risk for future sexual offending. Effective interventions with this population require recognition of this heterogeneity and adherence to the risk-need-responsivity principles.

Risk-Need-Responsivity

Risk-need-responsivity principles encompass the heterogeneity of the youth by guiding decisions based on the individual youth. Risk looks at the factors within the youth and his/her environment that is associated with delinquent and/or sexual reoffending behaviors. The intensity of interventions and level of supervision are based on the youth's level of risk. Need refers to risk factors that can be changed and if changed reduce the risk for future delinquent and/or sex offending behavior. This principle ensures that what is being targeted in treatment is related to risk factors associated with recidivism specific to the individual youth. Factors not related to recidivism, but relevant for the youth, are also addressed to ensure the overall well being of the youth. The responsivity principle directs attention to factors within the individual or his/her environment that affect his/her response to

interventions and applies effective methods that maximize the youth's ability to learn from rehabilitative interventions.

Treatment does not look the same for all youth and varies according to the risk and need needs of the youth. Assessment is key to identifying risk and need including identifying those youth at most risk for reoffending sexually. Intensive interventions are reserved for the higher risk group as intensive interventions with lower risk youth may actually increase their risk (Lowenkamp, Makarios, Latessa, Lemke, & Smith, 2010). Some youth who are at lower risk will need only limited interventions. Higher risk youth receiving higher intensity interventions potentially may need a more secure treatment setting than those who present at a lower level of risk. Lower risk youth should be treated in less restrictive environments to avoid being exposed to higher risk, more deviant peers and treatment should be more limited in length. In regard to treatment focus, for some youth interventions may focus on general delinquency/conduct disorder related issues with a more limited focus on sexually abusive behavior while for other youth there may be more of a focus on the sexually abusive behavior. The assessment provides information to guide decisions related to management of the youth including level of supervision, intensity of services and structure needed as well as guiding the treatment focus for the youth.

As noted the need principle looks at risk factors related to recidivism that can change. While further research is needed related to specific factors related to adolescents' risk of continuing to engage in sexually abusive behavior, the field has moved forward in this area and we do have a foundation of knowledge regarding factors that relate to risk and certain factors that do not relate to risk. There is clear research and literature regarding factors that relate to general delinquent offending which should also be addressed in assessments and treatment.

Factors that relate to risk include both those that are not changeable, which we call static risk factors, and those that are dynamic risk factors, which are changeable.

The current research literature focuses on factors related to sexual reoffending as well as factors related to general (non-sexual) recidivism. These factors are delineated in the table below.

| Sex Offending Specific | | |
|--|--|--|
| Static Risk Factors (factors that cannot change) | Dynamic Risk Factors (factors that can change) | Factors Not Likely Related to Reoffending |
| <ul style="list-style-type: none"> ▪ Prior charge for sex offenses ▪ Multiple victims ▪ Stranger victims ▪ Prior treatment failure ▪ Prior history of general criminal behavior ▪ Male victims | <ul style="list-style-type: none"> ▪ Deviant sexual interest ▪ Sexual preoccupation/obsession ▪ Attitudes supportive of offending ▪ Social isolation ▪ Difficulties establishing peer relationships ▪ Difficulties managing emotions ▪ Family dysfunction | <ul style="list-style-type: none"> ▪ Denial ▪ Clinician rated motivation at intake ▪ Victim empathy ▪ General psychological problems |

| Factors Related to General Delinquent Reoffending |
|---|
| <ul style="list-style-type: none"> ▪ Prior legally charged offenses ▪ Family functioning ▪ (including family supervision and discipline practices) ▪ School achievement and behavior ▪ Negative peer relationships ▪ Substance use and abuse ▪ Use of recreation time ▪ Antisocial/pro-criminal attitudes ▪ Certain behavior and personality traits such as aggression, poor frustration tolerance, impulsivity, defiance of authority ▪ Out of home placements |

General delinquency research also provides us with information about protective factors. Protective factors are factors that may moderate the effects of risk and can be viewed as strengths. The protective factors can be built on through our interventions and treatment planning for the youth.

Protective Factors-General Delinquency

- Positive Family Functioning
 - Adequate Supervision
 - Consistent and Fair Discipline
 - Non-Abusive/Non-Violent
- Availability of Supportive Adult
- Emotional Maturity
- Commitment to School
- Positive Peer Social Group
- Involvement in Positive Community Activities
- Interest in Hobbies/Sports
- Pro-Social/Non-Criminal Attitudes

Several of the protective factors identified in the juvenile delinquency literature mirror factors now being identified in the resiliency research as being related to healthy adolescent development. The similar factors include positive family functioning, positive peer social group and availability of support adult.

Responsivity factors inform how we adjust our interventions and approaches. As noted, these are factors that impact the youth's response to treatment. Unfortunately these factors and their potential impact are often overlooked. Treatment efforts are enhanced when responsivity factors are taken into consideration in our work with adolescents who have engaged in sexually abusive behavior. The responsivity principle also focuses on the use of effective methods that will change the youth and family's behavior and attitude. (is this sentence needed?) Effective methods include cognitive behavioral treatment and skills based approaches. The interventions need to be tailored to the learning style, motivation, abilities and strengths of the youth and take into consideration responsivity factors for the youth and family.

Examples of Responsivity Factors:

- Motivation and Readiness
- Cognitive Abilities
- Learning Style and/or Learning Problems
- Emotional /Psychological Difficulties
- Personality Characteristics
 - Anxiety, Self-esteem
- Religious Beliefs
- Bio-Social factors
 - Age, Gender, Ethnic/Culture

VI. Assessment

Introduction

In Tennessee, there are a variety of labels or terms for the specialized assessment of adolescents who have engaged in sexually abusive behaviors. Regardless of the label, the purpose of the evaluation remains the same. The evaluation addresses the risk, need and responsivity principals relevant to the individual youth. The evaluation:

- Addresses the youth's risk to engage in sexually abusive behaviors and/or general delinquent behavior
- Identifies treatment needs that if addressed can reduce risk
- Provides information to assist in decisions regarding:
 - disposition
 - level of supervision
 - intensity of treatment services
 - placement
- Identifies strengths and assets of the youth and family
- Identifies factors that may impact the youth's response to treatment

Overview of Use

The evaluator has the responsibility of ensuring that this type of evaluation is conducted with appropriate cases. At times, referral sources may not be clear about what the evaluation entails and/or what warrants an appropriate referral. In these situations, the evaluator can provide an explanation of the evaluation and review situations in which it is appropriate. This type of specialized evaluation is limited to use with youth who:

- Have a child protective services finding of having perpetrated the abuse or
- Have been adjudicated in court on a sex related offense or
- There has been a direct observation of illegal sexual behavior/sexually abusive behavior by a reliable source or
- Admit to having engaged in sexually abusive behavior/illegal sexual behavior.

Unfortunately, at times the specialized evaluation may be misused. It should be recognized that evaluations of this type:

- Should not be conducted or used to determine if a youth engaged in the alleged sexually abusive behavior or not; this is a misuse of the assessment process. The Department of Children's Services Child Protective Services and/or law enforcement are the investigative agencies in Tennessee.
- Should not be used to state whether a youth fits or does not fit the profile of a sexually abusive youth. There is no specific profile and no research to support such statements.
- Evaluations are most appropriately conducted post-adjudication to inform disposition. Pre-adjudication evaluations raise concerns about self-incrimination and statements of risk prior to adjudication may unduly influence court finding regarding guilt.

Overview of Content

Assessments should be developmentally appropriate and provide information related to risk, need and responsivity as well as strengths specific to the individual youth and his/her family. Adolescents who have engaged in sexually abusive behavior are a diverse, heterogeneous group with varying circumstances and situations that can impact the referral question and/or purpose of the evaluation which in turn can influence the scope and nature of the evaluation. The youth's individual circumstances and situation can also influence the content of the evaluation.

- In general a youth with more intrusive, higher frequency or lengthier history of problematic sexual behavior would warrant a more thorough exploration of the core areas. (See p. 291.)
- Cases in which decisions with potentially negative impact, such as removal from the community, are being considered also call for a more comprehensive approach.
- Significant mental health issues or developmental disabilities may warrant a more comprehensive evaluation.

Being aware of the referral question and the purpose of the evaluation allows the evaluator to determine the comprehensiveness of the evaluation. Evaluations may be requested to:

- assist in treatment planning
- inform placement
- inform supervision decisions
- inform disposition after a youth has been adjudicated on a sex offense.

The assessment should consist of what is necessary to answer the referral question and address the purpose of the evaluation. At a minimum the assessment involves:

- Face to face detailed clinical interview with the youth
- Face to face detailed clinical interview with the youth's parental unit
- Review of information related to the sexually abusive behavior
- Collecting of information from other sources including:
 - Social Services
 - Police
 - Court
 - Family
 - Mental Health Agencies
- Review of relevant records
 - Juvenile Court
 - Past evaluations and assessments
 - Past treatment records or information related to treatment
 - Relevant educational records, including grades, behavior, special education needs

There are several areas to be considered in the assessment process. These are not limited to the youth, but encompass other relevant components also. **Core areas** to be addressed in the assessment include:

- Issues specific to sexually abusive behavior(s)
- Issues specific to delinquent behavior, if present
- Psychosexual history
- Current situation and circumstances
- Mental status
- Youth's functioning and factors across all life areas (home, school/employment, community, social)
- Family characteristics and functioning
- Strengths and protective factors
- Interventions or immediate steps that can be taken to modify assessed risk (are the following bullets a bit too detailed?)
 - Youth's risk is impacted by lack of parental supervision and stable living environment.
 - Are there any relatives or friends who are appropriate and willing to provide a placement for the youth?
 - Youth's risk is impacted by significant behavioral health issues such as untreated ADHD
 - Can appropriate treatment immediately help relieve these symptoms?

Assessing Risk and Need

There are evidence-informed, structured risk assessment tools that have been developed to assess the risk and needs of adolescents who have engaged in sexually abusive behavior. Research related to risk and need assessment of these youth continues to evolve and professionals conducting evaluations stay current of the research literature. There are limitations to the current risk assessment tools. While recent research (Viljoen, Mordell, & Beneteau, 2012; Worling, Bookalam, & Litteljohn, 2012) provides preliminary support that existing instruments predict recidivism with better-than-chance accuracy, there is still a great deal of variability between studies and none of the currently available tools are an actuarial tool on which we can definitively base predictions of recidivism.

The most commonly used risk and need assessment tools are the ERASOR 2.0 and JSOAP-II. Risk and need assessment is a component of the evaluation and evaluators should be trained on the instruments. In general evaluators should remember that:

- The risk assessment tool is to be utilized to help facilitate the assessment of the relevant areas and to provide increased accuracy over unstructured clinical assessments. The tools assess static and dynamic factors currently identified in the research which evaluator use to make evidenced based judgments.
- Statements about percentages of risk to reoffend are not appropriate. At this time there is inadequate data to tie a specific score or risk level to a percentage risk to reoffend.
- Evaluations that outline the factors and situations that place the youth at risk and provide information about protective factors, strengths and assets are more beneficial in informing decisions for effective management and treatment planning.

- Evaluators should use caution if using terms such as “low,” “medium” and “high” risk; there is no agreed upon definition of these terms which can easily lead to misinterpretation and the “level” can unintentionally label the youth.
- Risk assessments need to be periodically updated to ensure that they are reflecting the youth’s current level of risk; updates are recommended every 6 months.

Qualifications of Evaluator

Assessment of adolescents who have engaged in sexually abusive behavior is not the same as conducting a general evaluation. Specific to these evaluations, the evaluator needs to:

- Be knowledgeable about sexually abusive youth and adolescent development. Sexually abusive behavior is differentiated from developmentally normative behaviors and it is important to be aware of both normative sexual development and general adolescent development.
- Be comfortable in conducting an interview that includes discussion of sexual behavior.
- Evaluators need to have participated in training on assessment and relevant risk assessment tools.

Summary

The specialized evaluation is grounded in risk, need, responsivity principles, taking into account the youth’s social, family and environmental context while incorporating relevant risk assessment findings to formulate an individualized plan for youth who have engaged in sexually abusive behavior. Adolescence is a period of rapid change, the youth’s circumstances are dynamic and in addition interventions related to risk can further impact the situation. The youth’s risk and needs are not stagnant and assessments should be updated every six months or when risk-relevant changes occur. Initial assessments should not be considered final assessments as changes associated with risk (maturity, school, friends, treatment progress, etc.) do occur over time.

VII. Interventions and Treatment

Given the current data on adolescent offenders and general delinquent offenders, treatment is most likely to be effective if it is skills based and cognitive behavioral in nature focusing on dynamic risk factors delivered in an appropriate therapeutic style, and involves systems impacting the youth outside of the treatment situation. Socio-ecological models of intervention recognize the importance of family and environment and their impact on adolescents. The youth’s environment, including school, peer selection, use of leisure time, is an important component of a comprehensive approach to rehabilitation. If interventions only focus on the youth, they will be less effective.

Treatment Related Research

There is support in the literature that treatment and interventions can be effective with adolescents who have engaged in sexually abusive behavior. A 20 year follow-up study (Worling, Litteljohn, & Bookalam, 2010) showed a 9 percent recidivism rate for a treated group and 21 percent recidivism rate for a non-treated group. There is also a meta-analysis which suggests youth receiving treatment have lower recidivism rates than youth who do not receive treatment (Reitzel & Carbonell, 2006). In addition, there have been randomized controlled trials of a social-ecological approach (Multi-Systemic Therapy) which supports treatment effectiveness in this population (Borduin, Henggeler, Blaske, & Stein, 1990; Borduin, Schaffer, & Heiblum, 2008; Letourneau et al., 2009).

There is also a large literature on intervening with youth engaging in general delinquent behavior that supports that programs that follow the risk/need/responsivity principals have better outcomes (Lipsey, Howell, Kelly, Chapman, & Carver, 2010; Vieira, Skilling, & Peterson-Badali, 2009). As noted earlier, adolescents who have engaged in sexually abusive behavior are much more likely to engage in non-sexual re-offenses than sexual re-offenses. This is important to remember in our interventions and treatment efforts.

Importance of the Therapeutic Relationship

There is strong support for the importance of therapeutic relationship variables (Karver, Handelsman, Fields, & Bickman, 2006) in the treatment of youth and families. Research and clinical practice with adult sex offender (Marshall, 2005) and adolescents (Smallbone, Crissman, & Rayment-McHugh, 2009) also supports the importance of the therapeutic relationship variables. Treatment will be most effective when the adolescent and family are treated with respect and where hope is present. Treatment will be least effective when harsh, confrontational treatment styles are employed. Treatment will be more effective if there is a focus on developing approach goals rather than being limited to the narrow focus of what should be avoided. Approach goals are defined as striving for more positive achievements and prosocial behaviors that are incompatible with sex offending (Mann, Webster, Schofield, & Marshall, 2004).

Treating the Whole Youth

It is important to treat those factors most relevant to reoffending. However, it is clearly recognized that many youth who engage in sexually abusive behavior, especially those at higher risk, have a number of other issues including significant general behavioral problems, co-morbid psychiatric issues, family dysfunction, and trauma. While these issues may not be directly related to reoffending, they should be addressed due to the impact on the youth and potential interference of the youth reaching their maximum potential and leading a healthy, fulfilled life.

Treatment as Part of a Broader Social-Ecological Approach

Youth who engage in sexually abusive behavior are impacted by a number of systems and providers need to recognize the impact these systems can have on the youth, both positive and negative.

- Families are an important part of the lives of all youth and this is also true on youth who engage in sexually abusive behavior. Families of adolescents who engage in sexually abusive families vary on a number of characteristic some with significant family dysfunction, some that function well. They vary on parenting skills. In all cases, where appropriate, families should be part of the treatment process. In cases in which abuse, neglect or other significant issues preclude direct involvement, the youth may well still feel a connection to the family and this should not be dismissed. In such cases intervention should strive to involve other potential adult support systems.
- Many youth experience problems in school, have poor peer selection and make poor use of leisure time, all factors that can increase at least risk for general offending. Working with these systems should be part of treatment. In cases where there are multiple problems, the addition of in-home services that actually work with community resources can be an important component of comprehensive management.
- Youth who engage in sexually abusive behavior are many times involved with the juvenile justice system and/or the social services system. Family Service Workers or court workers play an important role in the youth's life and should be seen as part of the treatment team. It is important that those providing therapeutic service develop relationships with these workers.

Treatment Targets

Assessment should guide the selection of the treatment needs since not all youth present with the same dynamic risk factors and treatment will need to be individualized. However, currently the following are thought to be the most relevant dynamic risk factors to address in the treatment of adolescents who have engaged in sexually abusive behavior:

- Attitudes and justifications supportive of offending
- Emotional Management
- Social Competence/Relationship Skills
- Healthy Sexuality
- Ability to establish peer relationships
- General self-management skills
- Family Education/Functioning
- Sexual Deviation or Sexual Preoccupation (if applicable)
- Development of Positive Life Goals
- Individualized Issues as Needed

Treatment Modalities

Various treatment modalities are used with adolescents who have engaged in sexually abusive behavior. While early clinical literature suggested that group therapy was the preferred modality, there is little evidence supporting one modality as superior to others. Therefore, the choice of modalities should be based on the youth's and family's needs.

Family Therapy

Family involvement is a crucial component of work with these youth. Caregiver(s) experience a variety of emotions and reactions to learning that their child has engaged in sexually abusive behavior. They may be resistant or hesitant about treatment and the treatment provider's role is to meet them where they are in the process. The caregivers' understanding of the problem, learning about managing risk and support of the adolescent contributes to the youth's success.

While specifics are tailored to the individual family, there are some basic components of family therapy. These include:

- Builds on family strengths
- Addresses dysfunctional family interactions and familial-based risk factors that contribute to the youth's sexual abusive behavior
- Reinforces and promotes healthy communication, interactions and parenting skills.
- Provides education regarding adolescents who have engaged in sexually abusive behavior and issues specific to their youth.

Group Therapy

- Group therapy provides a modality to address a variety of risk factors.
- Group therapy can be specifically beneficial in targeting interpersonal-based risk factors such as
 - power and control interactions,
 - social isolation,
 - communication,
 - passive and aggressive patterns of interactions and
 - other interpersonal, social issues.

Skills Focused Group Therapy

- Provides skills building focused interventions such as anger management, conflict resolution, problem solving, decision making, etc.

Individual Therapy

- Individual therapy is used to address specific individual issues, comorbid conditions, and special needs.
- Individual therapy can also be utilized to reinforce and prepare for work in the group therapy setting.
- Individual therapy can also include skills building focused interventions.
- Individual therapy is also utilized to address risk factors related to reoffending.

Reconciliation/Reunification

Adolescents who have engaged in sexually abusive behavior will potentially be reuniting with their families where the victim also lives and/or where there are other vulnerable children. This most often occurs when the victim is a sibling or close extended family member of the youth.

Reconciliation/reunification related work may be incorporated into several treatment modalities. The reconciliation/reunification process takes time and provides the victim, abusive youth and family opportunity to work through issues related to the abusive behavior while creating a safer and more secure family environment with an increased opportunity for success and growth. In many cases reconciliation and/or reunification is appropriate and can promote healing within the family. The core focus of reconciliation/reunification is the best interest and well being of the victim.

There are several aspects to be considered prior to initiating the reconciliation/reunification process including safety, both physical and emotional, supervision and readiness of the victim, the abusive youth and the family. It is helpful to think about the reunification process in steps, with adequate time in between steps to assess application of safety guidelines and the impact on the victim, youth and family. It is recommended that reconciliation/reunification take place in the context of therapy, which provides a safe and structured environment to explore difficult feelings and supports healthier relationships built on safety. This also allows the family to have the treatment providers' support during the process and transition period in which the youth may be returning to live with or be in regular contact with the victim. The Joint Task Force on Children's Justice and Child Sexual Abuse has developed considerations for reunification and these have been adopted by the Department of Children's Services; please refer to Appendix A.

Medication therapy

- Medication therapy such as SSRI's may be helpful for addressing sexual preoccupation in some youth. However, medication should be used as part of a comprehensive program.

Treatment Sequencing

An important part of treatment is how treatment is sequenced. Early approaches to this population focused on the sexually abusive behavior very early in the treatment process. However, clinical experience suggests that many times this early focus only increases the youth's and family's resistance and can actually extend treatment. Although each youth is different and may need more or less time in each phase of treatment, the phases described below provide at least one road map through treatment.

Phases

It is important to note that safety rules and guidelines to prevent sexually abusive behavior are in place throughout phases of treatment. It is the direct focus on the sexually abusive behavior that occurs later in the treatment process.

- Engagement and Motivation: The first steps to treatment is engaging the youth and family in the treatment process and trying to increase motivation. This phase will use techniques from motivational interviewing and will collaboratively work with the youth and family to establish some agreeable treatment goals. In general this phase does not focus on the sex abusive behaviors directly.
- Treatment Interfering Behaviors/General Treatment Skills: For higher risk youth many will display significant disruptive behavior and or significant co-morbid psychiatric disorders. Until some of these are resolved, it will be difficult for the youth to focus on sexually abusive issues, although it should be recognized that many of these behavioral issues such as poor emotional management are also related to risk for sexual reoffending. Therefore the goals of this phase are to stabilize significant psychiatric disorders and to focus on managing disruptive behaviors. This includes such interventions as anger management, impulse control, etc. For youth who show less disruptive behavior this phase is to learn basic skills which will be applied throughout treatments such as healthy decision making, problem solving recognizing the link between situations-thoughts-behaviors and developing basic cognitive restructuring skills. Most of this can be done by addressing general behavioral issues rather than sexually abusive behavior per se.
- Problem Identification: In this phase one begins exploring the sexually abusive behavior with the goal of identifying the factors related to the youth's sexually abusive behavior. One begins reviewing the history of sexually abusive behaviors to identify factors that may increase future risk for reoffending and attitudes that may support sexually abusive behavior. It is important to recognize that not all youth will have the same risk factors, that there is not a set cycle of abuse and that for some youth the sexually abusive behavior is not planned and is more a result of poor decision making and may not have a specific trigger.
- Skill Development: Once the dynamic risk factor for the youth has been identified then the focus is on developing the skills to cope with the dynamic factors and to be able to challenge any attitudes that support offending.
- Aftercare: For youth in residential or congregate care settings an important component is appropriate follow-up care to assist in generalizing what has been learned in treatment to a more natural environment. Some youth will need fairly extensive treatment that continues to focus on sexually abusive behavior while others may need treatment that focuses more on general adolescent issues and transition issues and some may only need treatment that monitors risk and reinforces change.

APPENDIX A: Considerations in the Reunification of Sexually Abusive Youth With The Families Where the Victims (or other vulnerable children) Reside
(From The Joint Task Force on Children's Justice and Child Sexual Abuse)

The following criteria are recommended guidelines for reunification of Sexually Abusive Youth (persons age 13 and over) back into the home where the victim resides. Each item in the criteria represents an element that should be considered and weighed carefully in a professional staffing that includes the DCS case manager, treatment professionals, and service providers working with the

individuals and family and with consideration of any court orders which may be in place. There is no magic formula or combination of factors that will guarantee a successful reunification. The consideration of each issue in concert with other professionals may help to identify gains in the treatment process thus far and potential pitfalls in the reunification effort.

I. The Sexually Abusive Youth (**SAY**) has undergone an adequate risk/needs assessment to explore issues, behaviors, and conditions related to the sexually abusive behavior. This assessment may have, but not necessarily will have, been conducted as part of a “psychosexual evaluation.”

II. The Adolescent has participated in a treatment program in which issues related to reoffending have been addressed. This covers a variety of issues which MAY include the following:

- a. Sexual Deviance
- b. Ability to establish and maintain peer relationships
- c. Anger management
- d. Thinking errors and attitudes that support reoffending behavior
- e. Impulse control
- f. Concomitant psychiatric/psychological issues
- g. Other issues as appropriate

III. There is an adequate Relapse/Safety Plan that is “do-able” (it is within the realm of possibility that these persons could “reasonably” live within the confines of this plan). The plan should account for issues that may include:

- a. Work schedules of parents or persons overseeing the children
- b. Schedules of children in the home
- c. Physical proximity of possible victim’s bedroom from SAY’s bedroom
- d. Physical layout of the home and how that layout lends itself to monitoring activity within the home
- e. Issues of personal space, securing boundaries and privacy of individuals in the home (e.g. doors on bathrooms)
- f. Established rules for expected behavior and how misbehavior will be dealt with
- g. Any court orders which may be in place.

IV. There must be an established plan for gradually increasing visitation between the SAY and the victim. This visitation would *typically* begin with initiation of contact in a therapeutic setting (clarification), progressing to short visits in a neutral setting, to short visits in the home that gradually increase over time. Family members or other people external to the family may supervise the visits. Visitation may unfold differently in each case situation but the steps of the visitation plan for each case should be clearly established in concert with therapists for all parties prior to initiation of the plan. The plan should include steps to evaluate the impact of visits on the victim at each stage of the progression.

V. Victim Re-assessment – In considering the reunification, there should be statements from a therapist who can speak to the impact of the reunification on the victim, the victim’s understanding of the reunification and how it will affect the victim’s life and lifestyle, and the victim’s knowledge and understanding of all of the provisions of the safety plan.

VI. There should be an assessment of parents'/caretakers' willingness to enact the safety plan. One would expect these persons were actively involved in developing this plan; that they show an understanding of the plan; and illustrate a commitment to implement the plan. The assessment would likely address parents'/caretakers' comprehension of how this plan will impact their lifestyles.

VII. Availability of Follow-up Services. The reports should indicate that some type of supportive services are available to the SAY, the victim, and family as they strive to live by the safety plan for AS LONG AS THEY NEED THESE SERVICES. These services may include:

- a. treatment/therapy services for individuals and for the family,
- b. home based crisis intervention type services to intervene in crisis or particularly challenging situations
- c. services to meet basic needs such as child care or economic needs
- d. advocacy to help in navigating other systems (schools?) and connecting with other community resources

Background

The Treatment Committee of the Joint Task Force on Children's Justice and Child Sexual Abuse and has been working for several years to develop recommendations for improving the system's effectiveness in dealing with Sexually Abusive Youth (**SAY**, formerly referred to as Adolescent Sex Offenders). These are individuals age 13 and older who have committed a sexual crime or who have perpetrated sexual abuse on another child. These youth are involved with the system in various ways:

- They may have been prosecuted and adjudicated through the juvenile justice system.
- They may have come to the attention of DCS through an abuse report (CPS).
- They may be in the Foster Care system for various reasons, either related or unrelated to their sexually abusive behavior.

The problems of **SAY** present in many different contexts and involve different components of the child welfare and juvenile justice system. Consequently, the Treatment Committee had some trouble getting its arms around the problem. We decided early on to narrow our efforts down to one particular group of **SAY**, namely those facing possible reunification with families where victims or other vulnerable children reside.

A major system problem in dealing with **SAY** is that professionals within the system (judges, juvenile court staff, DCS workers, therapists, and others) have widely varying levels of knowledge and sophistication regarding **SAY**. At one end of the spectrum is a naiveté that assumes if a **SAY** has had treatment of any kind, his/her offending issues must have been addressed. Professionals at this end of the spectrum do not have the knowledge to judge appropriate treatments or treatment providers for these youth. The "Considerations" were developed in part to aid this group in identifying whether effective treatment has taken place by identifying some elements that are likely to be present.

At the other end of the spectrum is a division of opinion among therapists treating **SAY** about best practices and what constitutes appropriate treatment. While there is general agreement that treatment

should have some “offender-specific” components, there is not agreement on what these components should be, and research data do not support the efficacy of a single model. Research also points to considerable heterogeneity among **SAY**, such that there should not be a “one size fits all” approach. The “Considerations” address this problem by listing elements that **may** be present without specifying that all **must** be present.

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