Treating the Mentally Ill Juvenile Sex Offender

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What do we know about youth with sexual behavior problems?

- Fully 70% of youth in the juvenile justice system have a diagnosable mental health disorder.
- Youth under 18 are responsible for 43% of sexual crimes against children (Bengis, 2011)
- Ybarra and Mitchell (2013) found that 9% percent of all adolescents perpetrated sexual violence in their lifetime.
- 8% used forced sexual contact
- 3% used coercive sexual contact
- 3% committed attempted rape
- 2% completed rape

Youth with sexual behavior problems

- Those who perpetrated sexual violence had significantly greater exposure to and use of violent sexually explicit media.
- 40% of the youth began at age 16
- Those younger than 16 were more likely to get in trouble with caregivers.
- Those whose onset was later, were more likely not to get caught.
Youth with sexual behavior problems

- 1/3 used coercive tactics
- 2/3 said they tried to make the person feel guilty
- 5% threatened
- 8% used physical force
- 15% used alcohol as a tactic to move beyond consent

Youth who began to perpetrate sexual crimes before 15 were 98% more likely to be male;

**HOWEVER**

By age 18-19, the split is equally male and female

Offender Characteristics

  “Congruence with children” predicts higher recidivism, more likely to offend outside of the family.

- CUG - higher on callous and unemotional traits predicts more victims, used more violence, and used more planning to execute the offense.
### Characteristics (Marks, 2010)

- 40-49% have a history of sexual victimization
- High levels of hostility and self-directed anger
- Lower sexual esteem, fewer satisfying and appropriate heterosexual experiences; more reports of loneliness, higher reports of obsessionality in adult offenders
- More externalizing behaviors, moodiness, and lack of respect for authority

### Characteristics (Marks, 2010 cont’d)

- More difficulty accurately recognizing emotional reactions on others’ faces.
- More likely to defy social norms against lying and cheating to gain friends
- Less social, less assertive and less supportive
- More open, less caring, more dependent
- Have more difficulty labeling their emotions

### College-aged men (Abbey, McAuslan, Zawacki, Clinton, and Buck, 2001)

- One third admitted to having committed a sexual assault.
- 8% reported behavior that met the legal definition of rape or attempted rape.
- Correlations were found between attitudes about gender roles and alcohol, # of consensual sex partners, how isolated the setting was, alcohol consumption during the event, the man’s misperception of the woman’s cues, and prior consensual sexual activity between the man and woman for situations that were considered sexual assault.
Youth with sexual behavior problems

- Of the youth in the study, 3/4 completed the forced sexual behavior within the context of a romantic relationship.
- 4/5 said the victim had at least some responsibility for the act.

More Facts:

- According to the Center for Sex Offender Management CSOM (2010), the following are other common traits among juvenile sex offenders.
  - Difficulties with impulse control and judgment
  - High rates of learning disabilities and academic dysfunction (30% to 60%)
  - Mental illness: up to 80% have a diagnosable psychiatric disorder
  - A minority of sexually abusive youth also have deviant sexual arousal and interest patterns. "These arousal and interest patterns are recurrent and intense, and relate directly to the nature of the sexual behavior problem (e.g., sexual arousal to young children)" (CSOM, 2010).

Who Is the Mentally Ill Offender?

- 70% of males admitted to juvenile detention
- 81% of admitted females
- Scored in the clinically diagnosable range for the following:
  - Alcohol and drug use
  - Angry/irritable
  - Depressed/anxious
  - Somatic complaints
  - Suicidal ideation (Cauffman, 2004)
Are they all ill?

• This population (sex offenders) is more likely to receive a diagnosis of severe mental illness, such as schizophrenia and bipolar disorder compared to the general population (Moulden, et al., 2010)

• Leue, Borchard, and Hoyer (2004) found that “Anxiety disorders, mood disorders, and substance use disorders were common among sexual offenders, as were cluster B and C personality disorders. While social phobia is most common among paraphilic sexual offenders, major depression was most prevalent in impulse control disordered sexual offenders.”

Most common emotional experience of rapists

• 88% experience general anger

• 77% anger toward women (BJS, 2003)

Mentally ill youth

• 71-85% of youth assessed in juvenile detention evidenced diagnosable disorders

• One third were found to have co-occurring mental health and substance abuse disorders (Robertson, et al., 2004)

• Rotter (2007) refers to sex offenders with mental illness as a subpopulation among the population of those with sexual behavior problems

• Less than 25% of offenders seen in out-patient settings have serious diagnosable mental disorders (BJS, 2003)
Mentally ill adult sex offenders

- (Rotter, 2007)
- 54% of a psychiatric population had arrest histories
- 34% had behavioral histories, but no arrest
- 12% had only institutional behaviors
- 21% were identified to have IQ's in the IDD range

Mentally ill juvenile offenders

- Girls more likely to have internalizing and externalizing disorders
- White youth were more likely to have mental health problems, African Americans least likely
- Scores taken at subsequent visits to detention remained stable (Caufman, 2004).

PTSD & Incarcerated Youth

- 75% of delinquent youth have experienced trauma victimization (King, et al., 2011; Ko et al., 2008)
- Study of 898 juvenile detainees in Cook County, Illinois, reported 93% being exposed to at least one trauma, with mean number of traumas equaling 14.6
- Rates of PTSD in incarcerated youth are up to 8 times as high as other community samples in similar-age youth
- In addition to PTSD, these youth also display other psychiatric problems related to trauma exposure
- Study of 100 incarcerated youth showed that all had comorbid substance abuse disorders, 76% had depression, 19% had psychosis, 16% ADHD, 38% had other anxiety d/o, 68% had attempted suicide (Kurg et al., 2009; Rosenberg et al., 2013)
Trauma and Sex Offending Behavior (McMackin, 2002)

- N=40 juvenile sex offenders, Massachusetts Department of Youth Services
- Some type of trauma was reported by 95% of the sample
  - Trauma exposures included:
    - Childhood physical and/or sexual abuse
    - Serious life threats/injuries
    - Witnessing severe injury or death
    - Involved in gang violence
- PTSD based on endorsement of symptoms was 65%
  - With histories of sexual abuse 86%
  - With histories of physical abuse 89%
  - With histories of physical AND sexual abuse 84%
  - History of physical, sexual, and being a victim of other violence 100%

Juveniles vs Adult treatment focus:

- Juveniles - rehabilitation and treatment, with focus on community protection.
- Adult criminal courts are predicated on punishment and deterrence.

Juveniles with mental illness more difficult to treat due to:

It is estimated that about 45 percent of offenders in state and local prisons and jails have a mental health problem comorbid with substance abuse or addiction. Treatment of comorbid disorders can reduce not only associated medical complications, but also negative social outcomes by mitigating against a return to criminal behavior and re-incarceration.

Difficult to treat due to the complexity of a combination of several diagnoses all at the same time.

It is estimated that 55% from the sex offenders with mental illness have been diagnosed with at least 2, up to 4, major diagnoses that are barriers to treatment.

-Comorbid mental illness (Oxnam & Vess, 2008)
Juveniles with mental illness more difficult to treat due to:

- prior maltreatment
- Abuse, neglect, prior sexual abuse and mistreatment can result in resistance to treatment and/or multiple other diagnoses such as PTSD
- poor understanding/judgment capacities
- Often in treatment the inability to understand the reason, purpose and goals are experienced by clients with mild or moderate mental retardation/intellectual disability (intellectual developmental disorder). Clients presenting severe mental retardation are often not suitable for treatment.

Juveniles with mental illness more difficult to treat due to:

- lack of inner resources and coping mechanism
- Emotional disturbance/dysregulation are a major barrier for proper stabilization of thoughts and feelings.
- lack of external resources – treatment centers, family support, social support (Reid & Way, 2001)

Juveniles with mental illness more difficult to treat due to:

- difficulty to tailor a specific treatment to incorporate most of the deficiencies as opposed to a “cure for all” response

Individualized plans require an in debt knowledge of clinicians when discussing methods of treatment, informed participation or evidence-based treatment plans. This will include but is not limited to assessment and evaluation of strengths, needs and pitfalls in creating such a tailored treatment.
Juveniles with MI are more difficult to treat

- comorbid mental illness (Oxnam & Vess, 2008)
- prior maltreatment
- poor understanding/judgment capacities
- lack of inner resources and coping mechanism
- lack of external resources – treatment centers, family support, social support (Reid & Way, 2001)
- difficulty to tailor a specific treatment to incorporate most of the deficiencies as opposed to a “cure for all” response

How Are the Risk Factors for Offenders with MI different?

- Sexual behavior problems as a symptoms of illness versus in addition to illness (Rotter, 2007)
  - For example, a person with schizophrenia may have general deviant sexual interest or only commit sexual violence in response to hallucinations/delusions
  - Someone with Bipolar Disorder may commit sexual offenses only when experiencing the hypersexuality of a manic episode

Elements that increase risk:

- Sexual/deviant preoccupation/interest
- MI clients will link their desires, fantasies to vacillation of mood, anxiety, hallucinations or delusions
- High degree of planning/aggression/duration of sexual offense
  - If degree of planning is not characteristic for the MI population, aggression and duration might be intensified – mood determining aggression and poor boundaries and impulses determine duration.)
Elements that increase risk:

- Multiple sexual offenses/victims
- (lack of selective approach is higher for MI clients)
- Extra familial victims (McPhail, Hermann, & Nunes, 2013)
- (lack of social boundaries is higher for MI clients)
- History of interpersonal aggression/substance abuse/family history of substance abuse (Lawing, Frick, & Cruise, 2010) (Van Vught et al., 2008)
- (poor familial relationships, MI familial history, greater risk of substance abuse due to MI)

- MH TREATMENT NONCOMPLIANCE WILL EXPONENTIAL INCREASE RISK FACTORS.

Elements that increase risk:

- Emotional dyscontrol/management of emotional dyscontrol (Baker, Tabacoff, Tornusciolo, & Eisenstadt, 2003)
- (lack of coping skills and tools to deal with illness)
- Social isolation/poor peer relationships
- (MI population is more isolated and/or less skilled in creating relationships)
- Unwillingness to admit/change sexual behavior
- (it might be due to inability or unwillingness denial – to change, characteristics that are as well part of the mental illness)

Elements that increase risk:

- Has no realistic relapse prevention plan
- (MI population is less skilled to create viable relapse prevention plans due to mental impairment, emotional disturbance or denial. Most of the time social rejection plays a key role)
- Family denies/ supports sexual offense/not supportive of treatment/unwillingness to provide proper supervision
- (family might suffer of same or more severe MI, family is disorganized, lacking basic resources)
- (Kingston & Yates, 2012)
Why regression in treatment and recidivism is higher in mentally ill sex offenders

• Target symptoms and improvements expected to be accomplished by the sex offender at the successful completion of the treatment – in Accordance with the curriculum and expectation from the Sexual Behavioral Treatment Plan in Texas Juvenile Justice Department.

• Development of awareness, knowledge and enrichment of one's own thoughts and identifying the factors that influence one's thinking.

  Awareness is properly developed by a client with reasonable stable emotions, and enrichment of thoughts requires individuals with a relative normal level to high self-esteem. Emotionally disturbed or clients diagnosed with trauma, PTSD, Mood Disorder, Depressive Disorders, Reactive Attachment Disorder etc., which have their thoughts influenced mostly by a dysregulation pattern, by thinking errors and by “all or nothing” type of thinking.

Why regression in treatment and recidivism is higher in mentally ill sex offenders

• Development of skills in empathic responding by understanding the role each person plays in relationships.

  Mental illness has the very roots in the fact that it is difficult for individuals to clearly understand roles and safe relationships. Boundaries issues, imbalance response are main characteristics for the mentally ill clientele.

• Development of the concepts of morality and moral reasoning.

  Clients diagnosed with Asperger (Autism Spectrum Disorders) or Reactive Attachment Disorder are known for the incapacity to understand and reciprocate abstract notions such as “morals” “morality” “ethical” or “empathy”. Therefore, this task will be only possibly accomplished with in a tailored treatment plan with adaptations.

Why regression in treatment and recidivism is higher in mentally ill sex offenders

• Developing the capacity for self-regulation of impulsive thinking, feeling and action.

  Experiencing, developing and building of trust and confidence in self and others.

  Research shows that Depressive Disorder, Anxiety Disorders, Panic Disorder, PTSD, simultaneously coexist with lack of/ or low self esteem

• Developing capacity for a sense of social connectedness (one's place and role in family, community and the workplace).

  Emotional dysregulation especially depression is characterized by lack of social connectedness and isolation.
Preferred treatment modalities for sex offender treatment

- CBT oriented groups and individual therapy with an emphasis on individual behavioral drivers
- Functional Family Therapy, Multi-Dimensional Treatment Foster Care, and Multi-Systemic Therapy (Letourneau, et al., 2009), (Finkel and Mendel, 2013)
- Risk-Needs Responsivity
- Relapse Prevention
- Self-Regulation
- Good Lives Model (Cortoni, 2011)

Tailoring an individualized plan for Juveniles Sex Offenders with Mental Illness

- Indiv Plan (Delisi et al., 2008) (Gerardin & Thibaut, 2004) (Calley, 2007)
- Plan Steps
- NOTE: Due to the complexity of the therapeutic relationship combined with the idea of a sex offender treatment provider there is a better chance for a successful treatment for sex offenders with mental illness when the LSOTP is also, at least in part, the therapeutic provider for the client.

Tailoring an individualized plan for Juveniles Sex Offenders with Mental Illness

1. Study in detail the client family, social, mental health, medical, educational, relational history, based on official documents, medical records, family statements and client self-disclosure.
2. Prior to starting treatment develop a therapeutic relationship based on mutual understanding, trust, fairness and consistency.
3. Train client in discussing with you as therapist any issues
4. Discuss with the academic professionals the barriers in learning process the client might encounter
5. if necessary perform additional testing to clarify unanswered issues
Tailoring an individualized plan for Juveniles Sex Offenders with Mental Illness

6. Assess and evaluate the individual trauma and other issues that might be major barriers in sex offender treatment
7. Tailor an individual plan based part on the evidence based curriculum however having in mind achievable goals. With this in notice, assess how far a client can go in understanding written materials, how proficient is in writing essays and letters and if there is a mental impairment in abstract notions understanding.
8. Have a clear understanding, while knowing the client what can be achieved and what is due to client resistance in treatment.
9. Make sure that in the outcome of treatment, even when successful, the potential for recidivating is noted as being high, due to major risk factors.

How Are the Protective Factors for the Offender with MI different?

• Treatment of mental illness may be sufficient to address sexual behavior problems
• Kim (2012) found that a 10-week cognitive behavioral treatment trial was not as effective as treating the mental illness symptoms alone.
• However, Levenson and D’Amora (2005) suggest that CBT reduces the chances of recidivism from 17% to 10%.

What do Offenders with MI need to learn in treatment?

• Treatment of mental illness may be sufficient to address sexual behavior problems
• Kim (2012) found that a 10-week cognitive behavioral treatment trial was not as effective as treating the mental illness symptoms alone.
• However, if doing SD treatment with a mentally ill youth,
• Emotional Regulation
• Symptom Management
• Social Skills
Emotional Regulation

Symptom management

Social Skills
What are the inherent accommodations that providers must make in treatment?

- A. For Schizophrenia and psychotic disorders
- B. For Affective disorders
- C. For Anxiety disorders
- D. For Posttraumatic Stress disorder
- E. For Personality disorders
- F. For Pervasive Developmental Disorders

Schizophrenia and psychotic disorders

- Typical treatment goals are medication compliance for symptom management, family involvement, reality-based therapies, skills training (Lehman & Steinwachs, 2003)
- Medication addresses positive symptoms best, with modest benefits to cognitive and negative symptoms (Remington, Fassias, & Agid, 2010)
- Accommodations (Rotter, 2007):
  - Additional assessment to determine sexual interest
  - Increased flexibility to allow for periods of psychosis, repetition, and review
  - Individual sessions
  - Psychoeducation about appropriate versus coercive sexual interactions
  - Nonjudgmental atmosphere and using external rather than personal examples
  - Medication of the mental illness

Affective disorders

- CBT to address disturbed thinking patterns and to confront irrational beliefs
- Medication helps the client to tolerate symptoms of depression and anxiety, initially assisting the client in improving sleep quality, later improving mood and anxiety tolerance
- And best is the combination of CBT and medication
### Anxiety disorders

- **Typical treatments include:**
  - Cognitive behavioral therapy
  - Behavioral therapy
  - Group therapy
  - Family therapy
  - Eye movement desensitization and reprocessing (EMDR)
  - Psychotropic medication

- **Accommodations:**
  - Using gradual exposure and disclosure
  - Medication management
  - Relaxation skills
  - Praise, encouragement, and validation
  - Combine individual sex offending counseling with group sex offender

### Posttraumatic Stress disorder

- **PTSD secondary to sexual victimization** may play direct role in the emergence of sexual behavior problems, and very likely exacerbates the sexual behavior.

- **Typical treatment for adolescents with PTSD** according to International Society for Traumatic Stress Studies (ISTSS):
  - Cognitive behavioral approaches
  - Exposure strategies
  - Stress management-relaxation
  - Cognitive-narrative restructuring
  - Parental participation

- **The American Academy of Child and Adolescent Psychiatry** don’t exclude:
  - Insight-oriented
  - Interpersonal
  - Psychodynamic

- **PTSD secondary to sexual victimization** may play direct role in the emergence of sexual behavior problems, and very likely exacerbates the sexual behavior.

- **Posttraumatic Stress disorder**

- **Accommodations:**
  - Dealing with trauma-associated feelings and experiences may be an important target for SO treatment to decrease risk of re-offending
  - Training SO therapists in understanding the link between trauma and sex offending triggers
  - Screening all SO for trauma histories
  - Assessing SO for the presence of PTSD and co-morbid condition
  - Having SO diagnosed with PTSD participate in trauma-focused treatment
  - Teaching SO how to better manage trauma associated affects

- **Cognitive behavioral skills training focused on gradual exposure using**
  - Approach based on an information-processing model of PTSD and is targeted at helping the client cope with their guilt/shame, while emphasizing the identification and differentiation of thoughts and feeling

- **Trauma Systems Therapy**
  - Unique in emphasizing youth’s emotions and behaviors as well as the role of a distressed or threatening social environment

- **Medication management**

  (Abram et al., 2007, Brown et al., 2013, Ovaert, Cashel, & Sewell, 2003)
Personality disorders:
Antisocial Personality

- Youth with elevated profiles on personality measures are at higher risk for treatment non-completion (Kraemer, Salisbury, & Spielman, 1998) (which elevates risk of recidivism)
- Youth with elevations on the Autism (Au) scale of the Jessness Inventory have a lack of empathy and are more egocentric
- Youth with personality difficulties are more likely to have peer victims and more antisocial behaviors (Kraemer, Salisbury, & Spielman, 1998)
- Treatment must therefore address general criminal thinking in addition to sex offender specific topics (Glowacz & Born, 2013)

Personality disorders:
Borderline Personality

- Safety must come first. Self-injury and suicidal behavior have to be stable prior to treatment (Linehan)
- Those with BPD already have significant shame and anger. Treatment focused on their harm towards others may elevate risk of suicide, early drop-out, and self-injury.
- Typical BPD treatment includes emotion regulation skills, a nonjudgmental stance, and building a life worth living.

Pervasive Developmental Disorders
Attachment (Rich, 2013)

• Rich suggests that attachment deficits may lead to “later emotional disturbances and dysfunctional behavior,” and that insecure attachment may set up a developmental vulnerability to engage in sexually abusive behaviors. He asserts that attachment problems create a “general condition associated with troubled and criminal behavior.”
  • There are five dimensions of attachment:
    • Strength – a sense of social connection
    • Security – confidence in relationships
    • Experience – subjective experience in relationships
    • Behaviors – how the individual engages in social interactions
    • Interest – desire for relationships

Attachment Theory as a treatment underpinning

• Rich (2013) wrote extensively about the attachment injuries inherent in the juvenile sex offender that does not necessarily cause sex offending, but is an area that relates to treatment approaches.
  • The following 7 elements to create an attachment-informed treatment environment:
    • Metacognition Trust and confidence in others
    • Empathy Trust and confidence in self
    • Moral reasoning Social connectedness
    • Self-regulation

Positive psychology
Integrated Developmental


Good lives

What are the possible outcomes that offenders with MI might reach?

- Assess treatment team’s expectations of progress
What types of Safety Planning is needed with Offenders with MI?

• Registration does not necessarily provide greater community safety (Letourneau, 2009, (Letourneau, 2010)
• Letourneau recommends instead to require registration based on risk factors, not adjudicated offenses, the duration of registration should reflect the developmental stage of the youthful offender, and registration information should be available only to law enforcement.
• Registration may predict higher recidivism

Safety Planning

References

• Kraemer, Salisbury, & Spielman, 1998
• Glowacz & Born, 2013
References


References


References


• Lawing, K., Frick, P. J., & Cruise, K. R. (2010). Differences in offending patterns between adolescent sex offenders high or low on callous-unemotional traits. Psychological Assessment, 22(2), 298-305.

References
