California Coalition On Sexual Offending
CCOSO Quarterly Newsletter
Perspectives
Summer 2005

Adapted from:

Prescott, D.S. & Longo, R.E. (2005 in press). Chapter One. Current perspectives: working with young people who sexually abuse. In R.E. Longo & D.S. Prescott (Eds.) *Current perspectives: Working with sexually aggressive youth and youth with sexual behavior problems*. Holyoke, MA: NEARI Press.

"Good people do bad things."

Introduction

The treatment of youth with sexual behavior problems has advanced in directions few could have imagined two decades ago. Of primary importance has been the development of a public health perspective in understanding sexual abusers (Freeman-Longo & Blanchard, 1998). Researchers and practitioners alike have come to recognize that the widespread problem of sexual abuse requires global prevention (Longo, 2003; Longo & Blanchard, 2002, Freeman-Longo, 1998; Freeman-Longo & Blanchard, 1998; Klein & Tabachnick, 2002).

In order to grasp the full spectrum of sexual abuse, we must understand that it exists in our own neighborhoods and communities, perhaps even in our own families. We cannot afford to take an "us-against-them" approach toward sexual abusers, especially youthful sexual abusers. It is natural to be horrified by sexual aggression. However, believing ourselves to be superior to abusers can only make our attempts to foster change more problematic. Accepting sexual abuse as a public health issue enables us to separate youth from their actions, and provides the support and encouragement necessary for them to confront their harmful behavior. At a societal level, this perspective allows society to go about the work of healing and prevention.

The trickle-down phenomenon

The trickle-down phenomenon is the importation of adult treatment strategies to the juvenile field. At present, this has continued for well over two decades (Developmental Services Group, 2000), and has pervaded our field (Chaffin & Bonner, 1998). The influence of adult models can keep youth in treatment longer than necessary because youthful sexual abusers are often perceived in a one-size-fits-all perspective inherited from "the adult world". Youth are too often considered as a high risk to the community, untreatable, and as "predators". Chaffin and Bonner (1998) note that many adult treatments are controversial and may include involuntary treatments (i.e., phallometry, polygraphy, and arousal reconditioning) for purposes of public safety, rather than for rehabilitative reasons. Further, there is no shortage of evidence that, in North American samples, the base rate of sexual recidivism by youth is considerably lower than among adults (Alexander, 1999; Prescott, in press; Worling & Curwen, 2000).

Unlike their adult counterparts, sexually abusive youth are still developing at the rapid pace that defines adolescence. Yet in a growing number of jurisdictions, many youthful sexual abusers are being waived into adult courts, based in part on the public's growing concerns for personal and family safety (Hunter et al., 2000; Levesque, 1996). Whatever the crime, these young people are still growing physically, cognitively, morally, and emotionally. In our experience, they can often be far more idealistic than their behaviors would suggest.

Younger children's beliefs and values can be altered or distorted through exposure to family violence and abuse. One often hears the phrase "children without a conscience", with respect to sexually abusive and violent youth. However, children leaving this impression often have understandable reasons for behaving as they do. Although they must become responsible for their behaviors, it is vital to remember adolescents aged 13-18 are still in development, can change rapidly, and can be better served without pejorative labels.

Histories of abuse, neglect, and trauma do not make growing up any easier. Even healthy youth are clarifying their understanding of what it means to be responsible. Society does not give them the full complement of adult responsibilities, and practitioners should not think that we can arbitrarily single out particular behaviors (criminal or otherwise) to selectively treat them as adults. Chaffin and Bonner (1998) write:

> *"To the extent we can identify those truly at risk and work productively with them, our communities will be safer. But in the process, we should not forget that these are our children. And as professionals committed to children's rights and welfare, we should think carefully about their rights and welfare before responding to their behavior."*

Sadly, over the course of the past two decades, our field has been subject to the *pendulum effect*, swinging back and forth between the rehabilitation and punishment of youth (Leversee & Pearson, 2001). While treatment strategies have become more effective (Hanson, Gordon, Harris, Marques, Murphy, Quinsey, & Seto, 2002), we have also witnessed greater emphasis on punishment in many jurisdictions. Rehabilitation of youthful sexual abusers must take into account their developmental abilities as well as potential developmental lags. Many adolescents with sexual behavior problems also have learning disabilities. These youth, as well as their families and communities, would all benefit if the legal and mental health systems took such factors into account.

Typologies and risk assessment

Typologies of sexual abusers provide useful information for assessment and treatment planning. Initial typology research suggests two broad categories of youthful sexual abusers, those who rape peers and adults, and those who sexually abuse children (Hunter et al., 2000; Hunter & Longo, 2004).

Further typological research will help to guide the development of risk assessment tools. At this time there is no empirically validated typology or risk assessment tool for children (ages 12 and under) who sexually abuse, with the growing number of programs treating children in this age group, this is essential for advancing the field.

As our field grows, ongoing research will continue to help refine typologies, and clarify risk factors for youth. Ryan (in press) states:

> *"Emerging research has demonstrated that: (1) childhood neglect, physical abuse, and witnessing family violence may precede sexual offending even more often than sexual abuse (Widom & Williams, 1996); (2) many child victims recover without long-term damage or dysfunction, even without treatment, (Rind, Tromovitch, and Bauserman, 1998); (3) sexually abusive youth are less at risk for sexual offense recidivism than for non-sexual reoffense; and juveniles reoffend less often than adult sex offenders, especially after treatment, (Borduin, et al., 1990; Alexander, 1999; and Worling, 2000); and (4) only a small portion of juveniles who sexually abuse have deviant sexual arousal patterns (Hunter and Becker, 1994; Hunter, 1996 & 1999). Combining offense-specific theories with developmental, contextual, and ecological theories, (Strayhorn, 1988; Donovan & McIntyre, 1990; Scales & Leffert, 1998) a new set of hypotheses developed and were described by Ryan and Associates (1999)."*

Static and dynamic risk factors

Current investigation into risk factors for sexually abusive youth suggests there are two types of risk factors associated with them (Andrews & Bonta, 2003; Rich, 2003; Prescott, in press). Static risk factors are established in an individual's history and are permanent in nature (i.e., previous sex offense convictions, age of onset, numbers of victims, histories of abuse and neglect). Dynamic risk factors are those factors that can be changed over time (e.g., low self-esteem, poor anger management skills, self-reported and/or documented sexual arousal to paraphilias, treatment experience).

Ryan (in press) recommends that practitioners consider three types of risk factors:

1) Static (e.g., permanent disabilities, family of origin, early life experience);
2) Stable (life spanning, but potentially changeable) risk factors (e.g., temperament, intellectual potential, physical attributes, heritable neurological characteristics); and
3) Dynamic risk factors (e.g., situational, cognitive, emotional, and behavioral factors that may change throughout the individual's life).

Some common etiological factors associated with sexually abusive youth include prior sexual aggression, entrenched patterns of deviant sexual arousal, stranger victims, having child victims, a history of child abuse, general delinquency, deficits in self-esteem, deficits in assertiveness, inadequate interpersonal skills, poor life management skills, and lack of family support (Worling, & Curwen, 2000; Worling, & Curwen, 2001; Worling, & Curwen, 2002; Prentky et al., 2002; Caldwell, 2002). However, the factors that contribute to first offense are not necessarily those that signal a propensity for re-offense (Prescott, in press). Ryan (in press) considers other factors when addressing static risk factors:

> *Defining static factors as those which are retrospective/historical variables, we know that these factors cannot be changed because we cannot change history. Such factors might include: (1) the condition at birth; (2) permanent disabilities; (3) family of origin; and (4) early life experience.*

Ryan proposes that an additional type of risk factor, "stable" risk factors, should be considered in assessing youth. She describes stable risk factors as, "risk factors, which may be relevant to the

risk of dysfunctional behaviors, may include such things as difficult temperament, low intellect or learning disabilities, negative internal working model, heritable psychiatric disorders, and chronic PTSD reactivity" (Ryan, in press). This shares many similarities to Hanson and Harris (2001), who describe dynamic risk factors as being either stable across time or acute.

The need to clarify our understanding of dynamic risk factors for children and adolescents who sexually abuse is apparent. Some of the risk assessment scales mentioned above include dynamic risk factors, but are not comprehensive. Many are simply "laundry lists" of risk factors, and do not address the interactive effects of static and dynamic risk factors.

Some of the dynamic risk factors for adolescents with sexual behavior problems that are now being recognized include attitudes toward offending, negative peer influence, emotional self-regulation, general self-regulation, intimacy deficits, resistance to treatment, anger management, deficits in self-esteem, deficits in self-confidence, deficits in independence, deficits in assertiveness, deficits in self-satisfaction, deficits in competency skills, inadequate interpersonal skills, inadequate social skills/social competence, and poor life management skills.

Many of these risk factors have their origins in child maltreatment and neglect. These have a demonstrated role in the etiology of aggressive conduct problems (Ryan et al., 1999). Further, the impact on the brain of abuse and neglect is established. Childhood maltreatment is a crucial treatment need. It can contribute to biologically based vulnerabilities (such as impulsivity and hypervigilance) as well as the thoughts, beliefs, and attitudes that contribute to re-offense. Unfortunately, some of the impact on the brain is not reversible. However, children are resilient and we can promote health and recovery by addressing dynamic risk factors.

Finally, there are risk factors previously thought to be associated with sexual recidivism among youth whose roles are questionable or not supported by research. These include denial, empathy deficits, and victim penetration (Worling & Curwen, 2002). Although each of these is worthy of a volume itself, they serve as a reminder that what may appear important is not always supported empirically.

Other research cautions us that the sexual arousal patterns of youth are "fluid" and dynamic, and may be less of a concern in youth than in their adult counterparts (Hunter & Becker, 1994). Many of us practicing in this field 20 years ago discovered that much of what we believed turned out not to be true.

Best practice

The definition of best practice in treating sexually abusive youth is still in question (Chaffin and Bonner, 1998; Developmental Services Group, 2000, Hunter and Longo, 2004). While the field is not new, conceptualization of what constitutes effective treatment for this population is still evolving, (Hunter and Longo, 2004).

All too often, clinical approaches have overlooked developmental and contextual issues. Many programs have focused treatment on areas that may not be relevant for the juvenile sex offender population, such as deviant sexual arousal (Freeman-Longo, 2002; Hunter, 1999; Hunter & Becker, 1994). Techniques and modalities used in treating adult sexual offenders have been directly applied to youth, or modified only slightly to make materials more easily understood,

without taking into consideration learning styles and intelligence variations of these clients (Gardner, 1983). High levels of confrontation are still used in many programs. When used with traumatized youth, these techniques may serve to re-traumatize them instead of promoting healing, forgiveness, and respect for self and others. Even the recent research with adult sex offenders demonstrates that warm, empathic, rewarding, and directive therapeutic styles can produce better treatment outcomes than harsh and confrontational methods (Marshall, Fernandez, Serran, Mulloy, Thornton, Mann, & Anderson, 2003).

As of 2002, the majority of juvenile sexual offender treatment programs still adhere to a traditional adult sex-offender model (Burton & Smith-Darden, 2001). According to national surveys, the most popular treatments for both adult and juvenile sex offenders include relapse prevention, the sexual abuse cycle, empathy training, anger management, social and interpersonal skills training, cognitive restructuring, assertiveness training, journaling, and sex education (Freeman-Longo et al., 1995; Becker & Hunter, 1997; Hunter, 1999; Burton, Smith-Darden, Levins, Fiske, & Freeman-Longo, 2000; Burton & Smith-Darden, 2001). Questions about the appropriateness and effectiveness of these approaches requires the development and testing of juvenile-specific intervention programs (Hunter & Longo, 2004; Prescott, 2002).

We endorse the use of a holistic/integrated approach to treating youthful sexual abusers (Longo, 2001; Hunter & Longo, 2004). This approach blends traditional aspects of sexual abuser treatment into a holistic, humanistic and developmentally consistent model for working with youth. While cognitive-behavioral treatment methods appear promising, treatment must go beyond the sexual problems, and address "growth and development, social ecology, increasing health, social skills, resiliency, and incorporate treatment for the offender's own victimization and co-occurring disorders" (Developmental Services Group, 2000). If successful risk reduction involves changing thoughts and behaviors, then a holistic/integrated model prepares the youth to make these changes while respecting his long-term development.

Summary

One may well argue that the field of treating children and adolescents is itself barely out of adolescence. The past two decades have seen the recognition of sexual abuse by youth, but it is only recently that research and treatment have come to appreciate the heterogeneity of this population. We have imported many of our strategies for understanding, assessing, treating, and managing youth from adult populations. However, youth are, by definition, different. They exist in a different context and at different developmental stages. They often have unresolved histories of trauma, both physical and psychological.

Although treatment strategies aimed at thoughts and behaviors are promising, we cannot expect youth to respond to them without also attending to their needs at a more holistic level or incorporating the assets they bring into treatment. We believe that the best practitioners are warm and empathic, addressing all aspects of the youth's functioning, while maintaining a focus on those areas demonstrated to be associated with risk. We also believe that interventions that do not take the youth's family circumstances into consideration may well do harm in the long run.

Finally, the field has struggled to develop standards and a continuum of care based on treatment needs and community safety. While many decisions around sexually abusive youth have been, and remain, driven by public fear and furor − not to mention economics − we remain confident

and optimistic that efforts in these areas will continue to bear fruit in the long run. To that end, we hope the chapters that follow are helpful.

References

Alexander, M. (1999). Sexual Offender Treatment Efficacy Revisited, *Sexual Abuse: A Journal of Research and Treatment, 11,* 101-116.

Andrews, D.A. & Bonta, J.L. (2003). *The Psychology of Criminal Conduct, Third Edition.* Cincinnati: Anderson Publishing.

Becker, J. V., & Hunter, J. A. (1997). Understanding and treating child and adolescent sexual offenders. *Advances in Clinical Child Psychology*, 19, 177-197.

Burton, D.L., & Smith-Darden, J. (2001). *North American survey of sexual abuser treatment and models: summary data 2000*. Brandon, VT: Safer Society Press.

Burton, D.L., Smith-Darden, J.P., Levins, J., Fiske, J.A. & Freeman-Longo, R.E., (2000). *1996 Nationwide survey: a survey of treatment programs & models serving children with sexual behavior problems, adolescent sex offenders, and adult sex offenders*. Brandon, VT: Safer Society Press.

Caldwell, M.F. (2002). What we do not know about juvenile sex offender reoffense risk. *Child Maltreatment, 7(4), pp. 291-302.*

Chaffin, M. & Bonner, B. (1998). "Editor's Introduction: 'Don't shoot, we're your children': Have we gone to far in our response to adolescent sexual abusers and children with sexual behavior problems?" *Child Maltreatment 3(4): 314-316.*

Development Services Group (2000). *Understanding Treatment and Accountability in Juvenile Sex Offending: Results and Recommendations From an OJJDP Focus Group (*Prepared for Office of Juvenile Justice and Delinquency Prevention Training and Technical Assistance Division). Bethesda, MD. Author.

Freeman-Longo, R.E. (1998). A Public Health Model for Sexual Abuse. In Whitman, C., Zimmerman, J., & Miller, T. (eds.) Frontiers of Justice: Volume 2: Coddling or Common Cause. Biddle Publishing Co. Brunswick, ME 04011.

Freeman-Longo, R. E. (2002). Myths and Facts About Sex Offenders. Center For Sex Offender Management. Silver Spring, MD.

Freeman-Longo, R.E. & Blanchard, G.T. (1998). *Sexual Abuse in America: Epidemic of the 21st Century*. Brandon, VT: Safer Society Press.

Freeman-Longo, R.E., Bird, S. Stevenson, W.F. & Fiske, J.A. (1995). 1994 Nationwide survey of treatment programs & models: Serving abuse reactive children and adolescent & adult sexual offenders. Brandon, VT: Safer Society Press.

Gardner, H. (1983). Frames of Mind: The Theory of Multiple Intelligences, New York, Basic Books.

Hanson, R.K., Gordon, A., Harris, A.J.R., Marques, J.K., Murphy, W., Quinsey, V.L., & Seto, M.C. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14,* 169-194.

Hunter, J.A. (1999). Adolescent Sex Offenders (pp. 117-130). In V.B. Van Hasselt & M. Hersen, *Handbook of Psychological Approaches with Violent Offenders*. Plenum: New York.

Hunter, J.A. & Becker, J.V. (1994). The role of deviant sexual arousal in juvenile sexual offending: Etiology, evaluation, and treatment, *Criminal Justice and Behavior* 21, 132-149.

Hunter, J. A., Hazelwood, R. R., & Slesinger, D. (2000). Juvenile-perpetrated sex crimes: patterns of offending and predictors of violence. *Journal of Family Violence.* Vol.15, No 1. pp 81-93.

Hunter, J. & Longo, R.E. (2004). Relapse Prevention with Juvenile Sexual Abusers: A Holistic/Integrated Approach. In G. O'Reilly & W. Marshall, A. Carr, & R. Beckett (Eds.), *Handbook of clinical intervention with young people who sexually abuse.* Sussex, UK: Brunner-Routledge.

Klein, A. & Tabachnick, J (2002). Finding ways to effectively prevent sexual abuse by youth. *The Prevention Researcher.* Vol. # (No 4. pp. 8-10.

Leversee, T. & Pearson, C. (2001). Eliminating the pendulum effect: a balanced approach to the assessment, treatment, and management of sexually abusive youth. *Journal of the Center for Families, Children, & The Courts.* Pp. 45-57.

Levesque, R. J. R. (1996). Is there still a place for violent youth in juvenile justice? *Aggression and Violent Behavior*, I, 69-79.

Longo, R.E. (2001). *Paths to Wellness*: *A Holistic Approach and Guide for Personal Recovery*. Holyoke, MA: NEARI Press.

Longo, R.E. (2003). Emerging Issues, Policy Changes, and the Future of Treating Children with Sexual Behavior Problems. In R.A. Prentky, E.S. Janus, & M.C. Seto (eds.) Sexually coercive behavior: understanding and management. Annals of the New York Academy of Sciences. Vol. 989.

Longo, R.E. & Blanchard, G.T. (2002). Prevention of sexual offending by among adolescents. *The Prevention Researcher.* Vol. 9, No 4. pp. 5-8.

Marshall, W.L., Fernandez, Y.M., Serran, G., Mulloy, R., Thornton, D., Mann, R.E. , & Anderson, D. (2003). Process variables in the treatment of sexual offenders: A review of the relevent literature. ***Aggression and Violent Behavior, 8,*** **205-234.**

Prentky, R., Harris, B., Frizzell, K. & Righthand, S. (2002). An actuarial procedure for assessing risk with juvenile sex offenders. ***Sexual Abuse: A Journal of Research and Treatment*****. Vol.12 No 2. pp-71-94.**

Prescott, D.S. (2002). Collaborative treatment for sexual behavior problems in an adolescent residential center. In Miner, M.H., & Coleman, E., Ed.s (2002). ***Sex Offender Treatment: Accomplishments, Challenges, and Future Directions*****. Binghamton, NY: Haworth Press.**

Prescott, D.S. (in press). The Current State of Adolescent Risk Assessment. In Schwartz, B. The Sex Offender. New York: Civic Research Institute.

Rich, P. (2003). Understanding, assessing, and rehabilitating juvenile sexual offenders. New Jersey: Wiley.

Ryan, G. & Associates (1999). Web of Meaning: A Developmental-Contextual Approach in Sexual Abuse Treatment. Brandon, VT. Safer Society Press.

Ryan, G. (in press). Static, Stable and Dynamic Risks and Assets Relevant to the Prevention and Treatment of Abusive Behavior. (Poster Presentation at the First National Sexual Violence Prevention Conference, May. Dallas, Texas).

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

Worling, J. R., & Curwen, T. (2001). Estimate of Risk of Adolescent Sexual Offense Recidivism (Version 2.0: The "ERASOR"). In M. C. Calder, ***Juveniles and children who sexually abuse: Frameworks for assessment (pp. 372-397).*** **Lyme Regis, Dorset, UK: Russell House Publishing.**

Worling, J. R. & Curwen, T. (2002). The "ERASOR" estimate of risk of adolescent sexual offense recidivism. Version 1.2. SAFE-T Program, Thistletown Regional Centre. Canada.