Since its inception in the mid 1980’s, the child/adolescent sex abuse-specific field has been gradually evolving away from the “one size fits all” adult cognitive-behavioral-relapse prevention model (CBRP) towards a more individualized, holistic or eclectic approach. This latter approach more accurately incorporates both the developmental realities of children and youth and the complexity of the diagnostic profiles of those who engage in abusive/ offending behaviors. Certain central tenets of this specialized field have remained consistent (i.e., protecting future victims, ensuring safety and appropriate levels of containment within which to conduct treatment, developing continuum of care services, and providing specialized assessments conducted by qualified practitioners). However, finding the most effective treatment interventions remains a fluid and ever-expanding realm within which practitioner creativity and research-based outcomes continue to co-exist in, creative/dynamic and sometimes-destructive tension.

Practitioners who understand that sex abusing is a behavior, not a diagnosis, continue to seek the most effective treatment approaches for a wide spectrum of children/youth engaging in similar behaviors, i.e., those with Mood and Personality Disorders, Autism Spectrum Disorders, and those with Learning Disabilities, ADHD and other neurological disorders. Common themes amongst many of these varied treatment approaches are: optimizing the conditions by which behaviors can be stopped; enhancing the likelihood that various concepts/information can be learned/internalized; healing the impact of life experiences/trauma that contribute to sexually abusive behaviors. and remediating underlying neurological deficits that contribute to behaviors, choices, and learning deficits.

Crafting the appropriate set of interventions is a complex matter that requires:

- an interweaving of both abuse-specific and traditional clinical paradigms;
- an understanding of neurodevelopmental deficits and their impact on behavior;
- the development of safety plans based on risk assessments provided by qualified practitioners with expertise with the population being assessed;
- thoughtful integration of quality research as well as evidence-based principles;
- an understanding about the limits of present-day research;
- the development of treatment objectives that correspond to the child/youth’s age, clinical diagnosis, developmental issues, and cognitive limitations;
- a willingness to practice creatively, but only, when operating from an understanding and integration of the present knowledge in the field;
- the development of a range of placement options, organized along a care continuum from most to least restrictive, with the ability to move children/youth from one level of service to another based on treatment progress (Note: all children/youth have the right to be treated in the least restrictive placement in which they can be safely managed. But “step-down” placement decisions must be made by practitioners with abuse-specific expertise);

The low base-rates of sexual recidivism for youth who have been apprehended (approximately 7%-18%), and the positive impact of sex abuse-specific interventions enhances the likelihood that the well-qualified practitioner will have very positive results with youth who abuse/offend sexually. By using both the principles articulated above as well as the books, online training workshops, workbooks and face-to-face trainings, that are relatively accessible, crafting quality treatment interventions is well within the reach of policy planners and clinicians.
CHOOSING APPROPRIATE TERMS

Over the past twenty plus years, a variety of terms have been used to describe the sex abuse-specific population. These have included:

Sexual Perpetrators
Juvenile Sexual Offender
Adolescent Sex Offender
Sexually Abusing Youth
Sexually Abusive Youth
Sexually Reactive Children/Youth
Youth/Children With Sexual Behavior Problems
Children/Youth Who Sexually Offend

Throughout the literature, you will find all of the above terms used, sometimes interchanged within the same sentence. The choice of terms is very important given the implications to the children/youth and their families of one designation or another. It is very different to talk about a youth who has sexual behavior problems as opposed to a sex offender or perpetrator. Each of these terms creates different internal images in those hearing it, as well as certain emotional responses. Generally, when we hear the term “sexual perpetrator” we think of a dangerous, violent adult. With that association comes a demand for certain actions/public policy, interventions, etc. If the label fits the client, then perhaps we should use it. But we cannot be frivolous with that “labeling”.

While linguistically awkward, I have chosen to use the term, “children/youth with sexual behavior problems” or “youth who abuse sexually” or “sexually abusive youth” to describe most child/adolescents who act-out in an abusive manner. On rare occasions, when an adolescent has: 1) committed a particularly heinous/violent sexual act, 2) has been assessed both as being high risk and as having already developed a pattern of such behaviors, and, 3) has been adjudicated for his/her offense, I may use the term Juvenile Sex Offender. Use of this latter term should be a conscious choice based on the realities of an individual adolescent’s situation.

CHOOSING A CLIENT POPULATION TO TREAT

The following different “kinds” of youth who engage in sexually abusive behavior are not mutually exclusive, (i.e., a youth may be traumatized and conduct disordered, or hypersexualized and on the autism spectrum).

Abuse-Reactive
Traumatized/Emotionally Disturbed/Psychiatric
Neurodevelopmentally Challenged, i.e., Autism Spectrum (PDD, NVLD, Asperger’s, Mild-Moderate-Severe Autism)
Conduct Disordered
Hypersexualized/Impulsive
Group Influenced

In addition to the above, it is critical to decide about appropriate diagnostic categories that can safely and appropriately mixed together, i.e., conduct disordered youth should not be mixed with autism spectrum highly traumatized youth.

ISSUES TO CONSIDER FOR AGENCIES DECIDING WHETHER OR NOT TO PROVIDE SEX ABUSE-SPECIFIC SERVICES

Please consider the following when making your decision about future treatment of adolescent youth who engage in sexually abusive behaviors:

1. Do you want to treat this population and, is there high level administrative /Board support to do so? Is your agency/program prepared either to prosecute youth in the program for any new sexual offense or administer some other significant consequence?
2. Do you have knowledge of the specialized approaches necessary to work with this population and/or are you willing to commit the resources necessary to acquire the needed knowledge and skills (i.e., train all staff-line staff, therapists, teachers, administrators, caseworkers, in abuse-specific assessment and treatment?).

**General Rule:** It is imperative that providers adopt an approach for the treatment of this population that integrates both abuse-specific and traditional clinical interventions. Failure to provide integrated treatment imposes unethical risks on other clients and on the community. Treat this population appropriately or do not treat them at all. Either position is perfectly acceptable.

3. Where along the continuum of care does the program fit? What are the staff:client ratios, what types of youth can the program safely treat? What are the program’s intake criteria?

4. Do you have a homogeneous or heterogeneous population? Do these client populations mix safely? Can you provide appropriate and safe residential/ group home/out-of-home/foster care settings for these youth? Is your direct-care staff trained to address sexually abusive and related behaviors? Are they willing/able to address sexually explicit issues and behaviors directly?

5. Has your program developed sexual safety rules to address the risks these clients pose to other clients and the community? Have you developed policies related to safe hygiene, bedtime and leisure-time routines, home visits, family contact, off-campus time, and victim reunification for incest offenders? Does your program have specific guidelines for ensuring actual (as opposed to theoretical) staff:client ratios consistent with its mandate? Does the program have a regular relief staff to cover planned for holidays, sick days, personal days, etc? Have you mentally walked through each day to find the programmatic gaps that might provide easy opportunities for youth with sexual abusing behavior problems to gain access to victims and to abuse again?

6. Do you have the capacity to perform your own pre-and-post-abuse-specific evaluations? If not, do you have agreements with other providers to perform this service for you?

7. Have you operationalized all the components of an integrated sex abuse program using competency-based criteria for determining treatment progress?

8. Do you provide, or have you developed agreements with other providers to provide, sex abuse-specific individual, group and family treatment?

9. If you use a psychiatrist for medication issues with this population, is the psychiatrist trained in integrated sex abuse treatment?

10. Have you developed interagency agreements with probation, police, aftercare agencies, referring agencies, etc., to ensure support for the integrated treatment you have adopted?

11. Will referring agencies guarantee you sufficient time to complete integrated sex abuse treatment? If not, have you developed a written plan that outlines the extent of the work your program will be able to complete, given the placement timeframes, and the risks of discharging youth prior to their having successfully completed treatment?

12. Have you developed aftercare plans with referring agencies, other providers, other services that you may administer, to accept these clients upon successful completion of your program?

13. Do you provide your staff with supervision by personnel trained to work with this population? Does your supervision model include addressing personal/interpersonal issues that inevitably arise for staff working with these youth (i.e., impact on their relationships with significant others, children, family? fantasies, urges, impulses, and new thoughts, or fears?)?
DEVELOPING A TREATMENT HYPOTHESIS

Some Questions To Consider:

1. At what age did sexual acting-out problems start?
2. What was going on in the child’s life at the time?
   Is there evidence of sexual abuse or other significant trauma?
3. Is there evidence of attachment issues (i.e., multiple early placements)?
4. Is there a family history of: mental illness; alcoholism; drug use/abuse, neurological problems (i.e., ADHD).
5. Is there any indication of neurodevelopmental issues (i.e., ASD, Developmental Delays, PDD, etc)?
6. Is there a placement history and in what agencies/institutions?
7. What is the history of treatment success/failure?
8. What worked and what didn’t work?
9. What is the youth’s acting-out history?
10. Is there evidence of learning disabilities, neurological deficits, or mental illness?
11. Is there evidence of substance use/abuse?
12. Is there evidence of early conduct disorder/anti-social personality disorder?
13. Is there evidence of significant deviant interest?

CASE MANAGEMENT OF SEXUALLY ABUSIVE YOUTH

Steps To Take

1. Ensure safety of other children in the family and those in surrounding community.
   a. Whenever possible, remove the abusing youth not the victim from the family
   b. **DO NOT** place a youth with sexually abusive behavior problems in a foster home with other children present unless a qualified expert has completed an assessment and deemed such a placement to be safe. **DO NOT** place a youth who abuses sexually in a foster home without informing the foster parents of the risks and providing them with management guidelines that are abuse-specific.
   c. Prevent contact between a victim and the youth who has abused until initial abuse-specific evaluations and treatment planning have been completed.

2. Refer the youth for an integrated sex abuse-specific evaluation and risk assessment. Make the referral to a sex abuse-specific expert with extensive knowledge and training in the field.

3. Ask the evaluator specific questions about the content of his/her report. Ensure that you are getting an abuse-specific evaluation that includes a risk assessment and a placement recommendation. Be an educated consumer.

4. Make every effort to find a sex abuse-specific residential, day or outpatient program. If that is impossible, assume that the youth may re-abuse unless a very tight behavioral plan is put into place.
   a. Ask very detailed questions about the type of sex abuse-specific programming being offered in the placement you are considering. Many programs provide cognitive-behavioral approaches well suited to conduct-disordered youth. Far fewer have the ability to address neurodevelopmental delays, learning disabilities or trauma issues. Try to ensure that there is resonance between the diagnosis of the youth and the treatment/service interventions provided by the program. Minimally, all sex abuse-specific programs regardless of the setting in which they are providing the service, should address:
      1. Self control techniques for stopping abusive behaviors.
      2. Attachment and trauma work for those who need it.
      3. Thinking Errors work if appropriate
      4. Assault Cycle Work if appropriate
      5. Pro-social sexual behavior treatment
6. Treatment adapted to diagnostic profile of the youth (LD, PDD, etc).
7. Family/Social Support Network support/therapy
8. Skill Development (i.e., communications, interpersonal, social, life, assertiveness, anger management, etc.)

Programs that are sex abuse-specific should be using the above language. A residential program that provides sex abuse-specific clinical services but is not designed as a twenty-four hour milieu treatment program for these youth should not be considered an appropriate residential placement unless all aspects of the youth’s treatment, including behavioral safety, can be addressed.

Also, for residential placements, ascertain: the staff: client ratio on all shifts; the program's procedures for ensuring safety (i.e., hygiene routines, access to the community, family visit policy, leisure time routines, etc.); the availability of appropriate clinical services. Ask about the program’s ability to address issues of learning disabilities, neurological dysfunction and other cognitive deficits. **DO NOT** place a developmentally delayed youth in a program designed for high functioning youth. There should be specific residential programs for the M-R population. Try to make M-R placements only to these programs.

5. Ask placement sources their criteria for success and how they measure that success. Monitor the youth's progress in the program using **objective/measurable criteria**. **Do Not** use traditional clinical criteria or behavioral compliance alone i.e., a youth may be following program rules within a highly structured program but fail to internalize self-control or have addressed the other issues that have contributed to his abusive behavior.

6. Insist on treatment progress that reduces risk prior to allowing or agreeing to family visits. If the youth's victim is in the family, insist on prior treatment for the victim and agreement between both the abusers and the victim's therapists that reconciliation between the two parties is timely. **Do Not** ever allow the youth to go home when his/her victim is present unless a formal therapist supervised reconciliation has occurred.

7. Whenever possible, request a risk assessment by a qualified expert outside the program, prior to discharging a youth to a less restrictive setting.

8. Attend treatment planning meetings and quarterly reviews. Insist on hearing about progress using competency-based criteria.

9. **Do Not** discharge a youth prematurely from treatment. However, in cases in which a youth is failing to progress in treatment over a significant period of time, ask for a total review of the youth’s diagnosis and treatment plan. Many youth fail to make progress because the treatment interventions being used fail to coincide with the youth’s diagnostic profile.

8. Seek outpatient abuse-specific clinical services for youth returning to the community.

**ROLE OF OUT-OF-HOME CARE PROVIDERS IN SEX ABUSE-SPECIFIC BEHAVIORAL MANAGEMENT**

1. Make a determination of the type of youth you can safely manage in your home. Do you have small children? Are there a lot of children who are in the neighborhood and are easily accessible to a youth with a history of abusing children? Do you have a teenage daughter? Try to match your situation with the type of youth being placed in your home.

2. Create a safe context within which treatment can take place. While most youth with sexual behavior problems continue to present some level of risk to abuse again, determining that level of risk and the protective factors that may contribute to reducing or enhancing that risk level is very important.

   a. Ask for a sex abuse-specific evaluation that outlines the level of risk that is represented by a given youth. A youth who has completed treatment successfully should pose a lower risk than a youth with a similar abusing history who
has not been in treatment. A youth who has only committed a minor abusing incident (i.e., making obscene phone calls) **may** be a very low risk to re-abuse even without extensive treatment. On the other hand, if a youth has never been evaluated, don’t assume that because you only know about a minor abusing incident that the youth is low risk.

b. Based on this risk assessment, together with case managers and therapists, determine what level of access a youth may have to potential victims, i.e., none (e.g., a youth may never be alone with children; a youth may only be alone with children in public environments; children are not his victim of choice and he may be alone with children but not alone with adolescent girls).

c. Based on the determination in (b) above, put together a behavioral management contract that relies on supervision and denial of access to keep victims safe, as opposed to internal self-control of the youth.

d. Try to learn the youth’s risk factors and help monitor for the presence of these factors. Risk factors vary from individual to individual. Any youth who has been through treatment should be able to identify his risk factors, as should the professionals with whom he was in treatment. Common risk factors include boredom; strong feelings like anger, hurt, frustration; access to children (being in playground); using drugs or alcohol,

e. Have a plan that is agreed to by case managers and therapists of who should be notified when you have concerns about “lapses” or the appearance of “risk factors”.

f. Have a stated and agreed upon understanding with the youth and with the program that you will consider criminal prosecution for sexually abusive behaviors in which the youth engages.

g. Insist that the youth be actively participating in sex abuse-specific treatment/therapy as a condition of keeping him in your home (if such treatment is recommended by sex abuse-specific professionals). While individual circumstances may vary, and, successful completion of treatment may mean a youth no longer requires active participation in treatment, most youth in out-of-home care should still be in treatment. For youth who fit this profile, failure to meaningfully participate may be considered a risk factor and reason to consider removing a youth from your home. Minimally, such a lack of participation should trigger a very early case conference and review.

h. For youth who have been adjudicated, try to meet with the youth’s probation officer or seek agreement through the case worker that the probation officer is willing to cooperate in setting limits, pulling a youth in, and or violating him for failure to adhere to agreed upon treatment contracts.

i. For youth who have not been adjudicated, try to ascertain the position of the caseworker of the referring agency regarding consequences for failure to adhere to treatment contracts.

3. Work on developing an ease about discussing sexual issues. Being able to discuss sexual issues frankly and openly is very helpful.

4. Ask the youth’s therapist to keep you informed about treatment progress in therapy.

5. **Be an active participant in the youth’s treatment. Address any/all inappropriate sexual comments/behaviors with interventions agreed to in collaboration with the treatment team.**

6. **Make unsupervised access to the community and other privileges dependent not only on the youth’s behavior at home but his progress in treatment (but do this in coordination with the youth’s therapist/case manager to ensure that the relationship of privilege to treatment progress makes sense for this particular youth).**

7. **Help to ensure that the youth does not have access to inappropriate stimuli (i.e., certain types of t.v. programs, music, magazines, etc.). Remember, these youth are not just “normal” adolescents. While sexually erotic materials of the playboy, penthouse, x-rated film type, may not be great for all adolescents, for certain youth they can be a serious problem. As the youth progresses in treatment, and depending upon the youth’s age, together with the youth’s therapist/case manager develop a way to reintroduce sexually appropriate interests into the youth’s life (i.e., teaching him her about having consenting sex, understanding and reacting appropriately to sexually stimulating images, etc).**
8. Remember that these kids are also adolescents. Don’t assume that every interaction, every sexual interest, every thought is inappropriate or part of his sexually abusive pattern. At some point, these youth will also need to develop appropriate dating skills and appropriate sexual interests, but even more than all adolescents, these youth need to be absolutely clear about consent, relationships, appropriateness, etc. Having open and honest talks about these issues can be very helpful.

9. Feel real good about the important job you are doing both for community safety and for providing the youth in your care with the opportunity, which he richly deserves, to turn his life around and become a productive contributing member of the community.

**REQUIREMENTS FOR EFFECTIVE TREATMENT**

Treatment Must Be Integrated and include interventions that address the youth’s sexual behavior problems.

Treatment Must Take Place Within A Safe Container That Matches The Youth’s Level Of Risk With The Level Of External Containment

Treatment Must Be Delivered By Qualified Professionals Who Have Been Trained In Sex Abuse-Specific Treatment Work

Treatment Must Take Place In Settings That Meet Quality Control Standards For This Population

The Offense-Specific Cognitive/Behavioral Adult Treatment Model Must Be Modified To Meet The Diverse Diagnostic Profiles Of Abusing Children/Youth

**PRINCIPLES GUIDING THE DEVELOPMENT OF A COMPETENCY-BASED CONTINUUM OF CARE FOR SEXUALLY ABUSIVE YOUTH**

1. Placements along the continuum must be designed to correspond to the level of risk posed by the youth.

2. The level of client risk should be determined by examining both the types of behaviors in which the youth can be expected to engage, the youth’s level of self-control, the "bottom-line" acting out which the placement has been designed to contain, and the staff: client ratios present "on-line" to contain these behaviors.

3. Whenever legally possible, movement along the continuum should be based on the competency level achieved by the youth (i.e., in situations where discharge is not controlled by the program, discharge summaries should reflect the level of self-control the youth has internalized).

4. Required competency-levels should correspond to the level of internal control required for safe placement at each level of the continuum.

5. Initially, youth can be referred to any level of the continuum that corresponds to their diagnosed level of risk. However, decision regarding movement to less restrictive placements should be competency-based.

6. The entire continuum of care should use the same sex abuse-specific assessment and treatment criteria. While specific placements may emphasize different aspects of sex abuse-specific treatment, all placements should adhere to the guidelines established by the National Task Force On Juvenile Sexual Offending and the “Standards of Care for Youth in Sex Offense-Specific Residential Programs”.

Sex abuse-specific treatment that takes place in other than outpatient settings, i.e., residential or day programs, should provide abuse-specific *milieu treatment*. As such, all staff in these placements should be trained: 1)-to provide abuse-specific interventions as part of their "on-line" work with these youth; 2)-to integrate the basics of abuse-specific treatment into interventions that do not involve sexually abusive behaviors; and, 3)-to integrate abuse-specific issues into vocational and educational curricula. Programs that offer specialized assessments and
specialized therapy but which **do not** provide specialized milieu treatment **should not** be considered sex abuse-specific programs.

7. Whenever possible, caregivers should remain consistent as a youth moves from one level of the continuum to another (i.e., probation officer, caseworker, therapist, etc.).

8. Placements along the continuum should be evaluated: 1) by professionals trained in both evaluation methodology and abuse-specific assessment and treatment; and, 2) according to sex abuse-specific criteria agreed to in advance by evaluators and those being evaluated.

9. Day programs and educational placements should be thoroughly integrated into the continuum of care and be required to provide sex abuse-specific treatment.

10. All youth placed in programs anywhere along the continuum should receive pre and post abuse-specific evaluations. These evaluations should be the basis both for initial placement and for discharge to less restrictive settings. These evaluations should also screen youth according to more traditional clinical criteria (i.e., thought disorders, clinical depression, ADHD, other neurological criteria, etc.).

**SUGGESTED CONTINUUM OF CARE PLACEMENT OPTIONS**

1. Locked-secure correctional and hospital-based programs.

2. Un-locked, intensive, primary treatment community-based residential programs.

3. Community-based group homes and half-way houses.

4. Out-of-home options including specialized foster-homes (preferably without other children present) and/or small living units staffed by professionals.

5. Day programs with vocational and/or educational emphasis.

6. Out-patient services including abuse-specific assessments and treatment and other more traditional clinical services, i.e., individual, family, psychiatric, etc.

**SAFETY CONCERNS FOR SEXUALLY ABUSIVE YOUTH IN RESIDENTIAL PROGRAMS FOR WHICH PROGRAM MUST HAVE APPROPRIATE POLICIES AND PROCEDURES**

1. Ability to maintain eye contact with client at all times if he/she is determined to be at significant risk of abusing another victim if given the opportunity. This should be determined through an evaluation of staffing ratios, facility construction, programming, etc.

2. Ability to make room assignments based on the assessment of risk of the youth. For very high-risk youth, this may include the capacity for either a single person bedroom, electronic monitoring aides (cameras, motion detectors, mattress pads), and/or awake night staff in visual site of the client all night.

3. Ability to design hygiene routines to minimize visual and physical contact between given youth and others.

4. Willingness to allow unsupervised community contact only after the youth has demonstrated the internalization of self-control.

5. Willingness to monitor/supervise family contact until evaluations determine that both the youth and his/her family can safely manage unsupervised time together.
6. Willingness to prohibit family contact in situations in which the youth’s victim remains in the family until such time as the victim has received victim-specific treatment and his/her therapist considers it timely to reintegrate the family. Then such contact must be part of a plan for reunification that includes the therapists of both the victim and the abusive youth. Alternatively, an independent evaluator with abuse-specific expertise must determine that it is safe for the victim and youth who has abused to be together.

7. Ability to provide residential staff with appropriate levels of training to provide services to a sexually abusing client.

8. Ability to provide appropriate therapy (for victimization or abusing). This should be determined by the level of expertise of the clinician in either or both areas. Alternatively, the program should be willing to hire an appropriately trained supervisor to oversee the clinical treatment of the client.

SUGGESTED READINGS


Rich, Phil, Stages of Accomplishment Workbooks, NEARI Press, 2010


Prescott, David S., Risk Assessment Of Youth Who Have Sexually Abused, Wood and Barnes, 2006


