203 Remote: Working with Juveniles Who Sexually Offend

INSTRUCTOR GUIDE

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All names and identities used in this training are fictitious. Any resemblance to actual persons, living or dead, is coincidental. Please contact the Resource Center at (717) 795-9048 for further information or permissions.

203 Remote: Working with Juveniles Who Sexually Offend

Agenda for Two-Day Workshop on
203: Working with Juveniles Who Sexually Offend

Day 1

203 Remote: Working with Juveniles Who Sexually Offend

Day 2

203 Remote: Working with Juveniles Who Sexually Offend

Section I: Welcome & Introductions

Estimated Length of Time:
30 minutes

Key Concepts:
- Participants come to this training with different thoughts, feelings, beliefs, and attitudes about juveniles who engaged in sexually abusive behavior.
- Participants might find the topic of this training difficult to talk about, so participants need to take care of themselves.

Methods of Presentation:
Lecture; large group discussion

Materials Needed:
- ✓ Laptop and shared screen
- ✓ Zoom Room Flow Chart
- ✓ **PowerPoint Slide #1: Sexual Abuse Series: 203: Working with Juveniles Who Sexually Offend**
- ✓ **PowerPoint Slide #2: Introductions**
- ✓ **PowerPoint Slide #3: Housekeeping**
- ✓ **PowerPoint Slides #4-5: Training Agenda**
- ✓ **PowerPoint Slide #6: Child Sexual Abuse Series**
- ✓ **PowerPoint Slide #7: Learning Objectives**
- ✓ **PowerPoint Slide #8: Competencies**
- ✓ **Handout #1: PowerPoint Presentation: 203: Working With Juveniles Who Sexually Offend** (participants received with registration letter)
- ✓ **Handout #2: What's In It For Children and Families** (for display only)

Prior to participants joining session: Set up Zoom breakout rooms, following the Zoom Room Flow Chart, set up all instructor-prepared Word documents needed for the session; track attendance of participants for entry into Bridge.

Outline of Presentation:
- ✓ Greet participants as they join the session. Confirm with participants that they can hear you and see the shared screen. Troubleshoot any technical difficulties. Conduct a final sound and screen sharing check before proceeding.
- ✓ Take attendance, making sure to get a verbal confirmation from participants that they are present. Review the 15-minute rule. Ask participants to notify you right away if they are late joining the session after any of the breaks, or if for any reason, they need to leave the session today or tomorrow.
- ✓ Review the agenda and learning objectives.
- ✓ Discuss potential for problems related to remote delivery and solicit ideas and feedback from participants on how to handle.

Section I: Welcome & Introductions

Step 1:
Welcome and Introductions

Display **PowerPoint Slide #1 (Sexual Abuse Series: 203: Working with Juveniles Who Sexually Offend)**.

Facilitator Note: It is important to make note of attendance at the beginning of both days of this session and after each break. At the end of Day 1 and Day 2 of this module, attendance must be submitted to CWRC using Bridge.

Introduce yourself to the group while making sure to include your background and experience(s) of working with adolescents who sexually abuse or children with sexual behavior problems as well as your experience(s) in working in the field of child welfare.

Ask participants to have something ready to jot down notes throughout the session.

Step 2: Team Formation

Use the criteria listed below to form teams that are diverse based on experience working with children/youth who sexually offend. Read the criteria listed beside each bullet point below, one bullet point at a time. Ask participants, to type their name in the Zoom chat after the criteria that matches their experience.

- You have experience working with 5 or more children or youth who has sexually offended or who display concerning sexual behavior
- You have experience working with 1-4 children or youth who has sexually offended or who display concerning sexual behavior
- You have learned about or read about working with children and youth who sexually offend or who display concerning sexual behavior
- You have no prior experience learning about or working with children and youth who sexually offend

Facilitator Note: The ideal team size is 4 members. You must have at least two teams. As participants say their name, list the names in order on the shared screen for participants to see. Starting with the first participant who shared their name, count off by the total number of teams that will result in teams of an appropriate size. List the team number beside each participant's name to reference throughout the session as needed.
-If there are 8 participants or fewer, count off by 2.
-If there are between 9 and 12 participants, count off by 3.
-If there are 13 or more participants, count off by the number of teams that will result in teams of an appropriate size.

Say: Ones, you are a team. Twos, you are a team… [etc.].

Do: Explain how teams will work together via Zoom on team activities throughout this module. Explain that next teams will work on introductions with the large group, and then provide guidance on how to enter your team's breakout room in Zoom.

Display **PowerPoint Slide #2 (Introductions)** and have each participant introduce themself by sharing the name of their agency, their position at the agency, and how long they have been working in the field of child welfare.

Explain that the purpose of this exercise is for participants to become familiar with each other in addition to gaining insight about people's thoughts and beliefs about "juvenile sex offenders" as well as information about what they want to learn from this workshop.

Ask participants to share three *words that come to mind when they hear the words "juvenile sex offender."*

Step 2:
Training Environment and Expectations

Explain that this training will be instructor-led and participant-centered. Discuss that participants possess a great deal of knowledge and have experience working with juveniles who have sexually acted out or offended; therefore, the instructor welcomes participant input, experiences, and feedback.

Ask if there is any experience or role in working with juveniles who sexually offend that participants want to share.

Display **PowerPoint Slide #3 (Housekeeping)** and explain the "15-minute" rule, which states that participants cannot miss more than 15 minutes of the entire training or they will not receive training credit for the training.

Remind participants to notify instructor right away if they are late joining the session after any of the breaks, or if for any reason, they need to leave the session today or tomorrow.

Ask participants for any potential difficulties that may occur specific to remote learning and discuss expectation for how to handle these situations. Reference the Remote Training Etiquette document that participants should have received and reviewed prior to any remote training.

Note that cell phone use is discouraged during the training, and that they may use phones during breaks and lunch. Remind participants that this learning time is for the purpose of learning new skills to improve practice with children, youth and families.

Remind participants that they should have receive and reviewed the Remote Training Etiquette document. Discuss that the use of the chat feature is available, and while

many of the activities are designed in the large group format with direct responses requested, the use of the chat feature will be discussed at those times that it applies.

Step 3:
Review Training Agenda

Display **PowerPoint Slide #4 (Child Sexual Abuse Series)** and explain to participants that this training is part of the Sexual Abuse Certification Series. This training will address assessment and treatment issues associated with case planning youth who sexually offend.

Display and review **PowerPoint Slides #5-6 (Training Agenda)**. Share **Handout #1 (PowerPoint Presentation: 203: Working with Juveniles Who Sexually Offend)**. Reiterate that not all issues raised by participants will be able to be discussed during this 2-day training, but welcome participants to ask instructor via chat or in discussions for additional information. The instructor should also agree to be a resource by being available during breaks as well as before and after the training day.

Step 4:
Review Learning Objectives

Display **PowerPoint Slide #7 (Learning Objectives)** and **PowerPoint Slide #8 (Competencies)**.

Instructor Note: The instructor will need to warn participants that the content of this workshop can be difficult; that the participants may have uncomfortable emotional reactions to the workshop content; and that they need to be aware of their reactions and take care of themselves.

Step 5: What's In It For Children and Families (WIIFCF)?

Explain to participants that they will now take a few minutes to think about how what they will learn, discuss, and practice in the training today will support their work with children, youth, and families.

Tell participants that many of us got into the field of child welfare to make a difference in the lives of children, youth, and families. This activity will help them make the connection between the information learned in today's training session and the direct impact your work will have on children, youth, and families. This activity will also activate prior knowledge and give them a chance to identify what they want to work on as it relates to this training session.

Display **Handout #2 (What's in it for Children and Families?)** and ask participants to consider the following learning points they will be learning, discussing, and practicing over the new two days:

Review list:

- Characteristics of children with sexual behavior problems and adolescents who have engaged in sexually abusive behavior
- Victim-centered approach
- Assessment of children with sexual behavior problems and adolescents who sexually abuse
- Treatment and supervision of children with sexual behavior problems and adolescents who sexually abuse
- Case planning with the families of children with sexual behavior problems and adolescents who sexually abuse
- Reunification and case closure for children with sexual behavior problems and adolescents who sexually abuse.

Ask participants to consider “What’s in it for children and families when I participate in this training session?”

Ask participants to share ideas about what they would like to learn from this training, or questions that they have. Respond to let participants know which of those issues/topics or questions will be covered in the training.

Ask participants to make a note of their ideas so that these can be referenced at a later time. Ask participants to share their thoughts with the group. Highlight any key points that are shared. If any key points seem to be missing, surface these points during discussion by asking participants to consider the missing idea.

Say the following, “Throughout this training session, we will continue to make connections to these items as they come up during activities and conversations. At the end of the training session, we will review this discussion to further identify the connections between the information, discussions, and skills practiced and the direct impact that will have on your work with children, youth, and families.” Remind them to keep the notes that they wrote for this.

Instruct participants that they will be asked at the end of each section to share something that they learned. Therefore, they should take notes throughout the training of information/concepts/ideas/applications that they are learning.

Advise participants that this ends the first section of the training, and before moving on to the next session, participants are invited to share what they have learned so far.

Ask for questions before moving on to the next section.

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Section II: Understanding Sexual Behaviors

Estimated Length of Time:
20 minutes

Key Concepts:
- Sexual behaviors can be looked at from a developmental perspective.
- Sexual behaviors that cause concern can be contact and non-contact offenses.

Methods of Presentation:
Lecture, Large Group Discussion, Large Group Activity

Materials Needed:
- ✓ Laptop and projector/screen
- ✓ Zoom Room Flow Chart
- ✓ **Appendix #1: True and False Quiz Answers**
- ✓ **PowerPoint Slides #9-10: True or False Quiz**
- ✓ **PowerPoint Slide #11: Sexualized Behaviors That Cause Concern**
- ✓ **Video: 203: Working with Juveniles Who Sexually Offend (Clip #1-Kevin's Story)**
    - **All videos for this course can be accessed here: http://www.pacwrc.pitt.edu/curriculum/sexualabuseseriesvideos.htm**
    - **Clip #1 (Kevin's Story) can be accessed directly using this link: http://www.pacwrc.pitt.edu/curriculum/SexualAbuseSeries/WorkingJuvenilesWhoSexuallyOffend/Kevin's%20Story.mp4**

Outline of Presentation:
- Conduct a quiz to ascertain the level of awareness surrounding healthy sexual behaviors.
- Review healthy sexual behaviors from a developmental perspective.
- Show the video clip of a juvenile talking about his sexual behaviors.

Section II: Understanding Sexual Behaviors

Step 1:
Healthy Sexual Behaviors

It is important for child welfare professionals to be able to recognize concerning or unhealthy sexual behaviors in children and adolescents and how those behaviors can lead to offending behavior. To be able to do this, it is first necessary to understand healthy sexual behaviors in children and adolescents.

Instructor Note: It may be helpful to get an idea of how many participants have already attended **203: Sexuality of Children: Healthy Sexual Behaviors and Behaviors Which Cause Concern**. Step 1 of this section will be a brief review of healthy sexual development of children and adolescents.

Advise participants that they will take the quiz as a large group. The quiz will focus on healthy sexual behaviors during various stages of child/adolescent development. Display **PowerPoint Slides #9-#10 (True or False Quiz)** and ask participants to respond to each statement by unmuting and sharing either "True" or "False." Refer to **Appendix #1 (True and False Quiz Answers)** for the suggested responses. If participants struggled with the quiz and they lack knowledge about healthy sexual behaviors, briefly review the following:

Display/Share screen of this information so participants can read while providing a general overview:

Most children ages 0 – 3 will:

- Be curious and explore their own body
- Watch or poke at others' bodies
- Randomly touch their genitals for pleasure
- Talk openly about their bodies
- Be able to say and understand, when taught, the appropriate names for body parts (head, nose, stomach, penis, vagina, etc.)
- Experience an erection or vaginal lubrication

Most children ages 4 and 5 will:

- Experience vaginal lubrication or erection
- Randomly touch their genitals for pleasure
- Feel curiosity about everything including bathroom functions and where babies come from
- Play games like "doctor"
- Have the ability to recognize males and females
- Begin to recognize traditional male and female gender roles and to distinguish these gender roles

- Be conscious of one's own body, how it appears to others as well as how it functions

Most children ages 6 through 8 will:

- Prefer to socialize with their own gender almost exclusively and maintain a rigid separation between males and females
- Recognize the social stigmas and taboos surrounding sexuality (especially if parents are nervous about the subject)
- Understand more complex ideas with regard to sexuality and begin to understand intercourse apart from making a baby
- Look to peers, media, and other sources for information about sex
- Mimic or practice kissing/dating
- May engage in same-gender sexual exploration
- Have a stronger self-concept in terms of gender and body image

Most children ages 9 through 12 will:

- Have an emerging sense of self as a young adult
- Feel conscious of their sexuality and how they choose to express it
- Understand jokes with sexual content
- Feel concerns about whether they are healthy (i.e. is healthy to masturbate, have wet dreams, etc.)
- Feel anxious about puberty, when it will happen, how it will occur, how to be prepared, etc.
- Feel shy about asking questions of caregivers, especially regarding sexuality, and may act like they already know all the answers
- Value privacy highly

Most children ages 13 through 17 will:

- Understand that they are sexual and understand the options and consequences of sexual expression
- Choose to express their sexuality in ways that may or may not include sexual intercourse
- Recognize the components of healthy and unhealthy relationships
- Have a clear understanding of the possible consequences of sexual intercourse and have the ability to make reasoned choices about sex based on knowledge
- Recognize the role media plays in spreading views about sex
- Have the capacity to learn about intimate, loving, long-term relationships
- Have an understanding of their own sexual orientation, which is different than sexual behavior

Most adolescents ages 18 and over will:

- Enter into intimate sexual and emotional relationships
- Understand their own sexual orientation, although they may still experiment
- Understand sexuality as connected to commitment and planning for the future
- Shift their emphasis from self to others

- Experience more intense sexuality

Step 2:
Sexualized Behaviors That Cause Concern

Now that we have reviewed healthy sexual behaviors, we will now begin to look at sexualized behaviors that cause concern. There are a range of sexual behaviors to include contact and non-contact offenses as well as related sexual behaviors. Have participants identify some concerning contact, non-contact and related sexual behaviors and write their responses on flip chart paper.

Display **PowerPoint #11 (Sexualized Behaviors That Cause Concern)**. Ask participants why both contact and non-contact offenses are concerning. Facilitate the discussion and review any information participants did not mention.

- Contact Offenses:
  - Touching breasts or genitals
  - Rubbing and humping (either clothed or unclothed)
  - Penetration of vagina, anus, and mouth (by fingers, penis, tongue or objects)
- Non-contact Offenses:
  - Exposing self
  - Voyeurism
  - Child pornography
  - Public masturbation
  - Forcing others to engage in sexual activity and watching sexual activity
- Related Sexual Behaviors:
  - Disrobing
  - Inappropriate or forced kissing
  - Viewing of pornography
  - Using sexual reference to demean and demoralize
  - Forcing others to get naked

Remind participants that it is easy to dismiss non-contact offenses (for example, in the video clip they will be viewing next, Kevin uses grooming). Those who engage in non-contact offenses only have higher rates of re-offending while the rate of re-offending for those who engage in contact offenses is much less.

Adolescents engaged more frequently in digital fondling while adults engaged in vaginal, anal, or oral intercourse more frequently than juveniles. Additionally, juveniles were more likely to offend family members than adults, and they were also more likely to utilize force more frequently than adults. Juveniles generally have fewer victims and shorter relationships with their victims than do adults.

Instructor Note: In the following video clip, Kevin explicitly describes exposing himself to his five-year-old brother, touching of genitals, fellatio, and anal sex. Advise

participants of the explicit nature of the clip and encourage participants to take care of themselves as needed.

Participants will now watch **Video Clip #1**, which is “Kevin’s Story” from the video, *Speak Out.* This documentary, *Speak Out,* bridges the distance between those who have sexually offended and those who have been survivors of abuse, giving them the benefit of hearing from each other directly. Kevin will tell his story of molesting his brother by describing both contact and non-contact offending behaviors. The goal of this clip is for participants to understand that both contact and non-contact offenses can be hurtful to survivors of abuse. Instructors should reiterate this goal at the end of the clip.

Instructor Note: Kevin can speak clearly and succinctly about the incidents, as he has been in treatment and he has been prepped for this documentary. Kevin also displays a lack of empathy in this clip, which is because of his treatment.

Ask participants to share their experiences with adolescents who sexually abuse and children with sexual behavior problems on their caseloads. Allow for some brief large group discussion about those contact and non-contact offenses that participants have seen in the juveniles on their caseload. Reiterate that non-contact offenses can be just as hurtful as contact offenses. It is also important to point out that non-contact offenses can ultimately lead to contact offenses.

Advise participants that this is the end of this section and solicit any key learning points/ideas/information/concepts/interventions that were learned during this section. Also ask if there are any areas they might want to note for improvement.

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Section III: Characteristics of Juveniles Who Engaged in Sexually Abusive Behavior

Estimated Length of Time:
1 hour, 30 minutes

Key Concepts:

- It is important to child welfare professionals to understand some common characteristics of juveniles who engaged in sexually abusive behavior, while at the same time understanding the needs of special populations.
- Child welfare professionals always need to be cognizant of cultural factors.
- Research has not yet determined what causes juveniles to engage in sexually abusive behavior, but there are some theories about sexual offending behavior.
- There are several factors to consider regarding sexual offending behavior of juveniles.
- Gathering information is a key task in understanding sexual behaviors.

Methods of Presentation:
Lecture; large group discussion; small group activity

Materials Needed:

- ✓ Zoom Room Flow Chart
- ✓ Managing Zoom Breakout Rooms: Instructor Guide
- ✓ Laptop and shared screen
- ✓ **PowerPoint Slide #12: Three Different Groups**
- ✓ **PowerPoint Slide #13: Review: The Sexual Behavior Continuum**
- ✓ **PowerPoint Slide #14: Sexualized Behaviors: Case Scenarios**
- ✓ **PowerPoint Slide #15: Factors to Consider**
- ✓ **PowerPoint Slide #16: Theories About the Etiology of Sexual Offending**
- ✓ **PowerPoint Slide #17: Cultural Factors to Consider**
- ✓ **PowerPoint Slide #18: Group Activity**
- ✓ **PowerPoint Slide #19: Robert**
- ✓ **PowerPoint Slide #20: Jorge**
- ✓ **PowerPoint Slide #21: Ester**
- ✓ **Handout #3: Adolescents Who Have Engaged in Sexually Abusive Behavior** (for display only)
- ✓ **Handout #4: Things to Consider When Working With Children Under 12** (participants received with registration letter)
- ✓ **Handout #5: Special Populations Who Have Engaged in Sexually Abusive Behavior** (participants received with registration letter)
- ✓ **Appendix #2: Pennsylvania's Safety Threats** (participants received with registration letter)

Outline of Presentation:

203 Remote: Working with Juveniles Who Sexually Offend

- Review some common characteristics of juveniles who engaged in sexually abusive behavior.
- Discuss how assessment and treatment of some special populations might look different in working with some juveniles who engaged in sexually abusive behavior.
- Review the cultural factors that a child welfare professional needs to consider when working with juveniles who engaged in sexually abusive behavior.
- Provide an overview to some etiological theories about why juveniles might engage in sexually abusive behavior.
- Identify those factors that assist the child welfare professional in ascertaining when sexualized behaviors cause concern.
- Point out why information gathering can assist the child welfare professional in assessing safety, establishing a safety plan, and making service recommendations.

Step 1:
Who are the Juveniles Who Have Engaged in Sexually Abusive Behavior?

> **Instructor Note:** This section will begin with a discussion regarding terminology, labeling, and the detrimental effect labeling can have on children and adolescents as they grow into adulthood.

Explain to participants that, although this course is called **Juveniles Who Sexually Offend**, that the language regarding children and adolescents has shifted to *children with sexual behavior problems* to refer to children under the age of 12 and *adolescents who sexually abuse* to refer to youth ages 13-17. Ask participants why this terminology may have shifted in the past few years.

The Association for the Treatment of Sexual Abusers (ATSA) (2017) explains that "although terms such as 'juvenile sex offender' and 'adolescent sex offender' are commonly used, these kinds of descriptors, which characterize a young person based on their behavior, imply that the behavior is long lasting, intractable, or permanent" (p. 3). ATSA continues to explain that research finds that problematic sexual behaviors in the vast majority of youth are transitory and that the term "sex offender" fails to make a distinction among the continuum of behaviors broadly described in legal and popular contexts, which can range from voyeurism to violent sexual assault (2017, p. 3).

Labels like "juvenile sex offender" have the potential to negatively shape a young person's identity and self-concept during an important developmental period through which they might not otherwise successfully navigate. Labels such as these are misleading, unhelpful, and at times harmful to the youth, their family, and/or the treatment process (ATSA, 2017, p. 4). Ask participants what type of impact being labeled a "juvenile sex offender" might have on a child under the age of 12? Between the ages of 13-17?

ATSA (2017) "selected the term 'abusive' to refer to sexual conduct that is interpersonally harmful to distinguish it from other sexual behaviors that may be potentially problematic but do not harm another person" (p.4). The term "adolescents who have engaged in sexually abusive behavior" describes rather than labels, and denotes that this is a past behavior rather than a current or future one, which helps the adolescent, practitioner, and public expect correction of the youth's harmful behavior (ATSA, 2017, p. 4).

Ask participants what the CPSL definition of Sexual Abuse or Exploitation is. Allow participants three-minutes to call-out components of the definition. Review any information not covered in the course of conversation. **NOTE: If participants took 203: Overview of Child Sexual Abuse, they will have previously reviewed this definition**.

Explain that the recent amendments to the CPSL now includes a definition of sexual abuse or exploitation (§6303 Definitions). **For your reference, the definition is on page 96 of this document.**

Display **PowerPoint Slide #12: Three Different Groups** and discuss the fundamental difference between kids under the age of 12, adolescents ages 13-17, and adults who engage in sexually abusive behavior. Many people think of adult males when they hear the words “sex offender,” but we know that children can display sexual behavior problems and adolescents can engage in sexually abusive behavior. According to the Kempe Center for the Prevention and Treatment of Child Sexual Abuse and Neglect, juveniles are the perpetrators of 30 – 50% of all child sexual abuse.

Instructor Note: The purpose of the following content is to review the differences between young children who have sexual behavior problems and older children or adolescents who have engaged in sexually abusive behavior. The instructor will then transition to the special populations of children/adolescents who have engaged in sexually abusive behavior.

Ask participants to consider what they noted when they were asked to think of when they hear the words “juvenile sex offender.”

Display/SHARE SCREEN for **Handout #3 (Adolescents Who Have Engaged in Sexually Abusive Behavior)**. Although these characteristics are common to a large number of juveniles who engaged in sexually abusive behavior, we know that juveniles who engaged in sexually abusive behavior are a remarkably diverse group of both children and adolescents.

For the purpose of this training, children will include those who are under the age of twelve and adolescents will include those that are twelve to eighteen. When discussing the importance of differentiating how a child welfare professional might work with children under 12 and older children or adolescents use **Handout #4 (Things to Consider When Working with Children)** which references Toni Cavanagh Johnson’s book, *Understanding Children's Sexual Behaviors - What's Natural and Healthy* (2007). In the book, she points out that when working with children under twelve there are several things to consider:

- Do children engaged in sexual play have an ongoing mutual relationship?
- Are the children of different ages or developmental levels?
- Are sexualized behaviors out of balance with other aspects of child’s life?
- Do children appear to have more sexual knowledge than typical for their age?
- Are sexual behaviors significantly different than those of other same-age children?
- Do sexual behaviors continue even after they’ve received consistent and clear requests to stop?
- Do children appear to be unable to stop sexualized behaviors?
- Do other children complain about the child’s sexual behaviors or do the sexual behaviors negatively affect other children?

- Are child's sexual behaviors directed at adults who are uncomfortable with them?
- Do children (ages 4 and over) appear to understand their rights and the rights of others?
- Do sexual behaviors progress in frequency, intensity, or intrusiveness?
- Do children demonstrate fear, anxiety, shame, or guilt related to the sexual behaviors?
- Are adult sexual behaviors extensive and persistent?
- Do children manually stimulate, have oral, or have genital contact with animals?
- Do children sexualize nonsexual things, interactions with others, or relationships?
- Do sexual behaviors cause physical or emotional pain or discomfort to others?
- Do children use sex to hurt others?
- Do children use verbal and/or physical aggression (coercion, force, bribery, manipulations, or threats) in conjunction with sexual behavior?
- Do children use distorted logic to justify their sexual behaviors?

Advise participants that this handout is available to them via link, and to consider it as a good resource for anyone who works with children under the age of 12 who have sexually acted out.

Instructor Note: Toni Cavanagh Johnson's sexual behavior continuum for children was reviewed in **203: Healthy Sexual Behaviors in Children**. If participants attended that course, the following information about children who: are "sexually reactive," "engage in extensive mutual sexual behaviors," and "molest" will be a review.

In Johnson's book*, Helping Children with Sexual Behavior Problems: A Guidebook for Professionals and Caregivers, 4th edition* (2009), Toni Cavanagh Johnson has identified a sexual behavior continuum for children. The continuum includes those children who exhibit "healthy sexual behavior," children who are "sexually reactive," children who "engaging in extensive mutual sexual behavior," and "children who molest." Display **PowerPoint Slides #13 (Review: The Sexual Behavior Continuum)**. Review the following information if participants are not familiar with the sexual behavior continuum.

<u>"Sexually Reactive"</u>

- Engage is self-stimulating behaviors
- Engage in sexual behaviors with other children
- Engage in sexual behaviors at times with adults
- Generally, in response to things that are going on around them
- In response to feelings which reawaken memories which are traumatic, painful, hard to understand

<u>"Children Who Engage in Extensive Mutual Sexual Behaviors"</u>

- Distrustful of adults
- Often abandoned by adults
- Chronically hurt by adults
- Relate best to other children
- Sexual behaviors become a way of making a connection to others

- Use sex as a way to cope with feelings of hurt, sadness, and anxiety

"Children Who Molest"

- Sexual behaviors are frequent and pervasive
- Evident history of sexual behavior problems
- Sexuality and aggression closely linked
- Use some type of coercion, bribery, trickery, and manipulation
- Select others who are vulnerable
- Impulsive and/or compulsive
- Problems in all areas of their lives

Suggestions for professionals and parents are listed below:

- Do not overreact as most sexual behaviors in children are within the typical or expected range.
- Inappropriate or problematic sexual behavior in children is not a clear indicator that a child has been sexually abused.
- Most children will stop the behavior if they are told the rules, mildly restricted, well supervised, and praised for appropriate behavior.
- If the sexual behavior is problematic, referral for mental health services is recommended.
- It is important to remember that children with problematic sexual behavior are significantly different from adolescent and adult sex offenders.
- A report to Child Protective Services (CPS) and/or law enforcement may be required by law for certain behaviors such as aggressive or forced sexual behavior.

Most researchers and clinicians agree that early intervention, before the behavior becomes habitual may be more successful at stopping continued abusive behaviors.

Step 2:
Special Populations

Although the population of juveniles who engaged in sexually abusive behavior most often includes males between the ages of 13 – 17 years of age, there are other populations of individuals who have been labeled as "juvenile sex offenders." We will now look at some specific populations within the category of juveniles who engaged in sexually abusive behavior to include adolescent females and juveniles with developmental delays.

Adolescent Females Who Have Engaged in Sexually Abusive Behavior: While there is general agreement that females engage in sexually assaultive and abusive behavior far less frequently than males, reported crime statistics have indicated a consistent rise in the number of sexual offenses committed by females since the late 1990s. Despite this rise, there also is the belief that sexually abusive behavior perpetrated by females is underreported (ATSA, 2017, p. 65).

According to the Association for the Treatment of Sexual Abusers (2017), “Research examining the issues related to females who have engaged in sexually abusive behavior has been very limited and has been hampered by small sample sizes. The research that has been done on females who commit sexual offenses largely has focused on adult females” (p. 65).

Like adolescent males who engage in sexual abusive behavior, adolescent females who engage in sexually abusive behavior are a heterogeneous group. However, research has suggested that, as a group, adolescent females who engage in sexually abusive behavior may differ from male counterparts in some key characteristics (ATSA, 2017, p. 65).

Display/SHARE SCREEN for **Handout #5 (Special Populations Who Have Engaged in Sexually Abusive Behavior)** and review the following on female adolescents who engage in sexually abusive behavior:

- A higher percentage of females who engage in sexually abusive behavior have a history of sexual victimization
- Females who have been sexually victimized generally have been victimized earlier than males and are more likely to have had more than one perpetrator.
- A higher degree of family dysfunction has been reported in the homes of adolescent females who have sexually abused when compared with males, including physical and emotional abuse and parents (especially mothers) with serious mental health problems.
- Females who engage in sexually abusive behaviors evidence a higher incidence of comorbid mental health problems than males. In particular, females who a higher incidence of internalizing mental disorders such as PTSD and depression.
- Adolescent females have higher rates of suicidal behavior, suicidal ideation, and other self-harming behavior (e.g., cutting) than adolescent males.
- Adolescent females may have higher rates of co-offending or group offending than adolescent males.
- Adolescent females are more likely than males to engage in sexually abusive behavior toward young children in the family or children with whom they are familiar.
- Adolescent females are more likely than males to target both genders and are more likely to commit offenses within the context of childcare roles.

(ATSA, 2017, pp. 65-66)

From the research so far, it appears that adolescent females who sexually offend are not just mirror images of adolescent males who sexually offend.

Advise participants that **Handout #5** is available to them via link, and to consider it as a good resource for anyone who works with females or children who have intellectual or developmental disabilities who have sexually acted out.

Review for the group the general information in **Handout #5 (Special Populations Who Engage in Sexually Abusive Behavior)** and review the following information on Adolescents with Intellectual Disabilities Who Engage in Sexually Abusive Behavior:

- It is unclear what percentage of adolescents engaging in sexually abusive or problematic behavior meet the criteria for intellectual disabilities.
- The prevalence of intellectual disabilities has been reported as being approximately 2 percent in the general population, and approximately 15 percent among children ages 3-17.
- One factor to consider is research indicating that children with intellectual and developmental disabilities are at a significantly greater risk for experiencing maltreatment and sexual abuse than individuals without disabilities. Research has shown that early histories of abuse and neglect, exposure to violence, and other adverse childhood events can lead to adolescents engaging in a range of problematic behaviors that may include sexually abusive behaviors. Many adolescents who are evaluated and treated for sexually abusive behaviors may present with histories of maltreatment and trauma.
- There is mounting evidence that the early experiences of trauma, neglect, and attachment disruptions may have a significant neurodevelopmental impact on children and adolescents, with earlier and more pervasive trauma experiences creating broader functional difficulties.

(ATSA, 2017, pp. 69-70)

Finally, refer participants to the third page of **Handout #5 (Special Populations Who Engaged in Sexually Abusive Behaviors)** and review the following information on Adolescents with Co-Occurring Mental Health Problems:

- Prevalence rates among adolescents who have sexually offended:
    - 69 percent had at least one mental disorder
    - 51 percent had conduct disorder
    - 44 percent had at least two mental disorders
    - 30 percent had at least one substance use disorder
    - 18 percent had anxiety disorder, with PTSD at 8 percent
    - 14 percent had ADHD
    - 9 percent had affective disorder
- Externalizing problems were more common in offenders with same age and older victims, while adolescents with child victims were more likely to manifest internalizing problems.
- Studies have not found a direct connection between mental health diagnoses and sexual recidivism for adolescents who engage in sexually abusive behavior.

(ATSA, 2017, p. 72)

Step 3:
Why Do Juveniles Engage in Sexually Abusive or Problematic Behavior?

Now that you are aware of *who* juveniles who engaged in sexually abusive behavior may be, it's important to consider *why* a juvenile might engage in sexually abusive

behavior. Ask participants to share experiences or offer ideas/reasons kids offend. Their responses could include scenarios such as:

- Kids at my lunch table in 6th grade called me "gay," and I didn't know whether I was or not, so I thought I'd be able to experiment with my younger sister to figure it out for myself.
- I didn't fit in with the kids in 7th grade, I wasn't doing well in school, and my Mom and Dad got divorced. My Dad was no longer in my life and my Mom was focused on trying to establish relationships with my new younger stepbrother and stepsister. I felt left out. I just wanted my new stepsiblings to hurt as much as I did.
- I saw all these things on porn and wanted to find out for myself. It looked fun.
- I was getting high a lot and I just didn't care. I was in 9th grade when my Mom said I couldn't go shopping with her, and in fact, I had to stay home and watch my two-year-old nephew. I was mad at my Mom. When my nephew followed me into the bathroom and was curious why I was standing up to go to the bathroom, I then "showed" him and fondled his penis. I just didn't care at the time.
- I heard kids talking about sex and what they'd done, but I didn't have anybody my age with whom I could try things out. I knew my Mom's boyfriend's seven-year-old daughter liked me and looked up to me. I thought she was too young to know what I was doing to her. She liked to play hide-and-seek with me, so I touched her when we were hiding together.
- I was just really lonely a lot. I just wanted someone to show me they cared.
- I didn't know how to let the girl in my class know that I liked her. I thought if I touched her sexually she'd know that I liked her more than just as a friend.
- I was never sexually abused. I never knew anyone who was sexually abused. I didn't really know how much I was hurting my younger sister's playmate when I sexually touched her while we were playing house. I knew it was wrong. I thought I'd get yelled at or grounded. I didn't know just how wrong it really was.

Instructor Note: This supports later discussion during the clinical assessment to determine the juvenile's motivation for the sexual behaviors (Handout #11).

It is important to address the assumption that kids who sexually offend have been sexually victimized themselves or that most sexual offenses are related to deviant sexual interests. The younger kids are, the more likely they were to have been sexually victimized. Regarding kids who engage in sexually abusive behavior:

- 80%-90% of children under 12 were sexually victimized (Bonner, 2009)
- Roughly half of adolescents, ages 13-17, were sexually victimized (Bonner, 2009)

In comparison, about one-third of adults who sexually offend were sexually victimized.

Studies have documented the high incidence of trauma exposure among general juvenile offenders. These exposures include:

- Childhood physical and/or sexual abuse (Cauffman, Feldman, Waterman, & Steiner, 1998; Smith & Thornberry, 1995; Weeks & Widom, 1998; Widom, 1995)
- Experiencing serious life threats and/or injuries (Burton, Foy Bwanausi, Johnson, & Moore, 1994; McMackin, Morrissey, Newman, Erwin, & Daly, 1998)
- Witnessing severe injury and/or death of another (Burton *et al*., 1994; Cauffman et al., 1998; McMackin et al., 1998; Steiner, Garcia, & Matthews, 1997)
- Being involved in gang violence (Burton et al., 1994; McMackin et al., 1998; Steiner et al., 1997)

The typical juvenile offender has been exposed to numerous potentially traumatic events and is likely to have a correspondingly high risk of developing Posttraumatic Stress Disorder (PTSD). The severity and number of trauma exposures seen in a delinquent population, combined with their psychological and developmental vulnerabilities and their lack of protective factors, place them at high risk for developing PTSD. Although PTSD rates are not available for juvenile or adult sex offenders, that many offenders have traumatic life histories has long been known (McMackin et al., 2002). Typologies of sex offenders refer to some offender types as “reenactment trauma” (Rasmussen, Burton, & Christopherson, 1990), “sexually reactive” (Gil & Johnson, 1993), and “trauma-induced reactions” (Gray & Pithers, 1993).

In a research study conducted by McMackin et al. (2002), it was discovered that the very high prevalence of trauma exposure among the juvenile sex offenders is consistent with earlier findings regarding trauma exposure among juvenile offenders (Burton et al., 1994; McMackin et al., 1998; Steiner et al., 1997). This study determined a 95% rate of trauma exposure among juvenile who engaged in sexually abusive behavior, with around 77% of youth exposed to trauma from three or more categories. Physical or sexual abuse was seen in all but 12.5% of the sample, with about half exposed to both (McMackin et al., 2002).

The overall rate of PTSD was 65%. The rate was 68% for juveniles who engaged in sexually abusive behavior with a history of physical abuse, 84% for individuals with histories of both physical and sexual abuse, and 100% for individuals with abuse histories who were also victims of other violence (McMackin et al., 2002). The increasing rates of PTSD for youth with exposures from multiple trauma categories supports recognition that exposure to multiple traumas has a synergistic impact (Kiser, Heston, Millsap, & Pruitt, 1991).

The need for understanding the link between trauma exposure and offender behavior is underscored by a survey of sex offender therapists (McMackin, Cusack, & LaFratta, 2001). This survey found that therapists that worked with youthful offenders estimated the patient PTSD rate to be 56%, with 77% having histories of physical abuse, 68% sexual abuse, and 65% both (McMackin et al., 2002).

Explain to participants that the following sections will cover assessment tools (such as ACE) that can help identify traumatic events experienced by the juvenile who engaged

in sexually abusive behavior and ways in which trauma treatment could be integrated into treatment and intervention.

Step 4: Factors to Consider

Display **PowerPoint Slide #14 (Sexualized Behaviors – Case Scenarios)**. Discuss one case scenario at a time. Based on the examples provided, ask participants to:

- Identify what additional information would be helpful for the child welfare professional to gather once they learn of a child/adolescent's sexualized behaviors.

Advise participants that we will follow up with these cases in a later exercise, so they should write down responses in their notes to keep for a later time. Discuss why this information is useful in determining whether or not further assessment/investigation is needed. Some possible participant responses could include:

- ***ROBERT:***
  - How old is Robert?
  - How old is Robert's cousin?
  - What is the gender of Robert's cousin?
  - What kind of oral sex (fellatio or cunnilingus) was initiated?
  - Where were these acts initiated?
  - How many times has this occurred?
  - Was force used?

- ***JORGE*:**
  - How old is Jorge?
  - How old was the male peer who touched Jorge's penis?
  - Was the male peer forced or coerced to touch Jorge's penis?
  - How many times has this occurred?
  - What is Jorge's developmental level?
  - What was Jorge's affect during these incidents?

- ***ESTER:***
  - How old is Ester?
  - How did Ester get the males at school to touch her?
  - How much of the sexual behavior at school was initiated v. becoming known by boys at school as "easy"?
  - What was the situation that younger children could observe Ester's sexual behavior?
  - Was the sexual contact with the same-age female consensual?
  - What was the extent of the sexual contact with the same-age female?
  - Was there any sexual contact with younger children?

Display **PowerPoint Slide #15 (Factors to Consider)** and explain that gathering information about the following factors is necessary and this information should be considered:

- Juvenile who engaged in sexually abusive behavior
    - Age
    - Developmental level
    - Intelligence
    - Social skills
    - Previous acts of delinquent behavior
    - Previous prohibition of sexualized behavior
- Juvenile who engaged in sexually abusive behavior and victim differentials
    - Age
    - Size
    - Relationship
    - Status
    - Intelligence
    - Social skills
- Offense specific information
    - Type of sex act
    - Frequency of behavior
    - Number of contacts
    - Duration
    - Force/coercion
    - Grooming/manipulation
- Response of juvenile who engaged in sexually abusive behavior
    - Affect/emotional response
    - Level of responsibility
    - How was the juvenile caught?
    - Who discovered the offense and what was the response?

It is also important for child welfare professionals to know that concern about a child/adolescent's sexualized behaviors should arise when a child/adolescent's focus on sexuality becomes more significant than the other areas of the child/adolescent's life or when the sexualized behaviors occur with individuals who are not of the same developmental peer group. Concern also arises when a child/adolescent does not seem to understand that the overt display of sexual behaviors is uncommon and/or inappropriate. Furthermore, if a parent/caregiver appropriately warns or reprimands a child/adolescent about his/her sexual behaviors yet the behaviors continue, this should raise further concern. In addition, it is important to note that when a child/adolescent displays secrecy, anger, anxiety, tension, fear, coercion, force, or compulsive interest and activity related to sex and sexuality, the child/adolescent's sexualized behaviors might be considered abusive and professional advice must be sought.

Step 5:
Etiology of Sex Offending Behavior

Child welfare professionals need to understand that sex offending is an unhealthy behavior that appears to be caused by a complex variety of experiences that occur. “A number of etiological factors (risk factors) have been identified to help explain the developmental origin of sexual offending. Factors receiving the most attention are abusive experiences and exposure to aggressive role models” (Center for Sex Offender Management, 1999).

Explain that there has been no determination about what causes adults or juveniles to engage in sexually abusive behavior. A common belief is that all individuals who sexually offend have histories of being sexually abused, and therefore these individuals sexually offend due to their prior victimization. While many who sexually offend do have a history of sexual victimization, some do not. Furthermore, most children/adolescents who have been sexually victimized do not grow up to sexually offend. The simple answer that those who sexually offend are shaped by a history of sexual victimization does not adequately address the issue of etiology. Display **PowerPoint Slide #16 (Theories about the Etiology of Sexual Offending)** and explain that these are just a few of the theories that have been established.

Biological Factors:
Some researchers have suggested that certain kinds of biological factors, such as hormones, contribute to why individuals engage in sex offending behaviors. Perhaps most common within this category is the role of high testosterone levels, which have been found to be associated with increased sex drive and aggression. Some biological theories suggest that certain individuals may be predisposed toward problematic sexual behaviors because of physiologically or biologically predetermined sexual appetites or sexual preferences (Center for Effective Public Policy, 2007).

As we consider biological factors related to why juveniles might engage in sexually abusive behavior, it is necessary to look at juveniles from a developmental context to include: physical development, sexual development, psychosocial development, and identity development. It is healthy for adolescents to experience instances of impulsivity, unstable emotions, empathy deficits, and even some narcissism. Furthermore, due to the fact that the brain’s frontal lobe continues to develop into adulthood, adolescents are still developing the capacity to be able to control such executive functions as problem-solving, impulse control, abstract reasoning, and long-term planning. Adolescents struggle with social cues and they often focus on immediate rewards as opposed to consequences for their behaviors. Finally, we also know that adolescents experience rapid physical and sexual changes as they progress through puberty, which can be overwhelming and cause confusion.

Behavioral Factors:
Other theorists believe that sexual offending behaviors develop in part because of conditioning or learning. In other words, just as it is believed that individuals “learn” appropriate or socially acceptable means of sexual behavior or sexual expression, behavioral theorists indicate that unhealthy sexual interests or behaviors can also be learned. For example, a father who commits domestic violence in the home is modeling

hostile and aggressive attitudes and behaviors toward women, and youth who are exposed to that kind of environment may learn to act in similar ways as part of their developmental experiences. A different type of behavioral theory involves conditioning, whereby over time, an individual's sexual interests or arousal patterns become strengthened through certain types of experiences or reinforcers. When someone masturbates to fantasies that are unhealthy, for example, it tends to strengthen their interest or arousal to those unhealthy or inappropriate fantasies, which ultimately may lead to offending behaviors (Center for Effective Public Policy, 2007).

Attachment and Intimacy Factors:
One of the common characteristics and risk factors are associated with attachment or intimacy deficits. More specifically, it has been suggested that different types of problematic attachments may lead individuals to have a variety of problems related to intimacy in his/her relationships, and that ultimately these intimacy deficits may lead individuals to engage in sexually abusive behavior. For example, theorists have suggested that insecurely attached persons may want to be emotionally close to others but avoid it out of fear of being rejected or hurt. In turn, some of these individuals may attempt to establish close relationships with others (with whom they may feel more "safe") and they may ultimately have inappropriate sexual contact with them. Furthermore, those with dismissive attachment styles may have no desire whatsoever to become close or intimate with others and may even harbor negative, angry, and hostile feelings toward others, and subsequently, they may act out their anger or hostility in sexually aggressive ways (Center for Effective Public Policy, 2007).

Sociocultural Factors:
Another way in which theorists have attempted to explain the etiology of sex offending emphasizes the role of societal and cultural structures, norms, and messages. For example, some theorists suggest that desensitizing messages of violence in television or video games may implicitly condone violence. Others argue that the ways in which women and children are sexualized or portrayed as submissive and passive – through advertisements, television programs, and films – may contribute to sexual violence. Yet others believe that men are socialized to be aggressive and to dominate, or "conquer" women and children, which some theorize encourages male violence (Center for Effective Public Policy, 2007). It is extremely important to keep in mind that the study of a link between violence and violent television/video games is fairly new and currently ongoing. Various research articles provide information that both negate and support the idea that the consumption of violent media directly relates/translates to violence in real life. In an article posted by The Guardian, Pete Etchells writes in his article "What is the Link Between Violent Video Games and Aggression?" that "to really get an understanding of what's going on, we need to be looking more at the way in which these sorts of games [violent video games] are being played." Furthermore, in an article of the MassGeneral Hospital for Children website, Dr. Gene Beresin writes that in a study of 1,254 7th and 8th graders and 500 parents:

> There were correlations between playing violent video games and self-reported physical fights and delinquent behavior, particularly with greater

> amounts of time played. However, this was only true in a small percentage of children who already exhibited aggressive traits and a high stress level. They found that the traits of aggression and stress were predicative of delinquent behavior and bully and not the playing of violent video games themselves. Researchers also found that parent involvement and parent/peer support seemed to be protective of these negative behaviors (2012).

Dr. Beresin goes on to write that “there seems to be a relationship between about five to six percent of kids who get into trouble, sometimes violent, and the amount of time playing video games. There were no causal relationships found between violent games and violent behavior, just correlations, and this could mean that there are other things in life that may be involved” (2012). There is a large amount of research that must be conducted before a decision can be made regarding whether or not violent media leads to or encourages violent behavior.

Still, even with all of these theories developing explanations for how a person might sexually offend, the truth is that in similar circumstances, some people develop unhealthy sexual behaviors and some do not. Some develop other dysfunctions and some do not. Continued research is needed to address the possible etiologies of sexual aggression or unhealthy behaviors.

Step 6:
Cultural Factors to Consider

We have looked at the characteristics associated with juveniles who engaged in sexually abusive behavior to include some special populations of children with sexual behavior problems and adolescents who sexually abuse. We will now look more closely at the cultural characteristics of the population of those juveniles who engaged in sexually abusive behavior.

There is no evidence to suggest that any cultural, ethnic, or racial group has greater rates of child sexual abuse than any other does. Worldwide, all cultures have codes of behavior for the care and nurturing of children and cultural prohibitions against incest, and the sexual exploitation of children. Nevertheless, despite these cultural prohibitions, sexual abuse of children is nearly universal. While cultures universally prohibit incest and other forms of child sexual abuse, cultural beliefs and values can affect the family's response to a sexual offense, both toward the survivor and the perpetrator.

Cultural norms, family and social messages, and life experiences shape sexual behaviors and sex roles. All those that sexually offend and their families bring these cultural beliefs and values into the child welfare system. To maximize interventions with each juvenile who engaged in sexually abusive behavior and each person in his/her family, a child welfare professional needs to be cognizant of the worldview of each parent and child, their attitudes towards sexual behaviors and how they view and act out

culturally defined roles. This is a hefty assignment but one critical to achieve healthy outcomes for the families and children.

Before displaying **PowerPoint Slide #17 (Cultural Factors to Consider)**, ask participants to share their experiences in working with families and how culture has impacted (either positively or negatively) their experiences in working with juveniles who engaged in sexually abusive behavior and the juvenile's family. Then display **PowerPoint Slide #17 (Cultural Factors to Consider)** and explain that in some cultures there is:

- Fear of the system
- A belief that justice cannot be obtained
- A belief that family problems should not be discussed outside the family
- A belief that counseling and other social services are not needed

Certainly, ethnic, racial, and cultural affiliations have an impact on identification, reporting of offenses, and on the treatment of juveniles who engage in sexually abusive behaviors and their families within the social service systems. This can have an impact on the willingness of families to prosecute juveniles because of concerns that the juvenile will be unfairly and severely treated by the criminal justice system, or discriminated against by the child welfare system and the treatment community.

Juveniles who engage in sexually abusive behaviors are from all socioeconomic levels. However, poverty can be a factor that may increase vulnerability, including victimization and offending behavior. The fewer resources a family has and the more economic stress in their daily life, the more difficulty they may experience in accessing services. Furthering the problem is the fact that offense-specific treatment is long-term treatment often involving every member of the family. Accessing and maintaining family members in treatment demands an organized response from the family and represents an ongoing drain on their physical, emotional, and financial resources. The fewer resources a family has, the greater the likelihood that the family will need to rely on the resources of the child welfare agency, which will most likely increase the demands on the caseworker and the casework challenge of keeping all members of the family in treatment, especially if there is no legal mandate backing up the treatment process.

Cultural competence by a child welfare professional includes recognizing, understanding, and valuing cultural differences and diversity and recognizing, understanding, and valuing the commonalties that underlie our differences. Working in a culturally competent way with juveniles who engaged in sexually abusive behavior and their families, requires acquiring a basic knowledge of the family's culture, (i.e. child rearing practices, attitudes toward sexuality and sex roles, family structure, religious belief, the extent the family is involved in larger community, etc.). This would mean becoming knowledgeable and sensitive to whether cultural mores allow or prohibit discussion of sexual issues between the sexes and male children are valued more than female children etc. Child welfare professionals must adapt their practice in order to help all families protect their children in a way that honors their culture whenever possible.

NOTE: Depending on the timing, this next activity may need to start right after the lunch break.

Step 7:
Information Gathering

Explain that when faced with limited information, it is important for the child welfare professional to take initiative in asking additional questions. Asking additional questions will allow the child welfare professional to ascertain the need for agency involvement, whether the case is a General Protective Services (GPS) case or Child Protective Services (CPS) case, whether there are any present threats or impending concerns, as well as the response time in which contact with the family should be made.

The instructor should then advise participants that additional information was gathered about Robert, Jorge, and Ester, the children from the case scenarios used earlier.

Display **PowerPoint Slide #18 (Group Activity)** and ask each small group to do the following:

- Determine whether there is a need for further agency involvement/investigation
- Identify the possible safety threats that exist
- Determine an appropriate response time
- Identify which individuals to interview (and in what order)
- Formulate questions to ask of those individuals being interviewed

INSTRUCTOR NOTE: Depending on time, this can either be conducted as large group or by teams in breakout rooms. If using breakout rooms assign each team to Robert, Jorge and Ester. If you have more than 3 teams, assign more than one team to Robert, Jorge and/or Ester. Groups can then reference the updated information for each of the three cases in **PowerPoint Slides #19, #20, and #21**. Share the case information using the chat with each group prior to sending them into their breakout room, and ask them to copy the text so it can be viewed in their breakout room. Each team should assign one person to take notes and report back to the large group.

Encourage participates to reference **Appendix #2 (Pennsylvania's Safety Threats)** to assist in making their decisions and to guide their discussion. Ask participants to discuss how they would proceed based on the additional information that was gathered.

During the debrief, please note that successful assessment relies on comprehensive information gathering. Further, it is important to understand not just the allegations made, but also the underlying causes behind the allegations. In order to do this, child welfare professionals must gain a robust understanding not only of the maltreatment but also how the family operates. There are six domains that are used to accomplish this. The six domains (Type of Maltreatment; Nature of Maltreatment-Surrounding Circumstances; Child Functioning; Adult Functioning; General Parenting; and Parenting Discipline) will be discussed in more detail later in this curriculum.

Point out that child welfare professionals will need to gather information about these factors when conducting child abuse investigations as well as to determine the need for further assessment and/or treatment services. Take time to explain to participants why these factors are relevant in determining the extent of concern as well as the level of assessment/treatment intervention that may be required.

Conclude this segment by asking the participants to take five minutes to reflect upon the materials and highlight any areas they might want to note for improvement. Ask participants to share key learning points from this section of the training.

NOTE: If you haven't yet done so, this is a good place to break for lunch.

203 Remote: Working with Juveniles Who Sexually Offend

Section IV: Victim-Centered Approach

Estimated Length of Time:
40 minutes

Key Concepts:
- Taking a victim-centered approach is a way of dealing with conflicting goals in sexual abuse case management.
- A victim-centered approach may be a shift in practice for some child welfare professionals.

Methods of Presentation:
Lecture; large group discussion

Materials Needed:
- ✓ Zoom Room Flow Chart
- ✓ Laptop and shared screen
- ✓ **PowerPoint Slide #22: Victim/Survivor Needs & Levels of Betrayal**
- ✓ **PowerPoint Slide #23: A Shift in Practice**
- ✓ **PowerPoint Slide #24: Stages of Family Intervention**
- ✓ **Video: 203: Working with Juveniles Who Sexually Offend (Clip #2-Michele and Cassie)**
    - **http://www.pacwrc.pitt.edu/curriculum/SexualAbuseSeries/WorkingJuvenilesWhoSexuallyOffend/Michele%20and%20Cassie.mp4**

Outline of Presentation:
- Review the victim-centered approach.
- Discuss the shift in practice to a victim-centered approach and why this shift is necessary in working with juveniles who engaged in sexually abusive behavior.

Section IV: Victim-Centered Approach

Instructor Note: Although the term "victim" is used in this section, the instructor should begin this section with a brief discussion regarding the terms "victim" and "survivor." The use of either term is a choice made by the person who experienced the abuse. Their choice of terminology must always be respected.

Step 1:
Victim-Centered Approach

Child welfare professionals may feel pulled in several directions in their work on child sexual abuse cases. Taking a victim-centered approach is a way of dealing with conflicting goals in sexual abuse case management. A victim-centered approach includes:

- Consideration of the ongoing risks of recidivism to both past and potential victims
- Consideration of the victim(s) when making decisions about supervision and treatment
- Inclusion of victim(s) and/or victim advocates

The victim-centered approach is one in which considerations of what is in the victim's best interest override competing concerns. Victims need to: feel safe; feel some level of influence/power; have information; be believed; not be blamed. What is in the victim's best interest will vary in each case and it might not always be easily identified. Questions may include: does the victim want to be removed from the home or have the juvenile who engaged in sexually abusive behavior removed; does the victim want the juvenile who engaged in sexually abusive behavior with them to be prosecuted or to get help. Of course, there are times when what the victim wants is not in his/her best interest, because there are risks to his/her safety and/or psychological well-being. In such cases, the child's best interest should be pursued, but with a developmentally appropriate explanation to the child about why his/her wishes cannot be granted.

Ask participants what they think the victim/survivor might need? Who might victims/survivors feel betrayed by? Display **PowerPoint Slide #22 (Victim/Survivor Needs & Levels of Betrayal)** and discuss the following points:

- The victim/survivor needs:
    - To feel safe
    - To have some level of power/influence
    - To have information
    - To be believed
    - To not be blamed
- Victims/survivors of sexual abuse feel betrayed on many levels:
    - By the offender
    - By their caretaker/significant other (e.g., parent cannot or does not do anything to prevent abuse

- By professionals (e.g., therapists, school employees, etc. who do not recognize signs of abuse)
- By themselves
  - Physically: sexual arousal or numbness
  - Emotional/mental: dissociative – lie to themselves about the event, believe the offender when they tell them it is "normal," do not remember the even until older

(Yeatter, 2015)

Explain to participants that sexual assault may have a significant impact on other family members of the juvenile who engaged in the sexually abusive behavior and family members of the victim/survivor. Sexual assault can have a far-reaching ripple effect. At the center is the person who was sexually assaulted, and the ripples – like the ripples created when a rock is thrown into a pond – represent the many people who may experience harm by knowing or caring for that person. These individuals include immediate family member, friends, relatives, acquaintances, and members of the community. Family members of juveniles who engaged in sexually abusive behavior may also have difficulty dealing with the situation and their own reactions to it. The offender's family may know the victim, and may be significantly affected by the experience of disclosure, criminal justice involvement, community stigma, and more.

Ask participants what they think the impact of sexual assault on secondary victims/survivors might look like. Use the following to facilitate a discussion:

- Individuals close to the offender and/or the victim/survivor may experience reactions that are similar to the victims. The intensity and variety of reactions may depend on their relationship with the victim/survivor.
- These individuals need to have their own support systems.
- They often need education about sexual victimization issues and about how they can best support the victims/survivors, such as what to say and do to be helpful and supportive.
- The revenge reaction of those close to the victim/survivor must be considered. Some victims'/survivors' partners may want instant revenge and threaten to harm the juvenile who engaged in the sexually abusive behavior. This reaction, which is a legitimate emotional response to the harm their partner has experienced, usually only serves to silence the victim/survivor further and requires them to focus on their partner's anger and potential actions, and not their own response to the sexual assault.
- Individuals close to the offender and/or victim/survivor may have been victims/survivors of sexual assault themselves. Their own experiences and feelings may be triggered by the assault by, or of, their loved one, which can render them less able to help.
- The pain experienced by individuals close to the offender and/or victim/survivor should never be underestimated.

(Center for Sex Offender Management, n.d.)

Instructor Note: This discussion lays some of the groundwork for the last part of the second day of this training module.

Step 2:
A Shift in Practice

Display **PowerPoint Slide #23 (A Shift in Practice)**. Lead a discussion which answers the following questions. The instructor needs to be aware that many participants will be surprised at this shift in perspective. The instructor needs to punctuate the paradigm shift during the rest of the training.

1. Who is the client?
2. What is the goal of intervention?
3. How do your personal values affect the work?
4. What are the limits of confidentiality?

Mental health providers are typically faced with a significant paradigm shift when working with the forensic population and, in particular, with juveniles who engaged in sexually abusive behavior. Most mental health training programs teach providers that their primary ethical and professional responsibility is solely to the treatment of the identified client, in this case the juvenile who engaged in sexually abusive behavior. In working with this population, this responsibility changes significantly. In most cases involving sexual abuse, the client is actually the victim or potential victims of the juvenile who has engaged in sexually abusive behavior. That is, the primary purpose of intervention is to protect the victim and the community from further victimization.

Unhealthy sexual behaviors can be defined in a variety of ways. It is essential to address the child welfare professional's personal value system to prevent decision making from the "heart" rather than from sound clinical practice. Given that most individuals find sexually abusive behavior repugnant, it is essential that child welfare professionals tune-in to self to identify and effectively manage personal values and to provide effective and safe treatment for the community. Even experienced professionals can either over or under identify with survivors or the juvenile who engaged in sexually abusive behavior; therefore, it is essential that child welfare professionals find a balance to this position. Children with sexual behavior problems and adolescents who sexually abuse tend to affect our personal value systems. That is, it is often difficult for child welfare professionals to view young individuals as having the ability to form malice and criminal intent in their actions and therefore tend to underestimate the capacity for young people to sexually offend. Child welfare professionals also tend to view younger individuals who sexually offend as purely "reactive" and therefore do not assign sufficient culpability to the abuse. (This is not to minimize the understanding that some juveniles have been victimized themselves and this may play a role in their acting out behavior.) Those involved in the case management of a juvenile who engaged in sexually abusive behavior must be careful not to view the juvenile as a victim at the expense of looking at his/her offending behavior. Child welfare professionals sometimes struggle to adequately identify risks and to carry out the primary task of ensuring community safety.

Step 3:
Video

Instructor Note: In the following video clip, Michelle discloses the details of sexual abuse perpetrated by her mother's paramour. Advise participants of the explicit nature of the clip and encourage participants to take care of themselves as needed.

The instructor will now show **Video Clip #2**, which is a scene from *Woman Thou Art Loosed*. This video clip will depict a child, Michele's, disclosure about sexual abuse perpetrated by her mother's paramour, Reggie. The clip goes on to depict the mother's denial of the abuse and the mother's decision to confront her paramour, his response to the allegations, as well as the mother's self-reflection on this issue. Although the video depicts sexual abuse of a child by an adult, the reactions of family members may be similar to those reactions of a child being victimized by another child/adolescent. The goal of this clip is to depict the "Crisis of Disclosure/Panic Phase" that families may experience following the disclosure of sexual abuse. Process out the video segment with participants then transition to discussing the stages of family intervention and the role of the child welfare professional.

Step 4:
Stages of Family Intervention and Child Welfare Professional's Roles/Tasks

The child welfare professional may not be involved during the entire time of intervention, but, if present, the child welfare professional plays an important role in the process. Even if they are not involved from the beginning of the case, it is important to understand the process and phases that the family needs to go through.

Display **PowerPoint Slide #24: Stages of Family Intervention**. Advise participant that there are three phases to the family process. They are:

1. Crisis of Disclosure/Panic Phase
2. Assessment -- Beginning Awareness Phase
3. Family Treatment and Restructure Phase

Ask participants to brainstorm what child welfare professional roles/tasks might occur during each phase of the family process. Review the roles/tasks that participants identified. Possible responses include:

- **Crisis/Panic Phase:** Underline the importance of the child welfare professional taking a firm stand around protection of the survivor (usually involves removal of the juvenile who has engaged in sexually abusive behavior), involvement of law enforcement and Court, connection with services, and immediate link with treatment. During a crisis, family members may be less resistant to engage in treatment and change. The family may be experiencing various feelings, such as denial, anger, shame, fear, sadness, disappointment, powerlessness, or shock. (Include an exploration of feelings and dynamics that can occur if either survivor or juvenile who engaged in sexually abusive behavior is removed.) For example,

if a juvenile who engaged in sexually abusive behavior was a scapegoat, someone else may get this role. If the survivor is removed, someone else may get victimized, etc. Discuss the dynamic of denial for the juvenile (and other family members) and recanting by victim. (NOTE: Recanting is common and does not negate the validity of the original concerns.) The child welfare professional has an important role to fulfill. All family members need support, guidance, and an education about the dynamics of sexual abuse.

- **Assessment – Beginning/Awareness Phase:** The child welfare professional's role is to make sure that caregivers receive essential information about the nature of the offenses. The child welfare professional should also support the adjudication and assessment processes and ensure that recommendations are followed. It is the child welfare professional's responsibility to coordinate treatment and talk to therapists. This role may be shared if youth is on probation and it is encouraged that the child welfare professional and probation officer work together.
- **Family Treatment and Restructure Phase:** Child welfare professional responsibilities include support for ongoing treatment and understanding of the treatment process (including tough times), dialoguing with and working in concert with the treatment providers to assure that information is shared among all, assisting with implementing the safety plan and relapse prevention strategies from the individualized treatment, and confronting anyone in the family who attempts to drop out of treatment. Part of the continuing paradigm shift to a victim-centered approach requires child welfare professionals to recognize and respond to the need to keep these cases open far beyond the usual time parameters for most cases in child welfare. Emphasize that the average length of treatment is usually two years. Explore the impact of this shift on caseworkers in terms of extra work and vigilance above and beyond that of other cases.

Conclude this segment by asking the participants to reflect upon the materials and highlight any areas they might want to note for improvement. Ask participants to share what ideas they had.

203 Remote: Working with Juveniles Who Sexually Offend

Section V: Assessment

Estimated Length of Time:
3 hours

Key Concepts:
- Assessment is a critical component of working with juveniles who engaged in sexually abusive behavior.
- Assessment should be an ongoing process that includes multiple disciplines.
- Confidentiality and informed consent are key components of working with juveniles who engaged in sexually abusive behavior.
- Assessment should be comprehensive and specialized.
- Child welfare professionals must conduct safety assessments and implement safety plans to assure safety of children/adolescents who are survivors of juveniles who engaged in sexually abusive behavior, while also assessing and planning for safety of the juvenile who has engaged in sexually abusive behavior.

Methods of Presentation:
Lecture; large group discussion; small group activity

Materials Needed:
- ✓ Zoom Room Flow Chart
- ✓ Laptop and shared screen
- ✓ **PowerPoint Slide #25: Multi-Disciplinary Approach Activity**
- ✓ **PowerPoint Slides #26 and #27: The Clinical Assessment**
- ✓ **PowerPoint Slide #28: Assessment Tools**
- ✓ **PowerPoint Slide #29: Ongoing Assessment**
- ✓ **PowerPoint Slide #30: Ongoing Assessment (list)**
- ✓ **PowerPoint Slides #31 and #32: General Re-offending Risk Factors**
- ✓ **PowerPoint Slide #33: Recidivism**
- ✓ **Handout #6: CPSL: Release of Information in Confidential Reports** (participants received with registration letter)
- ✓ **Handout #7: Case Scenario: John** (participants received with registration letter)
- ✓ **Handout #8: Assessment Domains** (participants received with registration letter)
- ✓ **Appendix #2: Pennsylvania Safety Threats (revisited)** (participants received with registration letter)
- ✓ **Video: 203: Working with Juveniles Who Sexually Offend (Clip #3-Jamal's Story)**
    - http://www.pacwrc.pitt.edu/curriculum/SexualAbuseSeries/WorkingJuvenilesWhoSexuallyOffend/Jamal's%20Story.mp4

Outline of Presentation:
- Review the importance of ongoing assessment.
- Review the importance of a multi-disciplinary approach.

203 Remote: Working with Juveniles Who Sexually Offend

- Child welfare professionals need to conduct ongoing safety assessments.
- Review the differences in confidentiality as it pertains to working with juveniles who engaged in sexually abusive behavior.
- Discuss informed consent.
- Review the goals of a clinical assessment.
- Discuss the various sources of information that should be considered in a clinical assessment.

Section V: Assessment

Step 1:
Confidentiality and Informed Consent
Given that the primary client is the survivor and the community, and given that one of the primary roles in managing sexual offending behavior of juveniles is the coordination of services, the issue of confidentiality must be addressed. In most cases, a "confidentiality waiver" is an essential component to providing safe and effective treatment of this population within the community. That being said, it is still not appropriate to share private information about the juvenile (or his or her family) with people who are not involved in the treatment or supervision. At the same time, it is essential for everyone who is involved in the supervision of, and who has direct contact with the juvenile, to have adequate information to carry out their tasks. Without adequately informing the school systems, youth leaders, and primary caretakers of the nature of the offending behavior, an environment can be created which fosters continued acting out behavior. Without a free sharing of information, the juvenile and the community are placed in jeopardy. Advise participants that **Handout #6 (CPSL: Release of Information in Confidential Reports)** was included with their registration letter. Review the handout briefly and explain to participants that the Child Protective Services Law, in §6340 Release of information in confidential reports, outlines who may have access to confidential reports.

Step 2:
The Multi-Disciplinary Approach

Discuss the multi-disciplinary approach to assessment and the need to have a variety of professionals working together to meet the needs of the juvenile and his/her family. Collaboration with the multi-disciplinary investigative team (MDIT) is required by the CPSL and is essential to ensuring the child's safety and well-being. Individuals on an MDIT must include those individuals and agencies responsible for investigating the abuse or for providing services to the child and shall at a minimum include a health care provider, county caseworker, and law enforcement in addition to who is on the MDIT, how these teams function varies from county-to-county. The amended CPSL (§6365 Services for prevention, investigation and treatment of child abuse [b] and [c]) now makes a distinction between multidisciplinary review teams and multidisciplinary investigative teams. The multidisciplinary review team convenes for the prevention, investigation, and treatment of child abuse. The multidisciplinary *investigative* team has the specific task of coordinating child abuse investigations between county agencies and law enforcement. The county agency and the district attorney will develop a protocol for the convening of multidisciplinary investigative teams for any case of child abuse by a perpetrator involving crimes against children. The protocol will include standards and procedures to be used in receiving and referring reports and coordinating investigations of reported cases of child abuse and a system for sharing the information obtained as a result of any interview. Child Advocacy Centers (CACs), along with multidisciplinary investigative teams, have received additional funding per the amended

CPSL. Inform the participants that in 2014 the legislature specifically provided funding for the establishment and support of Child Advocacy Centers and MDIT.

Display **PowerPoint Slide #25 (Multi-Disciplinary Approach Activity)**. Send the participants into three Breakout Rooms. Assign each group two categories of professionals (that cover the six categories) that might play a role in the assessment process of juveniles who engaged in sexually abusive behavior and have participants list what roles each professional can play and then have each small group report out their responses.

1. Forensic evaluators
2. Specialized treatment providers
3. The court system
4. Juvenile probation officers
5. Child welfare professionals
6. Educational providers

Possible responses from each of the groups might include:

- Forensic evaluators – conducting comprehensive psychosexual evaluations to include a comprehensive sexual history, social history, family functioning, developmental and physical health history, strengths, mental health history, use of drugs/alcohol, behavioral issues, delinquent/criminal behaviors, etc.
- Specialized treatment providers – looks at a variety of clinical variables such as involvement, compliance, and progress with treatment expectations.
- The court system – court-order services based on recommendations to the court.
- Juvenile probation officers – assess the structure provided by the parent/caregivers, strengths, and concerns within the home environment, compliance with supervision requirements, peer relations, and interactions, involvement in other delinquent activity, etc.
- Child welfare professionals – assess the structure provided by the parent/caregivers, strengths, and concerns within the home environment, compliance with supervision requirements, peer relations and interactions, risk and safety issues, etc.
- Educational providers – assess learning style, changes in mood and behavior, relationships with peers and authority figures and overall academic performance.

Information gathered by each of the above-referenced professionals, and ultimately shared amongst professionals, will better serve the juvenile because information is gathered and shared from a multi-systemic perspective. Collaboration and information sharing is a key task in the process associated with case management of juveniles who engaged in sexually abusive behavior. The multi-disciplinary approach needs to be an ongoing process.

Step 3:
Goals of Clinical Assessment

Once it is established that the juvenile's sexualized behaviors cause a level of concern that requires further professional intervention and assessment, the child welfare professional needs to continue with referral for a clinical assessment.

"The accurate and appropriate assessment and treatment of (juveniles who sexually offend) is necessary for public safety and for the juvenile's own development." (Fanniff, Amanda M. and Becker Judith V., 2005) Assessment must not be used to determine a juvenile's guilt or innocence. The goal of referring for further comprehensive assessment is to determine how to proceed with identifying the most effective treatment interventions to include determination of whether community based or residential treatment is the most appropriate treatment intervention for the juvenile. Furthermore, the assessment should offer insight into the level of supervision that is required. Finally, assessment can also offer insight into what other treatment interventions might be beneficial to the juvenile as well as his/her family.

Display **PowerPoint Slides #26 and #27 (The Clinical Assessment)** and review those things that should be looked at during the clinical assessment process. Ask participants why these components of the assessment are relevant and necessary. Have brief discussion about each component.

1. An evaluation of the number and types of sexual behaviors of the juvenile.
2. A history of the juvenile's sexual behaviors.
3. Whether the juvenile engages in sexual activities alone or with others.
4. The motivations for the juvenile's sexual behaviors.
5. Other individuals' descriptions, responses, and feelings in regard to the juvenile's sexual behaviors.
6. The juvenile's emotional, psychological, and social relationship to the others involved.
7. Whether trickery, bribery, physical or emotional coercion is involved.
8. The effect of the juvenile regarding the sexuality.
9. A thorough developmental history of the juvenile, including abuse and out-of-home placements.
10. Access and careful reading of protective services' reports, court reports, and probation documents (if applicable).
11. An assessment of the juvenile's school behaviors, peer relations, behaviors at home, and behaviors when participating in out-of-home activities, such as daycare or recreational programs.
12. A history of each family member, the overall family history, and an evaluation of the emotional and sexual climate of the home.

Ask participants what else they would expect to be included that is not on the list. Ask participants if they have reviewed clinical assessments which included additional information. A list of these items might include a juvenile's sexual development, any notable attitudes about sexual behavior and relationships, any history of questions of sexual identity and/or orientation, any history of juvenile delinquency or involvement with law enforcement, any family history of criminal involvement, any mental health history of the juvenile or the juvenile's family, any pertinent physical health and/or

medical issues, any substance use by juvenile and/or family members, how the sexual behavior was discovered, and how the sexual behavior was reported and by whom.

Step 4:
Safety Assessment

Instructor Note: Participants can use **Appendix #2 (Pennsylvania's Safety Threats)** to assist them in the following activity.

One of the many casework tasks to be completed by child welfare professionals includes the need to conduct ongoing safety assessments. Once a child welfare professional has gathered information about the offense(s), information about family members and family functioning, to include information about the six domains, the child welfare professional needs to assess the safety (and risk) of the child/children involved and work with the family to develop a safety plan.

NOTE: The timing of this activity may be close to the afternoon break time, in which case it may be helpful to add another five minutes to the break to read the materials before returning to the Breakout room for group.

We will now read the case scenario of "John" and you will work together with your team in your breakout room. Have participants read **Handout #7 (Case Scenario: John)** and utilize the information in the case scenario to answer all of the questions on **Handout #7**. The purpose of this activity is to have participants identify any present or impending danger threats that might exist as well as the identification of the specific safety threats that might be identified, based on the information provided in the scenario and based on information gathered in the six domains. If participants are unsure of whether the safety concerns raised in the case scenario have crossed the safety threshold to be a safety threat, participants should identify what additional questions need to be asked, who needs to be questioned and in what order those individuals should be interviewed. The instructor should process out this activity as a large group.

It is likely that participants will want to gather more information based on this case scenario. Transition to the next step, point out that there are several ways to gather additional information during the assessment/investigation.

Step 5:
Sources and Content of Information Gathered During Assessment

Information should be gathered through:

- Clinical interviews with the juvenile as well as his/her parents/caregivers;
- Record review – especially police reports and survivor statements (if available);
- Observations conducted with the juvenile both in the home and social situations;
- Sexual history provided by the juvenile;
- Assessment tools that gather information about sexual attitudes/fantasies;
- Assessment tools which assess sexual interests and/or arousal; and

- Psychological tests and inventories.

Instructor Note: Although the following content can be reviewed either as a brainstorm as a large group or as a small group activity with a large group discussion, it is recommended to use as a large group activity in remote format for both ease of facilitation and timing.

Content/Components of Assessment

List the components of an assessment on flipchart paper and proceed by leading the participants in brainstorming of the content of each assessment area or divide the trainees into four groups and assign each group one area to brainstorm so that each group then prepares a list of their ideas to present to the larger group.

- Sexual History: Gathering the sexual history is essential to begin the process of learning about precursors, past behavior, offense dynamics, arousal patterns, personal victimization, etc. Sexual history includes:
    - Sources of sexual knowledge and education regarding sexuality: the who, what, when, where, and how the youth gained his/her knowledge of sex. This part of the assessment includes exploring the juvenile's exposure to pornographic materials, videos, adult sexual activity, etc.
    - The actual sexual experience of the youth, thus far, positive and negative experiences and paraphilias.
    - Sexual fantasy life: Assessment seeks to get a preliminary sense of daydreaming, fantasizing about sex, what is arousing, etc.
    - Masturbation practices: This is an area of particular sensitivity. Cultural and religious issues come into play here. However, it is important knowledge for understanding the fantasies and unhealthy arousal patterns that may be involved in the youth's masturbation practices.
    - Personal victimization: The youth's history of sexual and physical abuse and knowledge of history of intra-family abuse.
    - Feelings and concerns about sexual development and sexual orientation, including how comfortable or uncomfortable youth is with sex and sexuality, physical appearance, etc.
    - Medical/Biological Issues: Assessor should check for any history of hormonal imbalance, organic problems, etc.

- Offense Specific Information: This part of the assessment is focused on exactly what happened during and after the abuse, as well as the juvenile’s perception of the meaning of the offense. The assessor should explore:
    - Events surrounding offense: What was going on in the juvenile’s life at home, at school, in family, and with friends? What situations or events (illness of parent, school performance, etc.) might the juvenile see as impactful?
    - Events leading up to offending: Discussion of this with the juvenile helps to track feelings, patterns of targeting and grooming victim, how secrecy was established and maintained, triggers to offending, risky situations, etc.

- Explore previous offending history, including opportunity and access to other victims.
- Juvenile's attitudes: feelings about the offense(s) and about victim(s).
- Impression of juvenile's current degree of minimization, denial, and sense of culpability.

Based on this information, the assessor can offer an impression of the factors or dynamics that drive the juvenile sexualized behaviors. They can also form a preliminary sense of the culpability of the offender based on their assessment of intellectual ability, developmental level, social status, sexual knowledge and history, victimization, and criminal history.

- Individual Factors and Characteristics: Gathering this information is important in determining relative strengths, weaknesses, and treatment issues. In some cases, this information can be obtained from collateral sources. Important information to know includes:
  - Intellectual functioning
  - Any learning difficulties/ school adjustment
  - Personality structure/any significant mental illness
  - Developmental status (any significant delays)
  - Social history (family and/or caretaker information)
  - Coping abilities/problem solving abilities

- Parent/Caretaker Interview: Meeting with the parents/caretakers is crucial in determining their ability to aid or obstruct treatment. Factors that need to be explored include:
  - Family's fear of further legal consequences
  - Parent's/Caretaker's desire to protect the survivor and/or their ambivalence towards the survivor; and parent's confusion about how to support the juvenile who sexually offended and the survivor
  - Response to assessor's educational information about the nature of the offenses and patterns of progressions in offending. Often the parents are ignorant about offending issues (and survivor issues) and the assessor educates as part of the assessment process
  - Parent's/Caretaker's levels of denial and minimization
  - Parent's/Caretaker's attitudes/feelings about offense and juvenile who has sexually offended
  - Family's past experience with, and anger towards, the systems involved
  - Parent's identification with the perpetrator
  - Cognitive functioning of family members
  - Current life stressors within the family unit. For example, are there financial pressures, relationship issues, illness, unemployment, etc.?

Instructor Note: Participants will now learn about assessment domains used in the assessment and treatment of juveniles who engage in sexually abusive behaviors. We will not be identifying specific tools.

Practitioners need to recognize that assessment of risk, needs, and responsivity are holistic in nature and that risk and protective factors associated with sexually abusive behavior and nonsexual offending are multi-determined. When conducting assessments, practitioners consider individual, caregiver/family, peer, school, and community factors, as well as situational risk and protective factors. Refer participants to **Handout #8 (Assessment Domains)** and briefly review the individual domains and areas of assessment from ATSA (2017, pp. 27-30):

Developmental History
Factors to consider in the adolescent's developmental history include:

- Relevant prenatal, birth, or early history information
- Child maltreatment, trauma, abuse, neglect, changes in caregivers, or placement instability
- Relevant injuries or medical problems
- Education (e.g., school engagement, problem behaviors and consequences, learning challenges, strengths, and positive achievements)
- Employment, if relevant
- Social/relationship history (e.g., quality of relationships with family members, positive and/or negative relationships with adults, delinquent and/or prosocial peer associations, and quality and quantity of the relationships or social isolation)
- Sexual history and overall sexual functioning (e.g., puberty, sexual knowledge, type and frequency of pornography use, sexting, sexual orientation and gender identity, past sexual activities, current sexual outlets, sex with multiple partners, sexual concerns or problems, masturbatory practices and frequency, fantasies, and sexual attitudes and beliefs)
- Illegal substance use/abuse
- Mental, physical, and behavioral health history and current psychological functioning including cognitive functioning, learning strengths and challenges, mental health diagnoses, and medications
- Conduct problems (e.g., delinquency or other rule-violating behavior, aggression, or violence) including age of onset, severity, frequency, and persistence, as reported by official records (e.g., police or school reports), the adolescent, and caregivers
- Strengths, goals, and motivation for treatment and prosocial living

Problematic and Abusive Sexual Behaviors
Factors to review include:

- Abusive sexual behaviors (current or previous):
    - Types of abusive sexual behavior (e.g., hands on or hands off)
    - Gender and age of person victimized
    - Relationship to the person victimized
    - Level of coercion or violence used

    - Degree of invasiveness
    - Adolescent's version of the abuse, victim(s)' version(s) by official or victim advocate report(s), and adolescent caregivers' version(s)
    - Consequences and responses to sanctions or interventions
- Patterns of offending (e.g., antecedents, frequency, duration/desistance, and escalation in frequency or severity)
- Other problematic sexual behavior including:
    - Excessive preoccupation with sexual fantasies and behaviors
    - Excessive sexual activities such as compulsive masturbation
    - Frequent highly sexualized language
    - Sexualized gestures and behaviors
    - Persistent sexual interests involving significantly younger children, or coercion or force

Family Domain

Caregivers and people residing in the home and extended family are important and can provide information on current and history factors such as:

- Reaction and response to the abusive sexual behavior and/or any prior problematic sexual behavior
- Emotional and behavioral stability
- Substance use and abuse
- Child maltreatment/family violence experienced or perpetrated
- History of child welfare or criminal justice involvement
- Knowledge of normative and non-normative behavior in childhood and adolescence
- Sexual attitudes (i.e., attitudes that justify sexual abuse)
- Personal sexual behavior and boundaries (e.g., sexual behavior that is or is not private)
- Caregiver monitoring/supervision
- Caregiver parenting style and behavior management skills
- Caregiver strengths, supports, and challenges

Home Environment

Factors in the home environment include:

- Communication and relationship quality among family members
- Rules and routines (e.g., clear, stable, and developmentally appropriate)
- Discipline (e.g., consistent and developmentally appropriate)
- Privacy boundaries reinforced and supported
- Level of conflict or violence in the home
- Exposure to sexual media or other inappropriate sexual behavior
- Unsupervised access to someone the adolescent could sexually harm
- Encouragement of healthy coping strategies and adaptive skills
- Good safety plans and follow-through
- Family strengths, supports, and challenges, including extended family and other supports

Social and Community
Social and community factors may include:

- School engagement
- School suspensions or expulsions
- Prosocial peers or lack thereof
- Involvement in positive extra-curricular activities (e.g., sports, theater, debate, and music)
- Peer rejection, harassment, or bullying
- Negative community response (e.g., ostracism)
- Public registration/community notification

Child welfare professionals must use reliable and appropriate assessment methods and document them, as well as assessment findings and recommendations, in a written report. Procedures and methods are developmentally appropriate, empirically-informed, and supported by professional guidelines. The depth and breadth of the report will depend on the type of assessment. Any and all limitations should be explained in the report.

Child welfare professionals must also use multiple sources of information, to the extent possible and practical, to enhance the accuracy of assessment findings. Sources of information are documented in the assessment report and child welfare professionals should note when information of interest could not be obtained. Sources of information include, but are not limited to:

- Interviews with the adolescent
- Interviews with caregivers and/or parents
- Interviews with other relevant collateral sources
- Reviews of relevant records (e.g., police reports, victim statements, and the adolescent's mental health, medical education, and juvenile court histories
- Structured evidence-based risk and needs assessment protocols
- Relevant developmentally appropriate and normed measures (e.g., psychological, psychosocial, and intellectual), as needed

Display **PowerPoint Slide #28 (Assessment Tools)** and draw participant attention to the point on the slide. Ask participants if they are aware of any assessment tools their county uses when working with juveniles who engaged in sexually abusive behavior. It is important to note that different counties may use different tools for assessment. Facilitate a discussion around the different tools that may be used in the counties. This list below is not exhaustive and no recommendations should be given regarding use. Again, remind participants that they should assure that the person doing the assessment knows the possibilities and can identify which tool is appropriate for a particular youth:

- Finding Your ACE Score (Adverse Childhood Experiences)
- Trauma Symptom Checklist for Children (ages 8-18) and Trauma Symptom Checklist for Young Children (ages 5-9) by John Briere

- Treatment Progress Inventory for Adolescents who Sexually Abuse by Brent J. Oneail, G. Leonard Burns, Timothy J. Kahn, Phil Rich, and James R. Worling
- Juvenile Culpability Assessment, 2nd Revision by Jan Hindman, MS, LPC (for children ages 12 and under)
- J-SOAP-II (Juvenile Sex Offender Protocol) by Robert Prentky, PhD and Sue Righthand PhD
- Internet Sex Screening Test – Adolescent by Delmonico and Griffin 2007
- About Me by William M. Reynolds, 1986
- PHASE Sexual Attitudes Questionnaire
- CATP Sentence Completion
- Screening tools for depression (such as the Children's Depression Inventory); anxiety (such as the RCMAS-2 or the SCARED – Screen for Child Anxiety Related Disorders); ADHD (such as the Connor's Scales for youth, parents, and teachers); Obsessive Compulsive Disorder (such as the Children's Yale-Brown OC Scale); and Autism (Checklist for Autism Spectrum Disorder)
- Values, Attitudes, and Feelings Regarding Sex and Sexuality by Toni Cavanaugh Johnson, in three different versions to use with grade school, middle school, and older adolescents
- For parents to complete: Child Behavior Checklist for Children Ages 6-18 and Child Sexual Behavior Checklist by Toni Cavanaugh Johnson

Instructor Note: It is important to note that the risk assessment tools used by clinicians in the field working with juveniles who engage in sexually abusive behavior are different than the Risk Assessment form used by child welfare professionals. Although the tools used are different, assessment of risk factors is a task that should be completed by all those involved in working with the juvenile and their family.

Explain to participants that there are also some assessments that are conducted only when clinically indicated. This includes objective assessment methods:

- The **Abel Assessment for *sexual interest*-2™ for Boys and Girls (AASI-2)** is a complex assessment used by clinicians to evaluate adolescents and teens with sexual behavior problems, including juvenile who engaged in sexually abusive behavior. It is specifically designed for use with boys and girls ages 12-17 to objectively measure their sexual interests and obtain information regarding involvement in a number of abusive or problematic sexual behaviors (Abel Screening, n.d.). Participants rate their sexual interest in 160 slides of pictures of clothes male and female children and adults. The computerized texting provides an objective measure of sexual interest, taken beyond the participant's awareness, which is compared with the participant's self-report. The participant also completes a questionnaire which provides additional information about the participant's cognitive distortions and interest in a number of deviant sexual behaviors.
- The **Affinity** assessment involves the computerized presentation of photographs of 28 males and 28 females in four age categories: toddlers, preadolescents, adolescents, and adults. All of the photographs are of clothes individuals, and none of the models are depicted in sexual poses. The 56 images are presented

in a fixed, random order, and participants are asked to rate the sexual attractiveness of each.
- The purpose of the **polygraph** tool is to verify an individual's completeness regarding comprehensiveness concerning offense history. The polygraph's benefit is based on the belief that full disclosure is necessary for treatment success. **NOTE:** used with those age 14 and over

Step 6:
Ongoing Assessment

Display **PowerPoint Slide #29 (Ongoing Assessment)**. Due to the fact that significant changes can occur during the course of a juvenile's life as well as the lives of their family and peers, it is important to conduct ongoing assessment. Display **PowerPoint Slide #30 (Ongoing Assessment - list)** and point out that ongoing assessment should include:

- Access to victim and victim safety issues
- Level of risk to the community
- Commission of additional sex offenses
- Commission of other delinquent acts
- Frequency and types of behavior – to include healthy and unhealthy behaviors
- Emotional and/or psychological difficulties
- Intellectual/Cognitive functioning
- Information about the family system, dynamics and environment
- Exposure to violence, aggression and/or maltreatment
- Community influences (i.e. socioeconomic conditions and culture norms and values)
- Strengths

Assessments of adolescents who have engaged in sexually abusive behavior encompass multiple domains and are most reliable when practitioners incorporate a range of sources of information in addition to the adolescent and caregiver. Other sources of information may include educational and treatment records as well as information from other professionals involved in the case such as probation officers, case managers, legal representatives, law enforcement officers, courts, and state agencies (ATSA, 2017, p. 17).

It is important to note that risk, needs, and circumstances change over time, and that the impact of adolescent development may therefore require ongoing periodic assessments of the adolescent to ensure changes, progress, and other developmental factors are taken into consideration (ATSA, 2017, p. 17).

Given that adolescents who have engaged in sexually abusive behavior are more likely to reoffend non-sexually than sexually, it is important that assessments address general risk. Assessments should focus on providing a broad, multidimensional assessment of the individual adolescent's treatment and support needs. This includes addressing issues that may be relevant to a youth's risk for sexually abusive behavior, factors

related to general risk, and identifying factors that can impact the adolescent's response to interventions. To be effective, assessments also must focus on issues that impact healthy adolescent development and identify strengths and protective factors (ATSA, 2017, p. 24).

The instructor can then discuss that there has now been sufficient research related to the risk of sexual recidivism for adults that there are actuarial tools developed to guide the assessment of risk (i.e., STATIC-99R, Static-2002, STABLE 2007, and ACUTE 2007); however, there has not yet been sufficient research to establish actuarial risk assessments for adolescents, ages 13-17. The risk assessments for adolescents that have so far been developed are utilized to direct "empirically guided" clinical judgement. There are no proposed risk assessments for children ages 12 and younger at this time. Risks are identified as historic – static factors that cannot be changed or dynamic – those factors that become targets for treatment and/or interventions.

Display **PowerPoint Slides #31 and #32 (General Re-offending Risk Factors)** and compare to the list of things participants felt were ***NOT*** risk factors:

Static Factors/Historical Factors – Cannot Change
Static and historical factors cannot change. These include:

- Prior legally charged offenses
- Unsuccessful prior interventions
- Out-of-home placements/multiple changes in caregivers

Dynamic Factors – Can Change
Dynamic factors can change in an adolescent's assessment. These include:

- Dysfunctional parenting
- Poor education/vocational skills
- Antisocial peer associations
- Substance use/abuse
- Poor use of leisure time
- Dysfunctional personality/behavior traits (e.g., aggression, poor frustration tolerance, impulsivity, and/or defiance of authority)
- Attitudes, values, and beliefs supportive of crime

(ATSA, 2017, p. 25)

Ask participants what they think are ***NOT*** considered a risk factors for reoffending. Facilitate a short discussion, record responses on a shared Word document. Be sure the following is covered in the discussion:

- Sexual deviancy
    - Can't diagnose juveniles under the age of 16 with sexually deviant interests
    - Sexual development is part of general adolescent development which is not established until older adolescence, so that there is much more experimentation at this stage of life that does not clearly reflect clearly established deviant interests/arousal

    - Clinicians are often still reluctant to diagnose older adolescents (ages 16-19) with sexual deviancy due to the developmental process
- Prior history of sexual victimization - Instead, move to asking a broader question of where the child got the idea or learned about the behavior from such as other trauma, porn, other kids, part of general delinquency, etc.
- Lack of empathy – research shows that adult sexual offenders do not differ from general public in indices of empathy but what ***is*** different is an offender's belief about their particular victim (e.g., "they asked for it") which is why cognitive-based therapy is the preferred treatment intervention where these "thinking errors" and distortions are identified, addressed, and replaced.
    - NOTE: there are many juveniles who engage in sexually abusive behavior who use empathy to groom the victim/gain compliance

Ask participants what they think some protective factors might be that protect against continued sexually abusive behavior.

Although research studies focusing on factors that protect against continued sexually abusive behavior by adolescents are limited, there are some general factors that warrant consideration. This includes, but is not limited to:

- A healthy sense of personal responsibility and self-efficacy
- Effective emotion regulation and coping strategies
- Self-control and impulse management
- Capacity for problem-solving and effective planning skills
- A close relationship with at least one competent, caring, prosocial adult
- Positive caregiver and family relationships
- Caregiver monitoring and positive discipline
- Friendships and/or romantic attachments with prosocial peers
- Prosocial investments, such as school engagement
- Involvement in positive activities
- Positive community supports
- An optimistic future orientation
- Finding meaning in life (e.g., spirituality)

(ATSA, 2017, p. 26)

Risk and needs assessment for adolescents is a continually evolving field in which there are new research results and tools regularly being developed. Therefore, child welfare professionals should seek evaluators who demonstrate best practices and are up to date on new research and tools being used for assessment. Risk assessment needs to include risk in balance with strengths and protective factors. Risk assessment should be multidisciplinary, multidimensional, holistic, comprehensive, and individualized. Risk assessments represent a point-in-time; therefore, risk factors need to be evaluated on an on-going basis. When reviewing risk factors, note factors which are not listed, including denial/minimization, prior sexual victimization, history of non-sexual offenses, lack of victim/survivor empathy, level of intrusiveness (penetration), level of motivation for treatment, and psychological concerns.

One such tool that that both identifies risks with a balance on identifying protective factors is Protective + Risk Observations for Eliminating Sexual Offense Recidivism (PROFESOR). This tool, created by James Worling, replaces the ERASOR tool that was deemed ineffective after years of research didn't support it. PROFESOR is intended to assist with planning interventions that can help individuals to enhance their capacity for sexual and relationship health and, thus, eliminate sexual recidivism. This tool is ***NOT*** designed for the purpose of predicting the risk of future offending. PROFESOR contains 20 bipolar factors (i.e., both protective and risk characteristics) that were chosen based on a review of the available literature and on clinical experience with adolescents and emerging adults who have offended sexually (Worling, 2018).

Refer participants to the bottom of **PowerPoint Slide #31 (General Re-offending Risk Factors)** for the link to the PROFESOR website, if they would like to learn more. This link can also be shared in the chat: https://www.profesor.ca/

Step 7:
Recidivism

Display **PowerPoint Slide #33 (Recidivism)**. Adolescents who have been arrested for sexual offense are well known to pose a relatively low risk of sexual recidivism as they age. Because of this relatively low rate of re-offense, it has been extremely difficult to establish a reliable base rate for adolescent sexual recidivism. A base rate for sexual recidivism is one of the most important considerations for assessing risk – the cornerstone that may be helpful for both public policy and in clinical application of risk assessment methods (Caldwell, 2016).

Michael Caldwell (2016) examined 106 studies involving 33,783 adolescents adjudicated of a sexual offense between 1938 and 2014. Caldwell found a weighted mean base rate for sexual recidivism of 4.92% over a mean follow-up time of nearly 5 years (2016).

In exploring the question about whether sexual recidivism rates are decreasing, Caldwell (2016) examined 33 studies between 2000 and 2015 and reported a weighted mean sexual recidivism rate of 2.75% - which is 73% lower than the rate of 10.3% reported by studies conducted between 1980 and 1995.

In another research study, it was clearly demonstrated that providing individualized treatment for adults and adolescents who sexually abuse significantly reduces their risk to reoffend. For example, cognitive-behavioral and multi-systemic treatment programs for adolescents (which takes place in the community and emphasizes family involvement) seemed to have more positives effects. Treatment programs in the community showed a larger effect on recidivism compared to treatment in prison. Treatment seemed to have a larger impact on adolescents than adults (Schmucker & Losel, 2015).

Participants will now view **Video Clip #3**. This clip shows Jamal telling his story about how he has offended several children (Sara, Jake, and Brian). After participants have

viewed the clip, the trainer should ask, “What did you hear?” Wait for participants’ feedback about Jamal’s story. Then have a discussion about Jamal’s perspective on his offenses, his perspective about how his victim’s responded to his offenses and talk about the thinking errors that he had during his offending behavior and how he groomed his victims. Then talk about how the various cognitive-behavioral interventions could assist Jamal in addressing his thinking errors, impulse control, building of empathy, etc.

Conclude this segment by asking the participants to take five minutes to reflect upon the materials and highlight any areas they might want to note for improvement. Ask participants to share at least one thing they learned which will impact/change their work.

This is the end of day one.

NOTE: It is likely that not all of this material is covered by the end of the day. However, close up the day about 3:40 with direction for participants to read the first six pages of Handout #17 and respond the two questions on page 7 of the handout prior to the start of Day #2.

203 Remote: Working with Juveniles Who Sexually Offend

Section VI: Treatment and Supervision Interventions

Estimated Length of Time:
3 hours

Key Concepts:
- Treatment interventions are key components in reducing re-victimization and recidivism.
- The primary goal of offense-specific treatment interventions is to reduce the probability of an offender returning to previously identified unhealthy sexual behavior.
- A secondary goal of intervention is to make the transition from externally controlled behavior to internally controlled behavior.
- Treatment and supervision are the key components of intervention in working with juveniles who engaged in sexually abusive behavior.
- There are three main treatment approaches in working with juveniles who engaged in sexually abusive behavior, but these approaches can be used in a variety of treatment modalities.
- Treatment approaches should be modified and individualized based on the needs of the juvenile and his/her family.
- Treatment interventions are based on a continuum of services from most restrictive to least restrictive.
- There are a variety of supervision strategies that can be used in conjunction with treatment interventions.

Methods of Presentation:
Lecture; large group discussion; small group activity; individual activity

Materials Needed:
- ✓ Zoom Room Flow Chart
- ✓ Laptop and shared screen
- ✓ **Instructor Resource #1: In the Interest of J.B., J-44A-G-2014**
- ✓ **Instructor Resource #2: Commonwealth of Pennsylvania v. Jose M. Muniz**
- ✓ **PowerPoint Slide #5: Training Agenda (revisited)**
- ✓ **PowerPoint Slide #34: Treatment + Supervision = Intervention**
- ✓ **PowerPoint Slide #35: Treatment Overview**
- ✓ **PowerPoint Slide #36: Supervision Strategies**
- ✓ **PowerPoint Slide #37: Purposes of Prosecution**
- ✓ **PowerPoint Slide #38: Registration Laws & Recidivism**
- ✓ **Handout #9: Assessment-Part 1** (participants received with registration letter)
- ✓ **Handout #10: Treatment Targets** (participants received with registration letter)
- ✓ **Handout #11: Federal Legislation Regarding Sex Offender Registration: The Victim's Stories** (participants received with registration letter)
- ✓ **Handout #12: Megan's Law Registration Requirements: Old v. New** (participants received with registration letter)

203 Remote: Working with Juveniles Who Sexually Offend

- ✓ **Video: 203: Working with Juveniles Who Sexually Offend (Clip #4-Youth Who Have Offended Talk About Treatment):**
  - http://www.pacwrc.pitt.edu/curriculum/SexualAbuseSeries/WorkingJuvenilesWhoSexuallyOffend/Youth%20Who%20Have%20Offended%20Talk%20About%20Treatment.mp4

Outline of Presentation:

- Review the goals of treatment.
- Outline the treatment approaches, modalities of treatment, and the continuum of treatment interventions.
- Discuss the importance of utilizing supervision strategies that can be used in conjunction with treatment interventions.

Section VI: Treatment and Supervision Interventions

Instructor Note: This is usually the start of Day 2. Instructors should start the day by asking participants one thing that they recall from Day 1 (or some activity/introduction to connect the learning from Day 1 to Day 2). Instructors are also encouraged to show **PowerPoint Slide #6 (Training Agenda: Day Two)** to outline the learning agenda for Day 2.

Step 1:
Utilizing the Offense Specific Assessment Report for Case Planning

Participants will need to become familiar with the component parts of a clinical psychosexual assessment so that they can utilize the assessment in understanding risk factors and recommendations for treatment interventions.

Ask participants to share what they learned after completion of **Handout #9 (Assessment-Part 1)**. The instructor should ask trainees to read the assessment and complete the last two sections of the assessment, including:

- Areas of Relative Strength/Positives; and
- Areas of Concern/Problem Areas.

Lead a discussion with the groups about their conclusions about the juvenile's strengths and areas of concern. Inform participants that they will later have an opportunity to compare their conclusions with the "expert's" assessment of risk level. To better understand the recommendations made by clinicians conducting psychosexual assessments, it is important to understand the importance of how supervision and treatment lead to effective intervention.

Step 2:
Goals of Treatment

Treatment interventions are key components in reducing re-victimization and recidivism. Although child welfare professionals are not clinicians charged with the task of providing treatment, child welfare professionals play a significant role in the treatment process. Child welfare professionals need to understand the nuances of the treatment process so that they can collaboratively work with other professionals in providing ongoing safety and risk assessment management while monitoring case plans. The planning and implementation of treatment services ideally reflects the collaborative involvement of the youth, family and all agencies involved in the youth's care as well as those agencies serving the victims of these youth.

Adolescents who have engaged in sexually abusive behavior are a diverse population in regard to age and maturity level, learning styles and challenges, protective factors, and risk factors associated with reoffending. Interventions should take into consideration these varied factors, as well as the law rates of sexual recidivism and significantly higher rates of nonsexual recidivism. Effective interventions are responsive to the diversity of the population in combination with the need to address sexual and

nonsexual risk for reoffending by providing an individualized, holistic treatment framework (ATSA, 2017, p. 39).

Current studies suggest that cognitive-behavioral, skills-based, and multi-systemic approaches that involve caregivers in treatment have the most research support for youth with a range of behavior problems, including adolescents who engage in sexually abusive behavior. Effective treatment interventions include:

- Focusing on dynamic risk factors supported by current research
- Promoting safety while facilitating prosocial and developmentally appropriate skill development
- Using evidence-based interventions that match presenting risk and needs
- Including caregivers and other positive supports
- Addressing risk and protective factors across the adolescent's natural ecologies (e.g., family, peers, and school)
- Providing treatment in the natural environment when possible to allow the adolescent and their caregivers to practice skills and use social supports in real-life situations
- Tailoring approaches to match individual characteristics and circumstances of the adolescent (e.g., developmental status, learning styles, gender, and culture)
- Addressing sexually abusive behavior problems as well as other conduct problems

(ATSA, 2017, pp. 39-40)

Specific ways in which trauma treatment could be integrated into treatment interventions include:

- Ensuring those who conduct assessments and provide treatment/intervention understand the close link between trauma and sex offending triggers
- Screening all juveniles who engaged in sexually abusive behavior for trauma histories
- Assessing juveniles who engaged in sexually abusive behavior for the presence of PTSD as a co-morbid condition
- Having juveniles who engaged in sexually abusive behavior diagnosed with PTSD and/or with histories of trauma exposure participate in a trauma focused treatment group that is integrated into their overall treatment plan
- Teaching juveniles who engaged in sexually abusive behavior how to better manage trauma associated affects

(McMackin et al., 2002)

Step 3:
Treatment + Supervision = Intervention

Display **PowerPoint Slide #34 (Treatment + Supervision = Intervention)**. Certainly, it is impossible to alter behavior without supervising behavior and directly attempting to alter the behavior, which is why both treatment and supervision play such a key role in intervention with juveniles who engaged in sexually abusive behavior. The primary goal of offense-specific treatment is to reduce the probability of a juvenile who has engaged

in sexually abusive behavior returning to previously identified sexually deviant behavior. Treatment should identify all of the different contributing factors that contributed to offending and all of the risk factors necessary to reduce recidivism.

A secondary goal of intervention is to make the transition from externally controlled behavior to internally controlled behavior. That is, the juvenile must learn how to self-manage behavior, rather than relying on others to manage his/her behavior. This requires the management of "precursor" behavior as well as “resultant" behavior. The juvenile must learn to manage his/her experiences that lead up to the deviant behavior in order to manage the problematic behavior. As a result of this need to manage precursor behavior, intervention must address all sexual behavior in order to extinguish deviant behavior and to enhance appropriate behavior. There are several approaches that can be used to address treatment issues.

Treatment services are best offered and provided along a continuum of care – from community-based (outpatient) interventions to secure residential or correctional-based treatment programs. To be most successful, the level of intensity and restrictiveness of services must match the current treatment and supervision needs which, depending on the youth and their family and circumstances, are likely to change over time. Most adolescents can be safety treated in community settings. Residential and correctional settings should be reserved for the minority of youth who present with significant risk factors for recidivism or other treatment needs that cannot be met in community settings (ATSA, 2017, p. 40).

Interventions such as psychiatric or mental health care, educational services, and community supervision contribute to public safety efforts and promote the overall stability and success of adolescents. To achieve this success, it is important for treatment providers and child welfare professional to collaborate (ATSA, 2017, p. 41).

Step 4:
Treatment Modalities

The approaches that we have discussed can be implemented in various treatment settings. It is often suggested that treatments incorporate the use of individual, group, and family therapy. Furthermore, treatment should be approached similarly to assessment in that treatment should be individualized, based on a multiple-system perspective, and all treatment providers need to communicate and collaborate with one another.

<u>Individual Therapy</u>
Treatment goals addressed in individual therapy may include dealing with personal victimization, correcting cognitive distortions, and accepting responsibility. However, these goals are often integrated into other modalities, as well.

Group Therapy
Group therapy can be effective for a number of treatment goals including peer support, developing social skills, addressing problems experienced by group members, developing effective decision-making and problem-solving skills, addressing educational and treatment concepts, and developing intra- and inter-personal interventions.

Family Therapy
Family therapy is a key component to treatment of the juvenile who engaged in sexually abusive behavior because family members are part of the environment that can both positively and/or negatively influence a juvenile throughout treatment in addition to post-treatment. Family therapy also provides an opportunity to address family issues that may have played a role in the dynamics of what led to the juvenile's sexually abusive behavior. (NOTE: This is NOT to say that the family members are responsible for the juvenile's sexually abusive behavior.)

Multi-systemic Therapy
It is suggested that systemic therapy should include individual or group treatment for juveniles who engaged in sexually abusive behavior by focusing on the denial of responsibility, abuse of power, personal trauma experiences, and personal attachment. It is also suggested that family therapy be used to focus on protection of victims and siblings, role clarification, facilitation of an apology on the part of the juvenile who engaged in sexually abusive behavior, and fostering parental support of the juvenile. Thus, treatment programs conceptualized within a systemic framework involve individual or group therapy for the juvenile, victims, siblings, and parents, with concurrent family intervention that may involve dyadic, group, and whole-family sessions.

Step 5:
Treatment Targets

Display **PowerPoint Slide #35 (Treatment Overview)** and review the information provided on the slide. Explain that treatment interventions primarily focus on needs related to healthy social, psychological, and cognitive development, and research-supported dynamic risk factors linked to sexual and nonsexual recidivism (e.g., criminogenic needs) over factors that have not been shown to be associated with recidivism (ATSA, 2017, p. 47).

It is important that treatment does not narrowly focus on the sexually abusive behavior, but addresses other assessed risk, relevant needs, and protective factors that can promote prosocial, healthy relationships and healthy lives (ATSA, 2017, p. 47).

Treatment provides strive to address treatment targets. The following treatment targets have been associated with sexual recidivism. However, specific targets might not be relevant for an individual youth or their family. Moreover, addressing unnecessary targets can reduce both the clinical and cost effectiveness of interventions and may

unnecessarily lengthen treatment duration, which could have unintended negative effects (ATSA, 2017, p. 48). Refer participants to **Handout #10 (Treatment Targets)**.

NOTE: Depending on time availability, this exercise may also be conducted as a large group activity.

Assign two target areas to each of the three Breakout Rooms. The fifth target area (Treatment Process or Discharge) can be assigned to two different groups. Assign groups the following targets:

- Target 1: Social Isolation/Low Social Competence & Attitudes Supportive of Abusive Behavior
- Target 2: Parent-Adolescent Relationships & General Self-Regulation
- Target 3: Healthy Sexuality Including Sexual Self-Regulation, Social and Community Supports, and Nonsexual Delinquency
- Target 4: Treatment Modalities
- Target 5: Treatment Process or Discharge

Once the groups have been assigned treatment targets, ask participants to review the information then think about their role as a child welfare professional. Then, ask them to identify areas where, as a child welfare professional, they could provide support, collaborate, educate, or coordinate with a treatment professional to help an adolescent who has engaged in sexually abusive behavior successfully achieve their appropriate treatment targets.

Ask participants to share their ideas and encourage those who are listening to take note on **Handout #10 (Treatment Targets)**. As an instructor, listen carefully while groups are presenting to identify any themes, fill in any gaps, identify areas where counties may differ in process, and generally facilitate the conversation around the treatment of juveniles who engaged in sexually abusive behavior.

Explain to participants that there are treatments that are only used when clinically indicated:

- **Pharmacological/Biological techniques:** "Use of biological and pharmacological treatments in the United States, specifically with adolescent (offenders), remains controversial and, thus, is infrequent" (Hunter & Lexier, 1998).
    - **Selective Serotonin Reuptake Inhibitors (SSRIs)** – Although generally used to alleviate depression and anxiety related disorders, these medications are also thought to reduce recurring thoughts and sexual preoccupations, as a common side effect of SSRIs is decreased sexual drive. It is important to note that the FDA has not sanctioned these medications for use in treatment for juveniles who engaged in sexually abusive behavior. ***This technique should only be utilized in conjunction with therapy and while under medical supervision***.
- **Polygraph** – the purpose of this method is to verify an individual's completeness regarding comprehensiveness concerning compliance with therapeutic directives

and terms of supervision. The polygraph's benefit is based on the belief that full disclosure is necessary for treatment success.

Treatment Models

The idea of "relapse prevention" has received increasing criticism, as there are significant aspects which have not translated to the needs of all youth and adults. And since 2007, relapse prevention has been even more marginalized. Relapse prevention focuses on the unhealthy aspect of sexual offending behavior to the exclusion of other related factors which support the unhealthy behaviors. Relapse prevention is based on the assumption that the individual wants to stop the sexual behavior, which is not always true. Some are troubled that sexually re-offending, in which a person is victimized, is called a "relapse." The model is based on a single "cycle" which is not characteristic of all behaviors. The model proposes that "relapse" is based on a negative event or negative effect, and again, many who sexually act out do so for different reasons (i.e. it feels good or to "reward" themselves). This model was not designed to include a focus on supervision and assuring safety. One of the major criticisms is that relapse prevention is avoidance-based in which escape and avoidance techniques are utilized. There are other theories that have since been developed that better address the needs of juveniles who engaged in sexually abusive behavior. Those theories include the Good Lives Model, Self-Regulation Model, and Risk-Need-Responsivity:

- The Good Lives Model (GLM) is a strengths-based approach to offender rehabilitation and is premised on the idea of building capabilities and strengths in people in order to reduce their offending. According to the GLM, people offend because they are attempting to secure some kind of valued outcome in their life. Offending is essentially the product of a desire for something that is inherently human and normal. Intervention should be viewed as an activity that should add to an individual's repertoire of personal functioning, rather than an activity that simply removes a problem, or is devoted to managing problems (Good Lives Model, 2015).
- The Self-Regulation Model is a nine-stage process of offending that addresses both the individual's goals with respect to the offending behavior (approach versus avoidance) and the manner in which the individual attempts to achieve these goals (passive versus active), resulting in four hypothesized pathways that lead to sexual offending (Yates & Kingston, 2006).
- Risk-Need-Responsivity Model is formed by three principles:
    - The risk principle states that the level of service should match an offender's risk of reoffending. Risk levels are determined by examining factors linked to re-offense.
    - The need principle states the corrections agencies should assess an offender's dynamic criminal risk factors and focus treatment on those.
    - The responsivity principle essentially entails providing the right treatment at the right level (Washington State Department of Corrections).

Participants will now view **Video Clip #4** which is a clip that shows several juveniles thoughts and opinions about what treatment has done for them, how they need to continue to monitor re-offense prevention plans, the importance of talking with family about their thoughts and feelings, and the impact that their offending behavior has on the survivors and their families. Process out the video with participant's by reviewing their reactions to the juveniles' beliefs about treatment.

When looking at possible treatment approaches, it is necessary for those assessing the juvenile to consider the need for possible modifications to the treatment approach based on the juvenile's individual needs. Professionals have recognized that a spectrum of interventions may be necessary to impact sexual recidivism, including mental health, physical health, family, peer, substance abuse, education and training, and employment. The trends toward positive approaches include treatment interventions to build intimacy, autonomy, self-reliance, knowledge, and effective emotional coping. Again, treatment interventions need to be informed by knowledge of child and adolescent development and not solely based on interventions proposed for adults.

Step 6:
Treatment Modifications for Special Populations

It is sometimes inappropriate to initiate each of these components to their full extent. It is essential to modify programming to a developmentally appropriate level. Certainly, some juveniles with developmental delays will be unable to grasp many of the treatment concepts and other elements of sex-offense-specific treatment. Therefore, treatment modalities must be framed to match the cognitive/developmental level of the group participants. As indicated previously, it may not be appropriate to use victim empathy as an intervention modality for sadistic behaviors. These are issues which must be addressed by treatment providers and those providing supervision.

Very young juveniles who engaged in sexually abusive behavior generally do not benefit from high cognitive intervention approaches. Therefore, behavioral therapy is considered the primary treatment modality. Expressive therapies such as art therapy, play therapy, and sand tray work are to be used only as interventions for specific issues, because in those types of interventions, the child is in "control" of the session and what does or doesn't get addressed. These interventions may need to be used to overcome specific barriers or assist children to integrate concepts that are generally beyond their cognitive/developmental level. However, in addressing sexual acting out and offending behaviors, the therapist needs to be more directive and assure that the issues are indeed addressed.

In general, there is a relatively small body of research that has examined the assessment, treatment, and treatment outcomes of specific subpopulations (e.g., adolescent females, developmentally delayed adolescents, adolescents diagnosed with autism, and adolescents with co-occurring mental health problems) of adolescents with sexually abusive or problematic behaviors. Treatment providers should be familiar with

the research available and should be cautious about making broad references or comparisons regarding these adolescents to other groups of adolescents with sexual behavior problems when using research, assessment tools, or treatment programs that did not consider these specific populations in their design, normative samples, or outcomes (ATSA, 2017, p. 60).

Whenever possible, treatment providers should work with child welfare professionals to education and provide further information about the current level of knowledge regarding sexual behavior problems in these populations as well as additional research that can help in making informed decisions involving assessment, treatment, and safety (ATSA, 2017, p. 60).

Ask participants how they think treatment might differ for various subpopulations and to consider how they might work differently with treatment providers. Use the information below to guide the discussion.

Treatment guidelines for treatment professionals regarding special populations include:

- Appreciating the diversity among adolescents who have engaged in sexually abusive or problematic behavior, and recognize that responsiveness to treatment can vary as a function of client characteristics such as gender, cultural background, developmental level, cognitive capabilities, and adaptive functioning.
- Recognizing that not all treatments have been developed or evaluated with various subpopulations of adolescents who have engaged in sexually abusive behaviors. Treatment professions must identify the limitations of different treatment approaches with these various populations prior to initiating treatment.
- Assessing and identifying responsivity factors such as comprehension, cognitive capabilities, executive functioning skills, adaptive functional level, and other variables that may impact an adolescent's ability to maximally benefit from different approaches to providing sexual-abuse-specific treatment.
- Adjusting approaches and interventions to match adolescents to appropriate services based on identified responsivity factors, to maximize the benefits of treatment.
- Making serious efforts to equip themselves with the knowledge and skills necessary to adequately address adolescents' responsivity factors and/or special needs by consulting with knowledgeable others, accessing specialized training, and participating in other professional development activities.
- Understanding that, for some subpopulations of adolescents, sexual-abuse-specific treatment services are best provided subsequent to or in concert with other psychiatric, behavioral, or responsivity-oriented interventions. Practitioners offering sexual-abuse-specific treatment need to collaborate with the providers of such services to ensure that sexual-abuse-specific services are optimized for the adolescent being treated.
- When providing sexual-abuse-specific treatment, treatment professionals work closely with family members, educators, and other community support persons

who can facilitate successful treatment outcomes because of their abilities to attend to these adolescents' specific needs.

(ATSA, 2017, pp. 62-63)

Step 7:
Continuum of Treatment

As there are a variety of approaches about how to treat juveniles who engaged in sexually abusive behavior, it is also important to consider what treatment interventions are available. As we talk about treatment interventions for juveniles who engaged in sexually abusive behavior, it is important to note that program availability varies across the Commonwealth. In addition, there are a variety of different programs that are available. There are some programs that are community-based, but there are also residential/institutional based programs. The continuum of treatment should be individualized and based on the level of risk as well as on the needs of the juvenile who engaged in sexually abusive behavior. Furthermore, the appropriateness of treatment needs to be continually monitored to assure that treatment is meeting the needs of the juvenile in addition to the safety of the survivor(s) and the community.

Community-based Treatment:
This form of treatment allows the juvenile to remain with or close to home and his/her family. Most often, the juvenile will also be able to continue to attend his/her school and maintain peer relationships while at the same time applying what is learned in treatment in his/her natural environment. This form of treatment also promotes the greater likelihood that the juvenile's family will be involved in treatment. Most often, community-based treatment offers less frequent treatment interventions, as individual/family/group sessions might only be offered once or twice a week, as opposed to residential/institutional programs. It is also important to note that the juvenile may still have access to the survivor(s) and he/she might be more vulnerable to high risk situations to include involvement with inappropriate peer groups.

Residential/Institutional Treatment:
Residential programs provide a unique opportunity for juveniles to become "immersed" in their treatment, which is a more intensive service that offers an around the clock therapeutic milieu. This structured, and at times locked down facility, offers greater structure and establishes an environment that allows for survivor and community safety.

Step 8
Supervision Strategies

The instructor will conduct a brainstorming exercise which identifies the pros and cons of supervision strategies including incarceration, probation, electronic monitoring, residential treatment, group home placement, foster home placement, and continued placement in the home. Display **PowerPoint Slide #36 (Supervision Strategies)** which outlines the continuum of supervision strategies from most restrictive to least restrictive.

Supervision strategies generally are identified as including the following interventions: incarceration, probation, electronic monitoring, residential treatment, group home placement, foster home placement, and remaining in one's home with community-based treatment services. Certainly, not all intervention strategies are equal in terms of the amount of intrusiveness involved and require varying quantities of community resources to implement. We are pragmatically faced with limitations in our ability to intervene, based on limited community resources, availability of supervision mechanisms, statutory limits, and the inability/unwillingness to prosecute. It is frequently not appropriate to use the more intrusive forms of supervision due to these limitations and the importance of maintaining autonomy for the individual.

In understanding placement options it is important to note that significant differences exist between specific facilities. For example, what is true of one foster placement may not be true of another. The classifications in **PowerPoint Slide #36 (Supervision Strategies)** are not meant to be exhaustive or to imply that absolute differences exist from one option to another. Rather, placement options can be thought of as a continuum ranging from most restrictive/intrusive to least restrictive/intrusive. Generally speaking, the more restrictive, the safer for the community, the easier to coordinate immediate services, and the better the community feels about the placement. The more restrictive the placement, the more expensive and disruptive it will be to the family system and the more difficulty the juvenile who engaged in sexually abusive behavior will have in generalizing new skills acquired when released from the placement. In determining placement options, it is important to weigh the needs of the survivor (and the community) with the particular needs of the juvenile.

Incarceration is generally thought of as the most restrictive/intrusive placement option. It is generally thought that as long as an individual is locked up, they cannot re-offend against the community (of course they can continue to offend against other incarcerated individuals.) Generally, those outside the family system and to some degree, depending on the family dynamics, the members of the family experience some relief when the juvenile is incarcerated or removed from the community as the community feels a sense of justice from punishing the juvenile who engaged in sexually abusive behavior.

At the same time, many families experience significant trauma from this experience as they may experience some guilt from sending a loved one away. Many institutions lack adequate treatment for juveniles who engaged in sexually abusive behavior, and therefore some juveniles may get little or no treatment for their sexual problems. It is often difficult for the local community to maintain management of the juvenile after release because jurisdiction is often transferred to a state agency, rather than the local agencies. Finally, because incarceration involves placing a juvenile who engaged in sexually abusive behavior into a secured environment, the juvenile does not often develop the ability to apply newly developed skills in the "real world." As a result, juveniles who have been incarcerated often find it very difficult to generalize coping skills learned while incarcerated into their home environment.

In most cases, probation is an important element to any placement. In every placement except incarceration, probation becomes the mechanism to ensure compliance with treatment. Unfortunately, this is often costly for the local community who often has an overworked juvenile probation department. It is often difficult to coordinate services with individuals who are on probation because several different agencies are involved in a particular case, which further enforces the need for a multi-disciplinary approach to intervention.

Electronic monitoring can be an effective addition to any placement option. In most cases an electronic monitoring system can be set up for only a few dollars a day. Several electronic monitoring approaches exist including: ankle bracelets to monitor the juvenile's current location, motion detectors to determine movement within an area, video surveillance to ensure compliance with rules, and alarms to restrict movement within an area. Unfortunately, electronic monitoring cannot ensure that a new offense will not occur. For example, an ankle bracelet will alert the supervisor that someone has left an area, but it will not keep the juvenile from leaving nor prevent him/her from gaining access to a survivor who enters the area where the juvenile is restricted.

Generally speaking, residential treatment programs offer increased supervision, more intensive intervention from a multi-disciplinary team, and a more restrictive environment than group homes or foster homes. Certainly this is not always the case. All three of these placement options aid significantly in preventing ongoing abuse within the family system, but at the same time cause a disruption of the family system that may cause other problems. Each of these placement options provides varying degrees of security, coordination of services, and exposure to the community. Any placement away from the juvenile's long-term home situation can cause potential problems with generalizing new skills into their lifestyle.

Eventually every juvenile who has engaged in sexually abusive behavior will return to their family system or be living on their own. This may occur when they turn the age of majority and/or are no longer eligible for services, have served their maximum sentence, or have successfully progressed through an intervention program. Independent living implies virtually no external monitoring and should generally only be considered for individuals very far along in treatment, or just prior to mandatory release from intervention programming.

Ask participants to identify the pros and cons of community-based and residential/institutional treatment. The instructor can encourage participants to make notes for themselves. Note that there are some concerns associated with residential/institutional treatment. Here are some possible responses:

- Residential treatment can be costlier than community-based treatment
- It can be disruptive to remove the juvenile from his/her home setting – especially when there are positive influences within the juvenile's community
- Exposure to unhealthy behaviors of other peers in the residential/institutional setting
- Separation from family supports

- Change in school setting and possible disruption to academics

No matter what setting is used for the juvenile, there are clear target goals to treatment for those juveniles who engaged in sexually abusive behavior. Refer participants to **Handout #10 (Treatment Targets)**. Even within this continuum of treatment, there are a variety of strategies that might also be utilized.

Step 9:
Purposes of Prosecution

The instructor should ask participants to brainstorm reasons why prosecution might assist treatment interventions and then display **PowerPoint Slides #37** (**Purposes of Prosecution)** and review the following with participants:

- Prevent further victimization
- Protect community
- Assure complete investigation of complaint
- Demonstrate that sexually abusive behavior is serious, illegal, and will not be tolerated
- Hold the juvenile accountable/responsible for his behavior
- Determine consequences
- Support survivor's rights and reduce minimization and denial by the juvenile and others
- Evaluate the need for treatment
- Facilitate and/or mandate entrance into specialized treatment and enhance the juvenile's motivation for change
- Assure continued treatment
- Provide for supervision and follow-up (orders for probation/parole, also safeguards/safety plan)
- Document record of the offending behavior
- Help families who are denying the juvenile's sexually abusive behavior to follow through with treatment

Step 10:
Federal and State Legislation Pertaining to Juveniles Who Engaged in Sexually Abusive Behavior

From the late 1980's to the mid 1990's there was an apparent increase in the rise of crimes committed by juveniles, which has led to some legislative reform. The juvenile justice system, which was originally designed to rehabilitate juveniles who engaged in sexually abusive behavior, has become increasingly punitive and there has been an increased legislative response in an attempt to ameliorate the concerns about juveniles who engaged in sexually abusive behavior. "As the issue of sex offending has received increased media and community scrutiny, (juveniles who engaged in sexually abusive behavior) have become caught up in a web of legislation originally designed for adult sex offenders – including registration, community notification, and civil commitment.

Legal definitions of sexual behavior outlined in federal and state legislation are very different from clinical definitions applied to juveniles who engaged in sexually abusive behavior. Legal definitions describe illegal behavior, but clinical definitions are much broader and describe legal and illegal behavior that may be tied to the abuse and sometimes the feelings and thoughts that go along with these behaviors. Clinical classifications might also address grooming behaviors that precede abuse, feelings of the child, and a lot of other information that may be much broader than the illegal act itself.

During *203: Overview of Child Sexual Abuse* and at the beginning of this course you learned about the legal definitions related to sex offenses that are found in the Child Protective Services Law (CPSL) and the Crimes Code – Title 18, Chapter 31 (Sexual Offenses). You learned that both adults and juveniles could be charged with the crimes outlined in the Crimes Code (i.e. Rape, Indecent Assault, Involuntary Deviate Sexual Intercourse, etc.). “The rise in juvenile perpetrated violence over the past decade has resulted in legislation designed to enhance public safety and raise the level of accountability of juveniles in the criminal justice system” (Hunter and Lexier, 1998). For this training, we will focus on some relatively new legislation that affects the registration of juveniles who engaged in sexually abusive behavior on Statewide/National Sexual Abuse Registries.

Advise participants that **Handout #11 (Federal Legislation Regarding Sex Offender Registration: The Victim’s Stories)** was included with the registration letter. Instructors should review this Handout for information regarding the survivor’s stories that led to the enactment of these federal laws.

The Jacob Wetterling Crimes against Children and Sexually Violent Offender Registration Act enacted in 1994, the Federal version of "Megan's Law" enacted in 1996, and the Pam Lychner Sexual Offender Tracking and Identification Act also enacted in 1996 were the original federal legislation that state governments base their sex offender legislation on.

Patty Wetterling, Jacob Wetterling’s mother, advocated for a list of sexual offenders located in the area be available to police as a resource when a sexually violent crime occurs. Because of her advocacy for such a resource, the idea was eventually coopted into a registry and written into law. This, however, was not what Ms. Wetterling had in mind when she came up with the idea of a resource for law enforcement. **NOTE:** This lays the background for the current challenges in Pennsylvania surrounding registry laws (see below).

“Megan’s Law” - On October 21, 1995, Governor Ridge signed into law Act 24 of 1995, commonly referred to as "Megan's Law," which became effective on April 21, 1996. The statute requires states to establish registration programs so local law enforcement will know the whereabouts of sex offenders released into their jurisdictions and notification programs so the public can be warned about sex offenders living in the community.

Juveniles are not required to register under Megan's Law unless they are convicted in adult court of one (or more) of the following crimes:

- Rape
- Involuntary deviate sexual intercourse
- Sexual assault
- Institutional sexual assault
- Aggravated indecent assault
- Indecent assault, where the offense is a misdemeanor of the first degree
- Kidnapping, where the survivor is a minor
- Luring a child into a motor vehicle
- Incest, where the survivor is a minor
- Prostitution, where the offender promotes prostitution of a minor
- Obscene and other sexual materials & performances, where the survivor is a minor
- Sexual abuse of children
- Unlawful contact with a minor
- Sexual exploitation of children
- Attempt to commit any of the offenses listed above
- A conviction of, a plea of guilty to, or an adjudication of delinquency of, an offense in another jurisdiction equivalent to any of the offenses listed above or if they are required to register under a sex offender statute in the jurisdiction where convicted, sentenced, or court-martialed

Adam Walsh Child Protection and Safety Act of 2006 (HR 4472) – The Adam Walsh Child Protection and Safety Act of 2006 was signed into law on July 27, 2006. The act contains several provisions related to the type of information that can be disclosed about the offender, the duration of registration requirements, the extent of community notification, and other issues. Prior to December 29, 2014 the act established a comprehensive national system for the registration of sex offenders, including juveniles who are 14 years of age or older whose offense (or attempted offense) was comparable to, or more severe than, aggravated sexual abuse (as described in section 2241 of title 18, United States Code), or an attempt or conspiracy to commit such an offense.

> "Aggravated sexual abuse" is defined in 18 U.S.C. 2241. State offenses that are comparable to this federal offense are those that cover:
>
> - engaging in a sexual act with another by force or the threat of serious violence (see 18 U.S.C. 2241(a));
> - engaging in a sexual act with another by rendering unconscious or involuntarily drugging the survivor (see 18 U.S.C. 2241(b)); or
> - engaging in a sexual act with a child under the age of 12 (see 18 U.S.C. 2241(c)).

On December 20, 2012, Megan's Law was updated in Pennsylvania to comply with the federal Sex Offender Registration and Notification Act (SORNA). It included ***five*** times as many offenses as were first listed in Megan's Law,

including nonsexual crimes such as interfering with the custody of a child (Melamed, 2018). Refer participants to **Handout #12 (Megan's Law Registration Requirements: Old v. New)** which was included with the registration letter. Discuss the differences in the pyramids as they relate to the law. Ask participants what effect this might have on the children and youth they work with.

Since the update, the revised Megan's Law has met several legal challenges:

- On December 29, 2014, the Supreme Court of Pennsylvania declared the Sex Offender Registration and Notification Act (SORNA), referring to Title I of the Adam Walsh Child Protection and Safety Act of 2006, unconstitutional. The decision states that the "High Court identified three critical distinctions between children and adults, specifically juveniles' 'lack of maturity' resulting in impulsivity, their vulnerability to external influences combined with their limited ability to control their environment, and the still-developing characters which make their actions less indicative of 'irretrievabl[e] deprav[ity]" (In the Interest of J.B., 2014). The decision also states that "SORNA failed to account for the substantial differences between juveniles and adults regarding juveniles' lessened culpability and enhances potential for rehabilitation" (In the Interest of J.B., 2014). To reach their decision, the courts relied heavily on research studies that indicated that "recidivism rates for juvenile sex offenders are far lower than the recidivism rates of adult sexual offenders, and, instead, are comparable to non-sexually offending juveniles" (In the Interest of J.B., 2014). The courts also considered research that addressed the effects of registration on juveniles "noting that registration leads to depression, isolation from society, and in some cases, an increased risk of other criminal acts" (In the Interest of J.B., 2014). In addition to research studies, the "York County Court also looked to recent United States Supreme Court decisions declaring children to be constitutionally different from adults" (In the Interest of J.B., 2014). For further information, please refer to **Instructor Resource #1: In the Interest of J.B., J44A-G_2014**.
- In July 2017, The Pennsylvania Supreme Court decided the case of Jose Muniz, a Cumberland County man who was convicted of indecent assault for touching the breasts of his girlfriend's 12-year-old daughter, and whose registration requirement was upgraded under the new law from 10 years to life. The court found applying the law retroactively was unconstitutional. Though the law's purported goal is public safety, the court declared it was in fact a new punishment being applied to an offense after the fact (Melamed, 2018).
- The Muniz case left an unanswered question: whether the law more broadly violates due process by unfairly labeling a person as sexually dangerous without first proving that fact and without giving the person an opportunity to challenge that message. Currently, the Pennsylvania Supreme court is considering whether Pennsylvania's current version of SORNA may constitutionally condemn people with sufficient due process. Or, if the law remains punitive, does it violate a host of other constitutional protections which accompany punitive laws, such as the prohibition on cruel and unusual punishment. A decision on this case is expected

sometime in early 2020. For further information, please refer to **Instructor Resource #2: Commonwealth of Pennsylvania v. Jose M. Muniz, J-121B-2016**.

Act 21 of 2003 (42 Pa. C.S. § 6401 – 6409) – Pennsylvania is the only state that civilly commits juveniles but not adults, though they commit juveniles when they age out of the juvenile system. Act 21 (42 Pa.C.S. §6401-6409) allows court-ordered involuntary treatment of certain sexually violent persons who have been adjudicated as juveniles. Act 21 mandates that a person who is committed to an adolescent treatment facility for sex crimes and is about to reach the age of 20, must be identified and referred to the Sex Offender Assessment Board (SOAB) for evaluation to determine if the person has "serious difficulty in controlling sexually violent behavior." If the SOAB determines the person meets the criteria for dangerousness defined in Act 21, and the court determines that a civil commitment is warranted, the person can be committed to the Sexual Responsibility and Treatment Program (SR&TP) operated by the PA Department of Public Welfare, Office of Mental Health and Substance Abuse Services (DPW, OMHSAS). Additional information on the implementation of Act 21 of 2003 can be found in the Juvenile Act §6358.

Display **PowerPoint Slide #38 (Registration Laws & Recidivism)**. Have a large group discussion about the participants' thoughts on the above outlined legislation and the impact that this legislation has on juveniles who engaged in sexually abusive behavior.

> **Instructor Note:** Based on interest, you may also wish to discuss the impact registration has on offenders and their families. This is an optional activity, especially if participants seem uninterested or unwilling to discuss this topic.

Conclude this segment by asking the participants to reflect upon the materials and highlight any areas they might want to note for improvement or change. Ask participants to share their thoughts.

203 Remote: Working with Juveniles Who Sexually Offend

Section VII: Case Planning with the Family

Estimated Length of Time:
1 hour, 50 minutes

Key Concepts:

- The repercussions of sexual abuse impact all family members.
- It is paramount that child welfare professionals develop a positive working relationship with the family because family involvement in case planning and treatment is necessary for positive outcomes regarding safety, permanency, and well-being.
- The child welfare professionals needs to assess family dynamics and understand how these dynamics might be a factor in reducing risk and recidivism.

Methods of Presentation:
Lecture; large group discussion; small group activity

Materials Needed:

- ✓ Zoom Room Flow Chart
- ✓ Managing Zoom Breakout Rooms: Instructor Guide
- ✓ Laptop and shared screen
- ✓ **PowerPoint Slide #39: My Greatest Concern Is…**
- ✓ **PowerPoint Slide #40: Establishing a Positive Working Relationship**
- ✓ **PowerPoint Slide #41: Family Cohesion & Adaptability**
- ✓ **PowerPoint Slide #42: Assessment of Family Dynamics**
- ✓ **Handout #13: Assessment of Family Dynamics** (participants received with registration letter)
- ✓ **Handout #9: Assessment-Part 1** (revisited)
- ✓ **Handout #14: Assessment-Part 2** (participants received with registration letter)

Outline Presentation:

- Conduct an activity which will facilitate the participants' awareness on both thinking and feeling levels of the impact of abuse on all members of a family.
- Discuss how to establish a positive working relationship with the family.
- Review the importance of family involvement in treatment and safety planning.
- Review the importance of assessment of family dynamics and how family dynamics can set up the climate for abuse, but reiterate that these factors are not the cause of the abuse.
- Outline the importance of case planning and the goals of collaborative case planning.

Section VII: Case Planning with the Family

Step 1:
Impact on Family Members

The repercussions of sexual abuse impact all family members. The impact on the family is increased many fold when both the survivor and the juvenile who engaged in sexually abusive behavior are in the same family. The goal of the next activity is to increase participants' awareness of the impact of abuse on all members of a family. Participants will have to tune-in to self to identify and delineate between objective facts and personal bias when working with the following members of a family.

Send participants into the Breakout Rooms. Encourage each group to develop their own case scenario (either made up or based on information related to one of their own case scenarios). Each group must be sure to incorporate the following identities into their case scenario:

1. Child sex abuse survivor
2. Juvenile who engaged in sexually abusive behavior (sibling of the survivor)
3. Father of the survivor
4. Mother of the juvenile who engaged in sexually abusive behavior

After each group has created their case situation to include each of the above listed identities, display **PowerPoint Slide #39 (My Greatest Concern Is…)** and advise each group member is to complete one of the following sentences depending on their assigned identity:

1. Survivor: "I am a molested child, and my greatest concern is..."
2. Juvenile who engaged in sexually abusive behavior: "I molested my sibling and my greatest concern is..."
3. Father: "My child was molested by a brother or a sister and my greatest concern is...."
4. Mother: "My son or daughter molested a brother or sister and my greatest concern is..."

Give each group time for discussion, then ask them to use the same sentence beginnings and add, "and I feel…". Then ask each group to use the Zoom chat to document each family member's response to "My greatest concern" and "I feel." Each group should share their case situation and then report the range of concerns and feelings to the large group.

The instructor should note the differences in the nature of concerns and feelings based on the age of survivor and/or perpetrator and between parents. Typically, survivors feel they are to blame for the abuse and the subsequent disruptions in the family because they disclosed what happened to them. Parents alternate between anger towards the juvenile who engaged in sexually abusive behavior and anger towards themselves for not protecting the survivor and guilt for the same reasons. Often parents feel torn between loyalty to the perpetrator and responsibility towards the survivor. The parents feel pushed to "choose" between two children. Parents may minimize or deny the

impact of the abuse thus discounting the survivor's issues and pain. This is a parallel process to the minimization and denial of the juvenile who engaged in sexually abusive behavior.

Be sure to emphasize to participants that the dynamics of denial are found not only within the family but also among child welfare professionals who serve juveniles and their families. Denial is systemic. Ask participants to discuss these dynamics both as they see them in families and within the child welfare system.

Step 2:
Establishing a Positive Working Relationship

Display **PowerPoint Slide #40 (Establishing a Positive Working Relationship)**. Professionals who are involved in the assessment and treatment of a juvenile who engaged in sexually abusive behavior are encouraged to utilize a variety of strategies when working with the juvenile and his/her family. The child welfare professional (and other professionals) should:

- Develop respectful relationships with the juvenile and his/her family
- Encourage hope and change
- Engage the family in the assessment and treatment process
- Promote an environment for cooperation and compliance

Conduct as large group discussion. Have each small group discuss any barriers that they might face in establishing this positive working relationship with the juvenile and his/her family. Some barriers might include:

- Fear on the part of the juvenile about being sent away or being criminally charged
- Fear and distrust of the child welfare system
- Struggles on the part of the child welfare professional to trust the juvenile and his/her family
- The child welfare professional’s lack of hope that the juvenile or family can change
- The juvenile and/or family’s denial that sexual offending occurred

By establishing a positive working relationship with the juvenile and his/her family, all parties will be much more motivated to work collaboratively. This will allow for more open communication during the assessment and treatment process.

Step 3:
The Importance of Family Involvement

Family or caretaker involvement is an integral part of working with juveniles who engaged in sexually abusive behavior. Parent/family roles in the process include: providing critical developmental information, participating in treatment, and becoming a partner in the treatment process. Remind participants that cultural beliefs will play a role in the family's understanding of the role of treatment. Families may need extra help in

understanding sexual abuse, the dynamics associated with offending behavior, and the need for treatment in order to prevent future offending, etc. This understanding can help families understand and actively participate in treatment and other interventions.

As with the juvenile's treatment, family treatment requires a paradigm shift in conceptualization about the goals of intervention and approach. The primary goal of offense-specific treatment for the family is the same as the primary goal in offense-specific treatment for the juvenile: to prevent re-victimization of a victim or victims or further victimization of other victims. In offense-specific family treatment, the victim is the client and the goal is to protect the victim and others in the community. Work with the family requires sensitivity and understanding of the culture of each family.

Step 4:
Family Dynamics

Family cohesion measures the degree to which family members are separated from or connected to each other. It is defined as the emotional bonding that family members have toward one another. The extremes of the cohesion continuum are: disengaged and enmeshed. Specific concepts used to describe the cohesion dimension are: emotional bonding, boundaries, coalitions, time, space, friends, decision-making, interests, and recreation.

An enmeshed family would manifest a lack of boundaries, secrecy both within and between family and the outside world, limited privacy, sexual and otherwise, and no self-identity. The family functions under the umbrella of a communal identity. There may be anxiety about the child's sexual behaviors reflecting on the whole family.

A disengaged family demonstrates an environment with rigid and extremely high standards. In this climate a child cannot develop her own self-regulation. Family members feel emotionally abandoned. There is tension and/or distance around sexual matters and evasion on sexual issues. Sex is something to be discovered, not discussed.

Family adaptability has to do with the extent to which the family system is flexible and able to change. The extremes of the adaptability dimension are: rigid and disengaged. Family adaptability is the ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situating and developmental stress. Specific concepts used to describe the adaptability dimension are: family power (assertiveness, control, and discipline), negotiation style, role relationships, and relationship rules.

A chaotically organized family might evidence a lack of accountability for sexual issues, disparity in values and behaviors with inconsistent standards, and consequences among family members. The children have no identity outside of the family and within the family there is little respect for personal space.

Characteristics of a rigid family are:

- "Right" or "wrong" thinking
- Extreme moralistic orientation
- Extreme control with severe punishment for minor transgressions.

Interestingly, these families are often intact units.

There are two typical patterns for families of adolescents who sexually abuse: the chaotically enmeshed family and the rigidly disengaged family. The first, the chaotically enmeshed, produces a less aggressive type of juvenile who usually offends against younger, smaller, less powerful children. The second produces the more aggressive juvenile who tends to victimize peers.

Display **PowerPoint Slide #41 (Family Cohesion & Adaptability)** and use the visual as a guide in the following discussion.

The instructor should then redirect the participants to reference. Suggest that they may want to take notes on their handout as the group discusses these different dynamic/types. Note that the full handout was included with their registration letter if they prefer to access for later reference. Then display **Handout #13 (Assessment of Family Dynamics)** with the descriptions of the different types. After review of the definition of each of these types, ask participants to share any experiences they have had with families who have demonstrated these characteristics. Ask the participants to discuss how these factors can set up the climate for abuse. Reiterate that these factors are not cause and effect, but climate setting. After discussion of each type, have participants identify at least two different interventions/approaches/techniques that they would use with each of these types in order to overcome barriers and build collaboration.

Over-involvement or Enmeshment: The physical, emotional, psychological, and/or sexual boundaries in the family may be blurred or non-existent. Generational boundaries (who is the parent or who is the child) and family members' personal space are not respected.

Isolation: The outside world may be seen as hostile, and the family has closed itself off. This has led to family secrecy, loss of perception or reality checks, and a lack of support systems in the community.

Extreme External and Internal Stress: The family has a large number of intra- and extra-familial problems, including debts, illness, legal difficulties, and extended-family conflict. Constant exposure to stress weakens family resources. Coping mechanisms may be poor or maladaptive.

Intergenerational Sexual and/or Physical Abuse: Juveniles who have engaged in sexually abusive behavior and other family members may have been victims of abuse or may have been abusive, sometimes dating back generations. It is not uncommon for

the juvenile to have been abused by older family members and for his/her parents to have been victimized as well.

Impaired Communication Styles: Communication patterns tend to be indirect, with feelings and thoughts expressed through behavior or in such obscure ways that family members often misunderstand one another.

Conflicting Parental Relationship Styles: Relations may either be too close or too distant (for example, the father is sometimes emotionally distant while mother is enmeshed). There is often inadequate control and an erratic limit setting.

Emotional Deprivation: Emotional needs for nurturance and closeness typically are not met and skills in this area are limited.

Abuse of Power: Family members, particularly parents, do not know how to use power, often reacting to external stimuli, instead of responding to an internal value system.

Step 5:
Goals of Case Planning

Keeping the survivor safe is the first goal in case planning. To that end, best practice usually recommends that the juvenile that has engaged in sexually abusive behavior be removed from the home throughout the assessment and case planning process, if the survivor lives in the home. This lessens the risk to the victim, sends a strong message that sexual victimization is wrong, and focuses the responsibility for the abuse on the perpetrator. With very young children with sexual behavior problems, however, it is recommended they be kept at home, assuming adequate supervision for the survivor. The young child's sense of security, identity, and coping ability are tied to and dependent on their familial relationships and their home environment. Removal from the home may seriously jeopardize the child developmentally, emotionally, cognitively, and physically. Of course, there are always exceptions to any rule. The exceptions depend on severity and frequency of the offending behaviors, the protective capacities of the caretaker to keep the survivor safe, and to manage the offending behaviors in the home setting. The safety of all individuals involved with the juvenile must be evaluated in deciding whether to remove the juvenile who engaged in sexually abusive behavior.

All juveniles and their families (biological, adoptive, foster, and kinship) need to be in treatment. The juvenile needs to gain control over his/her offending behaviors and the family needs to be supported in dealing with the offending behaviors and the impact that it has on all parties. In interfamilial abuse, the family has the complicated challenge of having a juvenile who engaged in sexually abusive behavior and survivor in the same family. Treatment has a better prognosis if the entire family is involved in the treatment to support the juvenile and to work on any areas in their lives that support the juvenile’s use of abuse to cope with his/her life situation.

Step 6:
Services Needed by the Family, Juvenile Who Engaged in Sexually Abusive Behavior, and Survivor

To give the participants experience in utilizing an assessment and planning appropriate interventions for each member of the family, distribute **Handout #14 (Assessment-Part 2)**. Ask participants to review the previous case example from **Handout #9 (Assessment-Part 1)** and to make recommendations for supervision and treatment for the juvenile who engaged in sexually abusive behavior and the family.

Send participants into the three Breakout Rooms with instructions to address the following questions, as listed in **Handout #14 (Assessment-Part 2)**:

1. Was this case appropriate for legal prosecution?
2. What intervention components are most critical?
    a. Can John remain at home? If not, where should John be placed?
3. What services are needed by John?
4. What services are necessary for John's parents?
5. What are the services needed by the survivor(s)?
6. What safeguards need to be implemented during assessment and treatment?
7. What do you, the child welfare professional, need to do now that the assessment is complete?
8. Who needs to know about the results?

Ask the group to report their recommendations to the full group with the instructor facilitating full group discussion when appropriate. Child welfare professionals will need to synthesize their understanding of balancing cost of services, risk to the community, pragmatic limitations, etc. It is good to address this case from both a "best practice" approach and a "what's available" approach.

In an ideal situation, it would be possible to involve the juvenile and his/her family in a comprehensive continuum of treatment services. For the juvenile, group treatment is usually recommended with individual treatment as needed; for the non-offending parents, group involvement can offer support and opportunities for education around the survivor and offending issues. Group treatment is usually preferred for the child victim as well, since group offers the survivor the understanding that he/she is not the only one to be victimized. The survivor will need some individual work, particularly if the abuse has been long standing and the family system has been dysfunctional. Ideally, family treatment would also be available at some point during the process. In practice, family treatment often begins in dyads: marital work with parents if needed, the juvenile and one parent, the survivor and one parent moving on to the survivor and/or juvenile and both parents. Reunification work is addressed fully in the next section.

Conclude this segment by asking the participants to reflect upon the materials and highlight any areas they might want to note for improvement. Ask participants to share what they will use and ways this may inform their work.

203 Remote: Working with Juveniles Who Sexually Offend

Section VIII: Reunification and Case Closure

Estimated Length of Time:
40 minutes

Key Concepts:

- Child welfare professionals must understand the nature of juveniles who engaged in sexually abusive behavior and the critical treatment milestones that the juvenile, family, and survivor must achieve before reunification can be considered.

Methods of Presentation:
Lecture; Large Group Discussion

Materials Needed:

- ✓ Zoom Room Flow Chart
- ✓ Laptop and shared screen
- ✓ **PowerPoint Slides #43, #44, and #45: Treatment Milestones Necessary for Reunification**
- ✓ **PowerPoint Slide #46: Typical Safety Plan Rules**
- ✓ **Handout #15: Process for Reunification** (participants received with registration letter)

Outline Presentation:

- There are some common treatment milestones that should occur prior to reunification.
- Throughout treatment, the child welfare professional should consider the process of reunification.

Section VIII: Reunification and Case Closure

Step 1:
Reunification Issues

Ask participants to brainstorm specific concerns they have when thinking about reunifying a juvenile with his/her family, especially if the survivor is in the home. Display **PowerPoint Slide #43 (Treatment Milestones Necessary for Reunification)**. Instructor should introduce the handout by stating that reunification should only be attempted if the following treatment milestones have been achieved. The instructor should explain how important it is that the family and juvenile understand that reunification is dependent on goal attainment and not on a specific timetable.

Explain that this handout delineates the "perfect" recovery process. Rarely, is the ideal attainable in practice. Therefore, the decision to reunify must be a joint decision between all players involved: probation officer, treatment providers, caseworkers, *guardian ad litem*, and CASA workers. The instructor should emphasize that the survivor's needs always take precedence in planning for reunification. The safety of the survivor and the community is the bottom line in deciding whether to reunify. Review the milestones. Continue to review/display **PowerPoint slides #44 and #45 (Treatment Milestones Necessary for Reunification, Cont'd)**. Encourage large group discussion of some of the milestones, the importance of each of them, potential problems, and interventions used by participants when negotiating the reunification process.

Treatment Milestones Necessary for Reunification

- ✓ All family members must have acknowledged the abuse and must understand the importance of holding the juvenile accountable.
- ✓ Adult family members must fully understand what is necessary to protect past and potentially future victims. A review and understanding of the context of the situation in which the juvenile who engaged in sexually abusive behavior and/or acted out in the past is helpful to identify all of the interventions and changes which need to be made to assure continued safety, to include level and type of supervision, access to potential victims, etc.
- ✓ The survivor must have a support system and must be able to talk openly about the abuse with the therapist and parent or caretaker.
- ✓ The juvenile must have identified his/her offending thoughts, feelings and behaviors, discussed high risk situations, grooming behavior and safety plans with all family members or caretakers.
- ✓ The juvenile must understand the damage resulting from his/her offenses.
- ✓ The parents or caretakers must not minimize or trivialize the offensive behavior and must be committed to the supervision necessary when the juvenile re-enters the home.
- ✓ Parents and caretakers must understand how their own history, sexual beliefs, and experiences impact their child's safety and recovery.
- ✓ The family and/or caretakers must have established physical and personal boundaries for family members.

- ✓ Concurrent diagnostic problems such as substance abuse or psychiatric disorders must have been treated.
- ✓ The family must utilize therapy or other community resources freely and must be expanding their network of extra-familial support.
- ✓ The family and/or caretakers must have openly developed a safety plan which includes direct instruction for children to report future offending and names of extra-familial adults to whom reports can be made. The family should be able to identify possible early indicators of abuse and should be invited to return to treatment if needed.
- ✓ All family members must understand that the potential for re-offending exists.

Step 2:
Process of Reunification

The reunification process is a gradual one which may occur over a considerable period of time, but issues surrounding reunification should be considered throughout the assessment and treatment process. The length of time in treatment is highly variable and may depend upon the length of time the court orders treatment and the degree to which the court supports treatment recommendations regarding separating the survivor and the juvenile who engaged in sexually abusive behavior. The process should be managed by the child welfare professional, the survivor's therapist, and the juvenile's therapist. Each new step should be carefully planned and gradually introduced after the previous steps have been successfully completed.

Address the concern that regardless of how successful the juvenile was at managing his/her issues in treatment while living away from home, entry back into the home is a powerful force. Reentry may trigger old behaviors, feelings, and thoughts. Old patterns of behavior can resurface for every family member, as well as old feelings that family members have not yet resolved. If reunification is to be successful, everyone in the family system, not just the juvenile, must be ready. This is a difficult and complicated period for the family and requires the maintenance of an open case and careful monitoring by the caseworker and therapists.

Identify that **Handout #15 (Process for Reunification)** was included with the registration letter. Briefly review the handout and discuss the nature of a reunification safety plan. Then display **PowerPoint Slide #46: Typical Safety Plan Rules**. Discuss that this safety plan must be developed by the juvenile who engaged in sexually abusive behavior with the help of the therapist, probation officer, and family members or caregivers. Ideally, a safety plan is created immediately after the offense is revealed (during the assessment process) and is amplified or modified during the intervention process as more information is gathered regarding family dynamics and the juvenile's offense-specific treatment issues. Then the safety plan is modified again at reunification.

The safety plan is a group of rules developed conjointly with the juvenile who engaged in sexually abusive behavior and the family with the focus on keeping the survivor, the

family, and the community safe. This plan would include prohibition of certain behaviors and situations such as caretaking of younger children, being alone at playgrounds, fairs, etc., avoiding certain types of activities, videos, movies, music, and the use of alcohol and drugs. The plan would include specific house rules and structure within the home aimed at keeping the survivor safe and the juvenile out of high-risk situations. A plan is also formulated to give explicit permission to everyone involved about how they are to monitor for safety and what they are to do if they believe that the juvenile is not following the safety plan. The young juvenile who engaged in sexually abusive behavior and the caregiver(s) must give sincere, explicit permission to the survivor or potential victims in the family, to disclose any problems to the caregiver(s), therapist, or child welfare professional. Everyone must see interrupting problems and calling for help as a positive, necessary response, not an attack on the family or juvenile. If the juvenile is reaching the age of majority or otherwise going on to live independently, the safety plan should include as many supportive people as possible to help him or her maintain non-abusive behaviors.

During the discussion, emphasize the following points:

- The needs of the survivor have priority; if he/she is not ready, meetings should be postponed until the survivor is ready
- Individual therapy should continue between these visits so that the survivor, in particular, has an opportunity to discuss his/her comfort and feelings of safety
- The visit should be terminated if the survivor becomes uncomfortable. No explanation is due to the juvenile who engaged in sexually abusive behavior; instead, the survivor should tell one of the family members or caretakers that he/she wishes to leave, and the visit ends
- Issues arising during the visits should be discussed and resolved preferably in the therapist's office
- The safety plan should be updated

Step 3:
Closing the Case

The decision to close a sexual abuse case is always difficult and should be made with the assistance of the child welfare professional's supervisor along with other members involved in the multi-disciplinary investigative team (MDIT). Prior to case closure, the child welfare professional should review all of the safety threats and risk factors associated with the abuse as well as the caregivers' protective capacities. The case should be closed only when the risk associated with all of the factors are considered low. In addition, the following must be in place to close the case.

Ask group participants to share their ideas on factors and indices that show that cases are ready to be closed. Additionally, ask participants to share and identify steps important to consider when closing a case.

- The juvenile who engaged in sexually abusive behavior must consistently implement the relapse prevention plan (i.e.: stop sexual thoughts about potential victims; remove him/herself from events, situations, and objects that triggered the sexualized thoughts and feelings, etc.)
- The juvenile who engaged in sexually abusive behavior and any family members must be committed to seeking help when they identify early indicators of sexual abuse, and must be willing to implement a safety plan if necessary. The safety plan should have been developed in a family meeting with all family members and their support people present.
- The child welfare professional should consider the following activities in the process of closing the case:
    - The number and intensity of child welfare professional contacts with the juvenile should gradually decrease over a time period of several months prior to case closure
    - The family should be helped and encouraged to function autonomously, or with the assistance of support people in their environment
- Casework tasks include monitoring the reunification process, and making sure critical information gets disseminated to all professionals

A willingness to keep the case open continues to be a primary casework responsibility. This places child welfare professionals in a sensitive and difficult position within their agencies since agency policy usually supports early case closure and family reunification. The instructor is encouraged to offer an understanding of these difficult agency issues and ask what they learned in this training today might help them advocate for their families involved in a juvenile sex offender case.

Conclude this segment by asking the participants to reflect upon the materials and highlight any areas they might want to note for improvement. Ask participants to share what they learned.

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Section IX: Closing and Evaluation

Estimated Length of Time:
30 minutes

Key Concepts:
- Utilizing an action plan will encourage participants to apply what is learned.
- Additional resources are available for further reference.

Methods of Presentation:
Lecture; large group discussion; individual activity

Materials Needed:
- ✓ Zoom Room Flow Chart
- ✓ Handout #2: What's In It For Children and Families (revisited)
- ✓ **Handout #16: Additional Resources** (participants received with registration letter)
- ✓ **Handout #17: References**
- ✓ **Electronic device (1 per participant)**

Outline Presentation:
- Formulate and review the action plan
- Point out that additional resources are available

Section IX: Closing and Evaluation

Step 1:
Action Planning and References

Ask participants to reflect on the two days of training and identify one or two things learned that will impact their work with clients.

Then display **Handout #2 (What's In It For Children and Families?)**. Review the information recorded at the beginning of the module and address any information that was not covered during the training session.

Advise participant that **Handout #16 (Additional Resources)** was included with the registration letter and display **Handout #17 (References)** on the shared screen and/or provide to participants using the chat feature.

Step 2: Conclusion and Evaluation

Thank participants for their participation and attention. Open Bridge and navigate to the manage check in screen and change the date in the "Attendance Date" field to the current date. Record the attendance for Day 2, followed by clicking the "Close Daily Attendance" button.

Finally, ask participants to log in to Bridge and complete their evaluation. Workshop evaluations are sent to each participant's que on their home screen of Bridge when their attendance has been confirmed on the last day of the workshop. These evals will not show up in the participant's que until their attendance is confirmed, and the workshop daily attendance has been closed.

Explain that this is their opportunity to provide feedback on the training and that the Resource Center values their critical and candid feedback.

Offer assistance to anyone having difficulty accessing or using the evaluation form.

Instructor Note: Participants will use their E-Learn username to enter Bridge. There is a tool tip below the field to remind them of how to determine their username. The form was built in responsive design, so it is phone and mobile device friendly.

Instructor Note: Paper participant feedback forms will no longer be provided. If a participant is unable or unwilling to complete the feedback form at the end of the session, please let them know that they may complete the feedback form after the training on their own time.

References

Association for the Treatment of Sexual Abusers. (2017). *Practice guidelines for assessment, treatment, and intervention with adolescents who have engaged in sexually abusive behavior*, Beaverton, OR: ATSA.

Awad, G., Saunders, E., & Levene, J. (1984). A clinical study of male adolescent sex offenders. *International Journal of Offender Therapy and Comparative Criminology*, 28(2).

Becker, J. V. (1998). What we know about the characteristics and treatment of adolescents who have committed sexual offenses. *Child Maltreatment*, *3*(4), 317-329.

Becker, J. & Murphy, W. (1998). What we know and don't know about assessing and treating sex offenders. *Psychology, Public Policy, and Law, 4*, 116–137.

Beresin, G. (2012). Research shows violent media do not cause violent behavior. *MassGeneral Hospital for Children News*. Retrieved on February 27, 2015 from http://www.massgeneral.org/children/news/newsarticle.aspx?id=3929

Bonner, Barbara L. (2009). *Taking Action: Support for Families of Adolescents with Illegal Sexual Behavior.* Safer Society Press.

Briere, J. (1996). *Trauma symptom checklist for children (TSCC), professional manual*. Odessa, FL: Psychological Assessment Resources.

Briere, J. (2005). *Trauma symptom checklist for young children (TSCYC), professional manual*. Odessa, FL: Psychological Assessment Resources.

Brown, J., Flanagan, T. J., & McLeod, M. (1984). *Sourcebook of criminal justice statistics–1983*. Washington DC: Bureau of Justice Statistics.

Burton, D., Foy, D., Bwanausi, C., Johnson, J., & Moore, L. (1994). The relationship between traumatic exposure, family dysfunction, and post-traumatic stress symptoms in male juvenile offenders. *Journal of Traumatic Stress, 7(1),* 83-93. http://dx.doi.org/10.1007/BF02111914

Butts, J. A., & Snyder, H. N. (1997). The youngest delinquents: Offenders under age 15. *Juvenile Justice Bulletin*, 1-11.

Caldwell, M.F. (2016). Quantifying the decline in juvenile sexual recidivism rates. *Psychology, Public Policy, and Law*, *22(4)*, 414-426. http://dx.doi.org/10.1037/law0000094

Cauffman, E., Feldman, S., Waterman, J., & Steiner, H. (1998). Posttraumatic stress disorder among female juvenile offenders. *Journal of the American Academy of Child and Adolescent Psychiatry, 37(11),* 1209-1216. http://dx.doi.org/10.1097/00004583-199811000-00022

Center for Disease Control and Prevention. (2019). *Adverse childhood experiences (ACEs)*. Retrieved on May 16, 2019 from https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html

Center for Sex Offender Management. (n.d.). *The impact of sexual assault on secondary victims.* Retrieved on May 16, 2019 from https://www.csom.org/train/victim/2/2_7.htm

Commonwealth of Pennsylvania. (2014). *The Child Protective Services Law (23 Pa.C.S. Chapter 63)*.

Delmonico, D.L. & Griffin, E.J. (2007). *Internet sex screening test – adolescent*. Retrieved on May 16, 2019 from https://www.researchgate.net/figure/Internet-Sex-Screening-Test-Adolescent-version-C-2007-Delmonico-Griffin_fig1_23481408

Department of Corrections, Washington State. (n.d.). Risk-Need-Responsivity model. Retrieved on February 27, 2015 from http://offenderchange.org/programs/risk-need-responsivity-model/

Efta-Breitbach, J. &Freeman, K. A. (2004). Treatment of juveniles who sexually offend: An overview. *Journal of Child Sexual Abuse*, Vol. 12 (3/4), 125-138.

Etchells, P. (2013, September 19). What is the link between violent video games and aggression? Retrieved on May 16, 2019 from https://www.theguardian.com/science/head-quarters/2013/sep/19/neuroscience-psychology

Fanniff, A. M., & Becker, J.V. (2006). Specialized assessment and treatment of adolescent sex offenders. *Journal of Aggression and Violent Behavior,* 11, 265-282.

Fernandez, Y. (2002). *In their shoes: Examining the issue of empathy and its place in the treatment of offenders.* Oklahoma City, OK: Wood 'N' Barnes Publishing & Distributors.

Freeman, K.A., Dexter-Mazza, E.T., & Hoffman, K.C. (2005). Comparing personality characteristics of juvenile sex offenders and non-sex Offending delinquent peers: A preliminary investigation. *Sex Abuse: A Journal of Research and Treatment*, 17 (1), 3-12.

Gil, E. & Johnson, T.C. (1993). *Sexualized children: Assessment and treatment of sexualized children who molest*. Rockville, MD: Launch Press.

Good Lives Model. (2015). The good lives model of offender rehabilitation. Retrieved on February 27, 2015 from http://www.goodlivesmodel.com/information#General

Gray, A.S. & Pithers, W.D. (1993). Relapse prevention with sexually aggressive adolescents and children: Expanding treatment and supervision. In H.E. Barbaree, Marshall, W.L., & Hudson, S.M. (Eds.). *The Juvenile Sex Offender*, (pp. 289-318). New York, NY: Guilford.

Hanson, R.K., and Bussiere, M.T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology*, 66 (2), 348-362.

Hanson, R. K., & Morton-Bourgon, K. (2004). Predictors of sexual recidivism: An updated meta-analysis. User Report 2004-02. Ottawa: Public Safety and Emergency Preparedness Canada.

Hanson, R. K. & Morton-Bourgon, K. E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology*, 73, 1154-1163.

Hanson, R.K. &Harris, A. (2000). The Sex Offender Needs Assessment Rating (SONAR): A Method for Measuring Change in Risk Levels 2000-1.

Hunter, J.A.,&Lexier, L.J. (1998). Ethical and legal issues in the assessment and treatment of juvenile sex offenders. *Child Maltreatment*, *3*, 339-349.

J-44A-G-2014, Supreme Court of Pennsylvania, Middle District (December 29. 2014). Retrieved on February 27, 2015 from

http://www.pacourts.us/assets/opinions/Supreme/out/J-44A-2014mo%20-%201020571522958825.pdf

J-121B-2016, Supreme Court of Pennsylvania, Middle District (July 19, 2017). Retrieved on May 16, 2019 from http://www.pacourts.us/assets/opinions/Supreme/out/J-121B-2016oajc%20-%2010317692521317667.pdf?cb=1

Johnson, T.C. (2001). Understanding the sexual behavior of children. *The Child Care Worker*, Vol. 13, No. 6

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

Johnson, T.C. (2009). *Helping children with sexual behavior problems: A guidebook for professionals and caregivers*. (4th ed). San Diego, CA: Institute on Violence, Abuse and Trauma.

Johnson, T.C. (1988). Sexuality curriculum for abused children, youth adolescents, and their parents.

Johnson, T.C. (2007). Understanding children's sexual behaviors: What's natural and healthy. San Diego, CA: Institute on Violence, Abuse and Trauma.

Juvenile & Family Court Journal. (1993). The revised report from the national task force on juvenile sexual offending of the national adolescent perpetrator network, 44 (4), 19.

Kiser, L.J., Heston, J., Millsap, P.A., & Pruitt, D.B. (1991). Physical and sexual abuse in childhood. Relationship with post-traumatic stress disorder. *Journal of the American Academy of Child and Adolescent Pychiatry, 30(5),* 776-783. http://dx.doi.org/10.1016/S0890-8567(10)80015-2

Laws, D. R., & Marshall, W. L. (2003). A brief history of behavioral and cognitive behavioral approaches to sexual offender treatment: Part 1. Early developments. *Sexual Abuse: A Journal of Research and Treatment, 15*, 75–92.

Letourneau, E.J. & Miner, M.H. (2005). Juvenile sex offenders: A case against the legal and clinical status quo. *Sex Abuse: A Journal of Research and Treatment*, 17 (3), 293-312.

Mann, R.E. & Barnett, G.D. (2012). Victim empathy intervention with sexual offenders: Rehabilitation, punishment, or correctional quackery? *Sexual Abuse: A Journal of Research and Treatment*, 25(3). Retrieved on February 27, 2015 from http://sax.sagepub.com/content/25/3/282.full.pdf+html

Marcus, A.J. (2019). *PA high court will again review sex offender registration*. Retrieved on May 16, 2019 from https://ccresourcecenter.org/2019/04/09/pa-high-court-will-again-review-sex-offender-registration/#more-19188

Marshall, W. L., & Laws, D. R. (2003). A brief history of behavioral and cognitive behavioral approaches to sexual offender treatment: Part 2. The modern era. *Sexual Abuse: A Journal of Research and Treatment, 15*, 93–120.

McMackin, R., Cusack, J., & LaFratta, J. (2001). [Trauma exposure among sex offenders: A survey of sex offender therapists]. Unpublished raw data.

McMackin, R.A., Leisen, M., Cusack, J.F., LaFratta, J., & Litwin, P. (2002). The relationship of trauma exposure to sex offending behavior among male juvenile offenders. *Journal of Child Sexual Abuse, 11(2),* 25-40. https://doi.org/10.1300/J070v11n02_02

McMackin, R., Morrissey, C., Newman, E., Erwin, B., & Daly, M. (1998). Perpetrator and victim: Understanding and managing the traumatized young offender. *Corrections Management Quarterly, 2(1),* 35-44. https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=170505

McManus, M.A., Hargreaves, P., Rainbow, L., & Alison, L.J. (2013). Paraphilias: definition, diagnosis and treatment. *F1000Prime Reports*. Retrieved on December 3, 2014 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3769077/

Melamed, S. (2018). *Thousands of Pennsylvania sex offenders no longer have to register. Should lawmakers put them back on a list for life?* Retrieved on May 16, 2019 from https://www.philly.com/philly/news/364467-sex-offenders-megans-law-pennsyvlania-sorna-adam-walsh-jerry-sandusky-20180205.html

Miranda, A. O. & Corcoran, C.L. (2000). Comparison of perpetration characteristics between male juvenile and adult sexual offenders: Preliminary results. *Sexual Abuse: A Journal of Research and Treatment*, 12, 170-188.

Motivational Interviewing Network of Trainers. (2013). What is motivational interviewing? Retrieved on December 3, 2014 from http://www.motivationalinterviewing.org/

Nussbaum, A. M. (2013). *The pocket guide to the DSM-5: Diagnostic exam*. Arlington, VA: American Psychiatric Publishing.

Office of Justice Programs, Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking. (n.d.). Sorna. Retrieved on February 27, 2015 from http://www.smart.gov/sorna.htm

Oneal, B.J., Burns, L., Kahn, T.J., Rich, P., & Worling, J.R. (2005). *Treatment progress inventory for adolescents who sexually abuse* [PDF]. Retrieved on May 16, 2019 from http://www.philrich.net/uploads/1/4/1/4/14142410/tpi-asa.pdf

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

Prescott, D.S. (2006). *Risk Assessment of Youth Who Have Sexually Abused*. Oklahoma City, OK: Wood 'N' Barnes Publishing.

Prescott, D.S. & Tabachnick, J. (2016). *Documenting the decline in sexual recidivism rates among adjudicated adolescents* [PDF]. Retrieved on May 16, 2019 from https://nearipress.org/wp-content/uploads/2017/10/nearinewsletteraugust2016.pdf

Prescott, D.S. & Tabachnick, J. (n.d.) *Impact of treatment on whether a sexual offender will reoffend*. Can be retrieved with membership from nearipress.org

Prentky, R., Harris B., Frizzell, K., & Righthand, S. (2000). An actuarial procedure for assessing risk with juvenile sex offenders. *Sex Abuse: A Journal of Research and Treatment*, 12, 71-93.

Prentky, R., and Righthand, S. (2003). *Juvenile sex offender assessment protocol-II (J-SOAP-II): Manual* [PDF document]. Retrieved on May 16, 2019 from https://www.csom.org/pubs/jsoap.pdf

Rasmussen, L.A. (2004) Differentiating youth who sexually abuse: Applying a multidimensional framework when assessing and rreating subtypes. *Journal of Child Sexual Abuse,* Vol. 13, No. 3 - 4.

Rasmussen, L.A., Burton, J.E., & Christopherson, B. (1990). *Interrupting precursors to perpetration in males ages four to twelve*. Paper presented at the annual conference of the National Adolescent Perpetrator Network, Albany, NY.

Ronis, S.T. and Borduin, C.M. (2007). Characteristics of Male Juvenile Sexual Offenders. *ATSA Forum*, Winter 2007.

Saunders, E., Awad, G. A., & White, G. (1986). Male adolescent sexual offenders: The offender and the offence. *Canadian Journal of Psychiatry*, 31, 542-549.

Schmucker, M. & Losel, F. (2015). The effects of sexual offender treatment on recidivism: An international meta-analysis of sound quality evaluations. *Journal of Experimental Criminology, 11(4)*, 597-630. http://dx.doi.org/10.1007/s11292-015-9241-z

Silovsky, J. F.,&Niec, L. (2002). Characteristics of young children with sexual behavior problems: A pilot study. *Child Maltreatment*, *7*(3), 187-197.

Smith, S., & Thornberry, T.P. (1995). The relationship between childhood maltreatment and adolescent involvement in delinquency. *Criminology, 33(4)*, 451-481. http://dx.doi.org/10.1111/j.1745-9125.1995.tb01186.x

Snyder, H. (2002, November). Juvenile Arrests 2000. OJJDP Juvenile Justice Bulletin (Cooperative Agreement No. 1999-JN-FX-K002). Washington, DC: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice.

Steiner, H., Garcia, I.G., & Matthews, Z. (1997). Posttraumatic stress disorder in incarcerated juvenile delinquents. *Journal of American Academy of Child and Adolescent Psychiatry, 36(3),* 357-365. http://dx.doi.org/10.1097/00004583-199703000-00014

Thomas, J. (1991). The adolescent sex offender's family in treatment. In G. Ryan and S. Lane (eds), *Juvenile Sexual Offending: Causes, Consequences, and Correction*. San Francisco, CA: Jossey-Bass.

U.S. Department of Justice, Office of Justice Programs. Center for Effective Public Policy (2007)

U.S. Department of Justice, Office of Justice Programs. (2006). *Understanding treatment for adults and juveniles who Have committed sex offenses*.

U.S. Department of Justice, Office of Justice Programs. (2007). *The importance of assessment in sex offender management : An overview of key principles and practices*.

van Wijk, A., et. al. (2005). Violent juvenile sex offenders compared with violent juvenile non-sex offenders: Explorative findings from the Pittsburgh youth study. *Sex Abuse: A Journal of Research and Treatment*, 17 (3), 333-354.

Waite, D., et. al. (2005). Juvenile sex offender re-arrest rates for sexual, violent nonsexual and property crimes: A 10-year follow-up. *Sex Abuse: A Journal of Research and Treatment*, 17 (3), 313-331.

Ward, T., Polaschek, D. L. L., & Beech, A. R. (2006). *Theories of sexual offending*. West Sussex, England: John Wiley & Sons, Ltd.

Weeks, R., & Widom, C.S. (1998). Self-reports of early childhood victimization among incarcerated adult male felons. *Journal of Interpersonal Violence, 13(3),* 346-361. http://dx.doi.org/10.1177/088626098013003003

Widom, C.S. (1995). *Victims of childhood sexual abuse – later criminal consequences* [PDF document]. Retrieved on May 16, 2019 from https://www.ncjrs.gov/pdffiles/abuse.pdf

Worling, J.R. (2006). Assessing sexual arousal with adolescent males who have offended sexually: Self-report and unobtrusively measured viewing time. *Sex Abuse: A Journal of Research and Treatment*, 18, 383-400.

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

Worling, J.R. (2017). *Protective + risk observations for eliminating sexual offense recidivism* (PROFESOR). Retrieved on May 16, 2019 from https://www.profesor.ca/

Yates, P.M. (2010). The self-regulation model of sexual offending: Relationship to risk, criminal diversity, treatment change, and good lives [PowerPoint presentation]. Retrieved on February 27, 2015 from http://www.atsa.com/sites/default/files/ConfHO2010Yates.pdf

Yates, P.M. & Kingston, D.A. (2006). The self-regulation model of sexual offending: The relationship between offence pathways and static and dynamic sexual offence risk. *Sexual Abuse: A Journal of Research and Treatment*, 18. Retrieved on February 27, 2015 from http://sax.sagepub.com/content/18/3/259.full.pdf+html

Yeatter, J. (2007). *Building a foundation for work with youth who sexually act out and/or offend*. Presented at a training sponsored by Juvenile Justice in Allentown and Westmoreland County in 2007.

Yeatter, J. & Goodling, C. (2009). *Inappropriate Sexual Behavior in Children and Adolescents: Victims and Offenders.*

CPSL Definition of "Sexual Abuse or Exploitation" (§6303 Definitions)

Includes any of the following:

1. The employment, use, persuasion, inducement, enticement or coercion of a child to engage in or assist another individual to engage in sexually explicit conduct, which includes, but is not limited to, the following:
    i. Looking at the sexual or other intimate parts of a child or another individual for the purposes of arousing or gratifying sexual desire in any individual.
    ii. Participating in sexually explicit conversation either in person, by telephone, by computer or by a computer-aided device for the purpose of sexual stimulation or gratification of any individual.
    iii. Actual or simulated sexual activity for the purpose of producing visual depiction, including photographing, videotaping, computer depicting or filming.

This paragraph does not include consensual activities between a child who is 14 years of age or older and another person who is 14 years of age or older and whose age is within four years of the child's age.

2. Any of the following offenses committed against a child:
    i. Rape as defined in 18 Pa.C.S. §3121 (relating to rape).
    ii. Statutory sexual assault as defined in 18 Pa.C.S. §3122.1 (relating to statutory sexual assault).
    iii. Involuntary deviate sexual intercourse as defined in 18 Pa.C.S. §3123 (relating to involuntary deviate sexual intercourse).
    iv. Sexual assault as defined in 18 Pa.C.S. §3124.1 (relating to sexual assault).
    v. Institutional sexual assault as defined in 18 Pa.C.S. §3124.2 (relating to institutional sexual assault).
    vi. Aggravated indecent assault as defined in 18 Pa.C.S. §3125 (relating to aggravated indecent assault).
    vii. Indecent assault as defined in 18 Pa.C.S. §3126 (relating to indecent assault).
    viii. Indecent exposure as defined in 18 Pa.C.S. §3127 (relating to indecent exposure).
    ix. Incest as defined in 18 Pa.C.S. §4302 (relating to incest).
    x. Prostitution as defined in 18 Pa.C.S. §5902 (relating to prostitution and related offenses).
    xi. Sexual abuse as defined in 18 Pa.C.S. §6312 (relating to sexual abuse of children).
    xii. Unlawful contact with a minor as defined in 18 Pa.C.S. §6318 (relating to unlawful contact with minor).
    xiii. Sexual exploitation as defined in 18 Pa.C.S. §6320 (relating to sexual exploitation of children).