Psychosexual Assessments and Treatment of Juveniles

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Workshop Objectives

1. When to refer juveniles for psychosexual assessments and treatment?
2. High risk factors as well as safety issues within the community, schools and homes.
3. Treatment goals and interventions used in effectively treating Juvenile sexual offenders.
4. Common barriers to overcome to ensure that treatment is successful.

Children vs. Adolescents vs. Adults

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Adolescents VS. Adult Sex Offenders

Adolescents who sexually offend are NOT more likely to become sexual offenders as adults.

Adolescents

- Account for 20% of all rapes and 30-50% of child molestation cases. Percentages have been dropping.

From 2002 through 2008, overall sexual rape/assaults among youth 12-15 has decreased by 24% and among youth aged 16-19 by 60%.

JSO Characteristics

- Most have been a victim of sexual abuse.
- Juvenile sex offenders frequently engage in nonsexual criminal and antisocial behavior.
- Usually males between 12-16 years old.
- Children who committed sex offenses vary in characteristics according to:
  - Types of offending behaviors
  - Histories of child maltreatment
  - Sexual knowledge and experiences
  - Academic and cognitive functioning
  - Mental health issues

JSO Characteristics

- Childhood experiences of being sexually or physically abused, being neglected, and witnessing family violence have been independently associated with sexual violence in juvenile offenders.
Some personality characteristics are also common correlates of juvenile sexual offending.
They include but are not limited to:
- Anxiety
- Aggression
- Depression
- Narcissism
- Pessimism
- Self-sufficiency

Youth who are engaged in sexually assaultive type behaviors have frequently been diagnosed with other comorbid behaviors. These include but are not limited to:
- Defiant Disorder and Conduct Disorder
- Substance abuse
- Attention Deficit Hyperactivity Disorder (ADHD)
- Developmental Disabilities and Learning Disorders
- Bipolar Disorders
- Reactive Attachment Disorder
- Posttraumatic Stress Disorder
- Biological deficits

There are no studies which validate the differences between types of JSO’s.
Despite this problem with the empirical literature, there are several typologies used when classifying youths who engage in risky sexual behavior.
JSO Typologies

- Berliner and colleagues - three types of sexually inappropriate behavior: precocious, inappropriate and coercive sexual behaviors.
- Knight and Prensky - six categories of offenders including: rapists, child molesters, sexually reactive, fondlers, paraphilic offenders and unclassifiable.
- Hunter and colleagues - three prototypes: lifestyle persistent, adolescent onset/nonparaphilic and early adolescent onset or paraphilic.

Labeling of Sexual Behaviors

- Accepted language – Child or adolescent with a Sexual Behavior Problem (SBP).
- Sexual offender refers to persons who have been charged or convicted of a sexual offense. Sexual predator likewise requires a specific judicial determination after conviction.

Psychosexual Assessment or Treatment? Review 101

1. Psychosexual Assessment VS. Psychological Evaluation, Comprehensive Behavioral Health Assessment, Psychosocial Evaluation, Sexual Behavior Screening, etc.
2. Forensic vs. Clinical Assessment?
3. Placement Recommendations?
4. Limitations - What it is and what it is not?
5. ATSA Guidelines should be followed.

Psychosexual Assessment or Treatment? Review 101

6. Testing should be developmentally appropriate.
7. Type and Mode of Treatment Necessary???
8. MUST include parents, caretakers & collateral information.
9. Qualified Provider is critical.
Qualified?

- Defined “Qualified Sexual Offender Practitioner” to mean a professional who is eligible to practice juvenile sexual offender therapy under s. 490.0145, F.S., or s. 491.0144, F.S., and who:
  (a) possesses:
  - at least 55 hours of post-graduate degree continuing education courses in one or more specified areas;
  - at least 2000 hours of post-graduate degree supervised practice in the evaluation and treatment of persons who have committed sexually delinquent acts; or
  (b) is directly supervised by a juvenile sexual offender therapist who satisfies the enumerated education and practice requirements.

Know Your Limits

Workshop Objective #1

When to refer juveniles for psychosexual assessments and treatment?
Refer for Psychosexual Evaluation when . . .

1. Compulsively engage in sexual behaviors (does not seem to enjoy the activity but keeps doing it, or seems to be unable to stop).
2. Angry, violent, or forceful in sexual behavior toward others.
3. Inappropriate age related sexual activity.
4. Intercourse or oral sex between young children.

Refer for Psychosexual Evaluation when . . .

5. Sex with animals.
6. Sexual activity with a child of a large age difference.
7. Sexual behavior is hurtful to others.
8. Continues to exhibit past sexually inappropriate behavior.
9. Sexual behavior is illegal. Inappropriate vs. Illegal.

Illegal Sexual Behaviors

- Touching private parts in public or masturbating in front of others.
- Peeping into others' windows.
- Exposing self (“flashing”) or stripping in front of others.
- Inappropriately touching others against their will.
- Sexual activity with children who are 3 or more years younger.

Illegal Sexual Behaviors

- Sexual activity with family members such as siblings.
- Sexual activity with a non-consenting partner or coercing others into having sexual contact.
- Stalking, maintenance and/or sexual grooming behaviors.
- Sexual activity with someone who is significantly weaker in some way, such as mentally, physically, emotionally, or socially.
**Illegal Sexual Behaviors**

- Engaging in sexual activity with animals.
- Sexually harassing others.
- Coercive sexual behavior.
- Deviant or paraphilic sexual behaviors such as frotteurism, exhibitionism and pedophilia.

**Workshop Objective #2**

High risk factors as well as safety issues within the community, schools and homes.

**High Risk Factors**

- Comprehensive meta-analysis - a number of risk factors specifically in regards to recidivism studies for juvenile sex offenders.
- Roberts and colleagues (2002) identified two risk factors domains: sexual deviance and antisocial activity.
- These two risk factors have also been used in other meta-analyses (See Hanson and Bussière, 1998; McCann and Lussier, 2008).
**High Risk Factors (from J-SOAP-II)**

**Higher Sexual Drive/Preoccupation?**
- Prior sex offense charges
- More victims
- Male child victim
- Longer duration of sex offense history
- Planned offense/s
- Higher level of sexualized aggression
- Victim of sexual abuse

**Impulsive/Antisocial Behavior?**
- Lack Caregiver Consistency
- Pervasive Anger & School Behavior Problems
- History of Conduct Disorder
- **Juvenile Antisocial Behavior**
  - Charged or Arrested Before Age 16
  - Multiple Types of Offenses
  - History of Physical Assault and/or Exposure to Family Violence

**Psychopathology**

**Amenability to Treatment/Intervention?**
- Fail to accept responsibility for offense/s
- Lack internal motivation for change
- Fail to understands risk factors
- Lack empathy, remorse and guilt
- **Higher level of cognitive distortions**
- Poor quality peer relationships
High Risk Factors (from J-SOAP-II)

Community Stability/Adjustment?
- Unable to management sexual urges/desires
- Lack anger management skills
- Unstable living situation
- Instability in school
- Lack positive support systems

Workshop Objective #3

Treatment goals and interventions used in effectively treating Juvenile sexual offenders.

“Children are likely to live up to what you believe of them.”
Lady Bird Johnson, former U.S. First Lady

“Best Treatment” Practices Needed!
Early Diagnosis & Effective Treatment !!!
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**Treatment Effectiveness**

- Studies have yielded inconsistent results.
- While some programs find evidence that treatment reduces reoffense rates of juvenile sex offenders, other studies indicate that only some kinds of treatment are effective for only some kinds of offenders.
- Although some studies report recidivism rates which range between 6-20%, there is at least some evidence to support that juvenile are more likely than adults to respond positively to treatment and less likely to recidivate than adults.

**JSO Treatment - Essentials**

- Should be Competency-based.
- Proper assessment, diagnosis and risk assessment.
- Male-Female Co-Therapy is possible.
- Include reunification goals.

**JSO Treatment - Essentials**

- Comprehensive approach.
- Correct mode, level and type of treatment.
- Maintenance polygraphs for moderate to high risk clients.
- CBT and MST seem to be the most effective treatment approaches.

**TREATMENT GOALS**

- Obvious Goal: Reduce & eliminate inappropriate sexual behavior.
GOAL #1: SAFETY PLANS ARE A MUST!!!

1. Develop, write, & update SAFETY PLANS with youth, siblings, family and all caretakers.

2. Establish specific “House Rules” regarding touching.

Safety plans should address:

1. Therapeutic Activities
2. Limits of Confidentiality
3. Contact with Victims and Potential Victims
4. Control of Inappropriate & High Risk Factors
5. Individualized Rules

Copy available on-line at: http://www.villagecounselingcenter.net/vcc_forms

APPROPRIATE TREATMENT GOALS

- Increase client’s understanding of offending behavior and abuse cycle.
- Teach healthy sexuality.
- Awareness of their own and family patterns.
- Teach caretaker’s to recognize and intervene during high risk situations.
- Integrate feelings and thoughts associated with prior victimization (e.g., Trauma-Focused CBT).

- Help client assess own behaviors and consequences.
- Victim empathy development???
- Social skill development (e.g., anger management, communication, dating, etc.)
- Refer for additional services when necessary (e.g., psychiatric treatment, substance abuse counseling).
Reunification?

VICTIM (Child)
- Ability to Protect Self (physically, emotionally, etc.)
- Successfully Completed any Necessary Assessments And Treatments?
- Evaluated and Ready for Reunification?
- Little Chance of Collusion?

ABUSER (Child or Adult)
- Successfully Completed Required Treatments?
- Low Risk of Re-offending?
- Competency Regarding use of Relapse Prevention Skills?
- Accepts Full Responsibility For Abusing Victim(s)?
- Ready, Willing & Committed to Reunification Process?

PARENT (Caregiver)
- Ability to Protect Self, Victim and Other Children?
- Ready, Willing & Committed to Reunification Process?
- Little Chance of Collusion?
- Participated Successfully in any Necessary Treatments (E.G., Non-Offending Parents Group)?

CHILD SAFETY ?

Appropriate Treatment Goals

- Use of Polygraph Assessments??
  - Sexual History
  - Specific
  - Maintenance

Workshop Objective #4

Common barriers to overcome to ensure that treatment is successful.

Common Barriers – Client/Family

1. Incorrectly assessed and/or misdiagnosed.
2. Unstable and severe psychological and/or substance abuse problems.
3. Lack of support and/or participation by caregivers, or they even undermine treatment.
Common Barriers – Client/Family

4. Client and/or family not held accountable.
5. Not invested in treatment process.

Common Barriers – Environmental

1. No safety plan.
2. Frequent placement disruptions or no placements available.
3. Ineffective JPO or Case Manager.
4. Reunification not possible.

Common Barriers – Environmental

4. Societal myths, labels and JSO Registry.
5. Lack of funding for assessments and/or treatment.
6. Services unavailable.

Juvenile Sex Offender Registry

<table>
<thead>
<tr>
<th>Commission of OR Attempt, Solicit, or Conspire to Commit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>s.794.011* Sexual Battery; *excluding subsection (10)</td>
<td></td>
</tr>
<tr>
<td>s. 800.04(4)(b) Lewd/lascivious battery where the victim is under 12 or the court finds sexual activity by the use of force or coercion</td>
<td></td>
</tr>
<tr>
<td>s. 800.04(5)(c)1 Lewd/lascivious molestation, victim under 12, where the court finds molestation involving unclothed genitals</td>
<td></td>
</tr>
<tr>
<td>s. 800.04(5)(d) Lewd/lascivious molestation, victim under 16 but more than 12, where the court finds the use of force or coercion and unclothed genitals</td>
<td></td>
</tr>
<tr>
<td>Or A violation of a similar law of another jurisdiction</td>
<td></td>
</tr>
</tbody>
</table>
Common Barriers – Provider

1. Treatment provider not qualified or incompetent.
2. Poor treatment model.
3. Poor Client-Therapist match.

Common Barriers – Provider

4. Incorrect placement, level or mode of treatment.
5. Therapist chasing symptoms, avoidant of dealing with sexual issues and/or unable to confront client effectively.
6. Therapist compassion fatigue or burnout.

Questions/Comments?

THANK YOU

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