Psychosexual Assessments and Treatment of Children and Adolescents

Who am I?
- U.F. - Ed.S., Marriage & Family Therapy
- LMHC, Certifications
- Dr. Ted Shaw & Brown Schools of Florida
- Village Counseling Center
- Child on Child Sexual Abuse Prevention Task Force
- Gabriel Myers Task Force
- Task Force for Fostering Success

Introductions and Goals?

Why all the Concern?
- 20% of all rapes
- Approximately 50% of child molestation cases
- Percentages have been dropping
  2002 - 2008, sexual rape/assaults among youth 12-15 decreased by 24% and among youth aged 16-19 by 60%
- Continued Stigmatization
- Children acting out sexually in foster homes and other dependency placements
- More children being charged legally/criminally for sexually inappropriate behavior

Compassion

Sexually acting out children need to be viewed compassionately and with a hopeful attitude toward recovery.

These children are often victims of maltreatment themselves and deserve a chance to heal and live a healthy life.

Psychosexual Assessments and Treatment of Children and Adolescents
S.A.I.N. Workshop
Robert Edelman, Ed.S., LMHC
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Why all the Concern?
Adolescents
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Why all the Concern?

Every time a child acts out in an inappropriate sexual way it increases the chances that he/she will sexually act out in the future.

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.

Children/Adolescents vs. Adult Sex Offenders

Youth with sexual behavior problems are very different and not the same as adult sex offenders.

REVIEW: You Decide – Common or Uncommon?

- 7-year-old girl inserting bath toys into her vagina
- 8-year-old boy telling his sister, “Give me a blow job.”
12-year-old girl frequently exposing herself to her peers at school.

8-year-old girl playing house and pretending she is pregnant.

5-year old boy laying on the floor after bath time and rubbing his penis.

13-year-old girl pretending to be a stripper

5-year-old boy who fondles his penis almost every night at bed time and is observed to have erections most of the time.

4-year-old boy dressing in girls clothing?
Inappropriate or problematic sexual behavior in children is not a clear indicator that a child has been sexually abused.

Some inappropriate sexual behavior in children should be dealt with in the way you would deal with all inappropriate behavior.

**Common:**
- Sexual language relating to differences in body parts, bathroom talk, pregnancy and birth.
- Masturbation at home and in public. Showing and looking at private body parts.

**Uncommon:**
- Discussion of sexual acts. Contact experiences with other children.

**Review:**

**Child Sexual Development — 6-12 Years Old**

- Questions about menstruation, pregnancy, sexual behavior. “Experimenting” with same-age children, including kissing, fondling, exhibitionism, and role-playing. Masturbation at home or other private places.
- Use of sexual words and discussing sexual acts.

**Common:**
- Questions about decision-making, social relationships, and sexual customs. Masturbation in private. Experimenting between adolescents of the same age, including open-mouth kissing, fondling, and body rubbing. Also, voyeuristic behaviors.

**Uncommon:**
- Sexual intercourse occurs in approximately one third of this age group.

**Review:**

**Child Sexual Development — 13-16 Years Old**

- Parental guidance - critical factor
- Important in instilling values about sexuality
- Sex as dirty, inappropriate, or secretive = rigid and restrictive limits on self-exploration, language, questions, or curiosity considered healthy in children
- If punished, chastised, or humiliated for their sexuality – likely to associate sex with shame or guilt.

Children need an open environment in which they can ask questions and learn about sexuality. If they can’t find that at home, they frequently designate their peers as educators.
Adolescents and adults are the ones typically criminally charged for indecent sexual behavior. However, children as young as 9-years-old are also being charged for sexual offenses and being placed on juvenile probation. For young children, appropriateness of sexual behavior is dependent on age and/or developmental issues.

**Review: Inappropriate vs. Illegal Sexual Behaviors**

- Adolescents and adults are the ones typically criminally charged for indecent sexual behavior.
- However, children as young as 9-years-old are also being charged for sexual offenses and being placed on juvenile probation.
- For young children, appropriateness of sexual behavior is dependent on age and/or developmental issues.

**Review: Inappropriate Sexual Behavior**

- Not just curious anymore – obsessive behavior
- Re-enact adult sexual activity
- Try to Coerce others
- Discuss sexual acts in public
- Put mouth on sexual parts
- Continued use of pornography

**Review: Inappropriate Sexual Behavior**

- Overly friendly or Kiss adults they don’t know well
- Draw sexual parts
- Touch adults’ or animals’ sexual parts
- Masturbate with objects
- Injure themselves via sexual activities

**Review: Illegal Sexual Behaviors**

- Public Masturbation
- Peeping
- Flashing
- Touching others against their will
- Sex with children

**Review: Illegal Sexual Behaviors**

- Sex with family
- Sex without consent
- Stalking and harassment
- Sexual activity with more vulnerable partner

**Review: Illegal Sexual Behaviors**

- Sex with animals
- Child pornography
- Deviant or paraphilic sexual behaviors such as frotteurism, exhibitionism and pedophilia.
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**CHILDREN: SIGNS OF SEXUAL DISTURBANCE**

When to be especially concerned:

A. A child appears preoccupied with sexual themes for extended periods, often with confused or anxious affect or if the child appears secretive, anxious, or confused about sexual behaviors.
   
   Case Example: Quinn

B. A child is angry, violent, or forceful in his or her sexual behavior toward others, is using objects, or is inserting objects or fingers in other children.
   
   Case Example: Willie

**Review: Why some children act out sexually?**

- History of Sexual Abuse & Sexual Reactivity
- Pre-sexualization
- Contributing Factors
- ‘Sexualization’ Issues

**Act out in sexual ways to:**

- Attempt to deal with difficult emotions (sadness, anxiety, fear, shame, abandonment)
- Decrease tension
- Satisfy impulsive sexual needs
- Cope with intrusive, trauma related memories

**Florida Rule: 64B4-7.007**

Requirement to Hold Oneself Out as Qualified to Practice Juvenile Sex Offender Therapy.

- Effective October 1, 2000, in order for a licensed clinical social worker, marriage and family therapist or mental health counselor to hold oneself out as one qualified to practice juvenile sex offender therapy the licensee must have:

**Florida Law: 490.0145 and 490.0144**

Certified Juvenile Sex Offender Therapist

- Under ss. 490.0145 and 490.0144, F.S., only a person who is licensed as a psychologist, clinical social worker, marriage and family therapist, or mental health counselor and who possesses education and training requirements specified in rule may practice juvenile sex offender therapy.
Florida Law: Qualified Sexual Offender Practitioner?

- Professional who is eligible to practice juvenile sexual offender therapy under s. 490.0145, F.S., or s. 491.0144, F.S., 22
- At least 55 hours of post-graduate continuing education in specified areas

Florida Law: Qualified Sexual Offender Practitioner?

- At least 2000 hours of post-graduate degree supervised practice in the evaluation and treatment of persons who have committed sexually delinquent acts; or is directly supervised by a Certified Juvenile Sexual Offender Therapist
- Complete 20 hours of continuing education credits each license renewal biennium in any of the subject areas stated

ATSA Membership Requirements

Clinical Membership

- Masters Degree or above, in the Behavioral or Social Sciences
- Minimum of 2000 hours direct clinical services (assessment, individual and/or group treatment) to individuals who have engaged in sexual offending behavior

Research Membership

- Masters Degree or above, in the Behavioral or Social Sciences
- Minimum of 2000 hours of conducting research specific to investigating issues related to sexual offending behavior

Florida Law: Juvenile Sex Offender Registry

- Commission of OR Attempt, Solicit, or Conspire to Commit
  - s. 794.011* Sexual Battery, *excluding subsection(10)
  - 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
  - s. 800.04(5)(c)1 Lewd/lascivious molestation, victim under 12, where the court finds molestation involving unclothed genitals
  - 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

  Or A violation of a similar law of another jurisdiction

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Adolescents VS. Adult Sex Offenders

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

Children VS. ADOLESCENTS vs. Adults

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

No profile or typologies available
No characteristic is universal
Wide range of severity & harm to other children
Sooooooo . . . Case by case decisions must be made about: removal, placement, notifying others, reporting, legal adjudication, restrictions on contact, etc.

History of Maltreatment – 59%
1. Sexual abuse - 48%
2. Physical abuse - 32%
3. Emotional abuse - 35%
4. Neglect - 16%

More trauma = higher risk for acting out sexually??????

Substandard parenting practices
Exposed to Highly Sexualized Environments
Chaotic and more stress
Divorce and/or a death in their immediate family
Exposure to other children (ex. daycare, foster care)

Children - Contributing Factors? Environmental:

Many Children with SBP:

Which children are most likely to act out sexually? Bad News?

- No profile or typologies available
- No characteristic is universal
- Wide range of severity & harm to other children
- Sooooooo . . . Case by case decisions must be made about: removal, placement, notifying others, reporting, legal adjudication, restrictions on contact, etc.

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Excessive Anxiety
PTSD (although freq. misdiagnosed as other disorders – ex. ADHD)
Past Mental Health Treatment – 60%
More behavioral and emotional disturbances
Very impulsive & reactive

Younger ages, males and females are equally represented.
As age increases, tendency for males to outnumber females.
As the level of aggressiveness increases, the number of females involved decreases.

Family violence is a model for boundary problems and intrusive behavior.

May reflect less consistent parenting and as a result may predispose a child to act out in a variety of ways.
Sexual acting out as a sign of distress.

- Most - victims of sexual abuse.
- Frequently engage in nonsexual criminal and antisocial behavior.
- Males between 12-16 years old.
- Vary according to:
  - Types of offending behaviors
  - Histories of child maltreatment
  - Sexual knowledge and experiences
  - Academic and cognitive functioning
  - Mental health issues

93% are male
Ages: 5% younger than 9
16% younger than 12
38% 12-14
46% 15-17

Finkelhor, Ormsod and Chaffin (2009)
Data collected in 2004 from the FBI’s National Incident-Based Reporting System (NIBRS)
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- 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.
  - Aggression
  - Depression
  - Narcissism
  - Pessimism
  - Self-sufficiency

- The most comprehensive analysis of 813 sexually abusive juveniles was conducted in Massachusetts by Schwartz and colleagues (2006).
  - They found that common characteristics of juvenile sex offenders had a history of:
    - Pregnancy and birth complications (25%)
    - Alcohol abuse during pregnancy (15%)
    - Drug abuse during pregnancy (20%)
    - Head trauma (14%)
    - More likely to attend Special Education classes

- Roberts and colleagues meta-analytical investigations (2002) identified two risk factors domains: sexual deviance and antisocial activity.
  - These two risk factors have also been used in other meta-analyses (Hanson and Bussière, 1998; McCann and Lussier, 2008).
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Differences from Adult Offenders

- More likely to offend in groups
- More likely to offend against acquaintances
- Less likely to rape
- More likely to have a male victim
- More likely to target young children
- 59% victim is under 12

Adolescent TYPOLOGIES

- 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.

- Berliner and colleagues - three types of sexually inappropriate behavior: precocious, inappropriate and coercive sexual behaviors.
- Knight and Prentky - 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.

Special Populations: Female JSO’s

- Only 7 percent of JSO’s
- Differences with male JSO’s
  - Younger
  - More likely to offend with others
  - More likely to have multiple victims
  - More likely to offend in a residence
  - More likely to have male victims

Special Populations: Dependent Children

- Require longer treatment due to other issues and problems
- Placement and Adoption are always an issue, but do they need to be???
- Placement stability is critical
  Ex. Gabriel Myers.

Special Populations: Developmentally Delayed

- Lack of treatment options and providers
- Less research
- Behavioral modification and on-going supervision is critical
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Psychosexual Assessments

Why?

• Level of risk
• Treatment needs
• Severity of disturbance
• Assets and strengths
• Amenability to treatment
• Required level of care

When?

• ASAP
• Delinquent: Post-adjudication and presentence

Psychosexual Assessment

According to Saunders and colleagues (2004:28-34) - 4 primary domains:
1. Intellectual and neurological
2. Personality functioning
3. Psychopathology
4. Behavioral and sexual deviance

Risk assessment accuracy in predicting treatment and recidivism are an essential piece of the assessment process.

There have been few studies which assess the accuracy of these measures.

Psychosexual Assessments

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. Confidentiality protocols and new disclosures need to be discussed.
10. Qualified Provider is critical.

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.
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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.

Psychosexual Assessment

Alternative: Sexual Behavior Assessment

Psychosexual Assessment

Should also include:
- Development and maturity/special needs
- Psychometric assessment of sexual attitudes, interests, and adjustment
- Environmental considerations
  - Structure, SUPERVISION, Victim Access, Caregivers
- Selective use of physiological measures
- Risk assessment

Assessment Areas: Sex History

- Sexual knowledge
- Sex education history (ex. where learned and from who?)
- Non-offending sexual history (ex. first time)
- Masturbation (age of onset, frequency, types, fantasies)
- Presexualization
- History and exposure to sexual behavior and pornography
- Sexual compulsivity/impulsivity
- Turn ons, fantasies, ideal partner characteristics

Assessment Areas: Sex History

- Sexual victimization
- Range of sexual behaviors
- Sexual arousal/interest
- Sexual preference/orientation
- Sexual dysfunctions and paraphilias
- Sexual attitudes/distortions (ex. hyper-masculinity)

Assessment Areas: Sexually Abusive Behavior

- Types of sexually abusive behavior committed
- Indications of progression over time
- Level of aggression
- Frequency of behavior
- Style and type of victim access
- Preferred victim type
- Associated arousal patterns
Assessment Areas: Sexually Abusive Behavior
- Changes in sexual abuse behaviors or related thinking
- Intent and motivation
- Extent of openness and honesty
- Internal and external risk factors
- Victim empathy
- Victim selection characteristics/typology

Assessment Areas: Amenability Issues
- Willingness and commitment to participate in treatment
- Insight into problem
- Family support and willingness to participate in treatment
- Mental health history and stability
- Developmental level
- Learning Disability
- History of ODD or CD

Clinician’s Perceptions of Amenability
- Surveyed 158 SOST providers through ATSA
- Rated as strong indicators of poor SOST amenability
  1. Youths’ unwillingness to alter deviant sexual interest/attitudes and
  2. Unsupportive parenting

Clinician’s Perceptions of Amenability
- Rated as strong indicators of good SOST amenability:
  1. Youths’ motivation for change and belief in treatment efficacy
  2. Strong social support and positive attachments
  3. Resilient personality traits

Placement Issues & Concerns
- Least Restrictive Environment
- Sabotaged Treatments/Placements?
- Qualitative Evaluations
- Psychosexual and Sexual Behavior Assessments
- Notification of Placement Changes
- Lack of Stability = Higher Risk for SBP’s

Continuum of Care Needs to Match Risk Level
- Low risk
- Moderate risk
- High risk
- Community-based options, day treatment, outpatient services
- Residential treatment centers, structured group homes, therapeutic foster care
- Secure correctional, secure residential, inpatient psychiatric facilities
Primary assessment goal is readiness for community reentry
Focus is generally on dynamic, changeable factors
   - Denial, cognitive distortions, empathy, disclosure
   - Emotional management
   - Healthy communication
   - Awareness of risk factors, offense cycles
   - Development and effective use of coping skills
   - Family/environmental readiness

Common Assessments: Young Children
- Child Sexual Behavior Inventory (CSBI)
- Trauma Symptom Checklist
- Child Behavior Checklist
- Connors Comprehensive Behavior Rating Scale or Connors 3rd Edition
- Parent Stress Index (PSI)
- About Me (Depression Inventory)
- Incomplete Sentence Form

Child Sexual Behavior Inventory – (CSBI)
- Parent report (mother or primary female caregiver)
- Measure of sexual behavior in children ages 2-12 years.
- For children who have been or who may have been sexually abused.
- Based on evidence that sexual abuse is related to the presence of precocious sexual behavior in children.
- CSBI MUST be used in combination with other clinical measures and procedures.
- 38 items, 5th-grade reading level.
- The mother (or primary female caregiver) writes directly in the Test Booklet, indicating how often she has observed each of the listed behaviors during the preceding six months.

Child Sexual Behavior Inventory – (CSBI)
- CSBI Total - overall level of sexual behavior the child exhibits.
- Developmentally Related Sexual Behavior (DRSB) - sexual behaviors that can be considered normative for the child's age and gender.
- Sexual Abuse Specific Items (SASI) - sexual behaviors that can be viewed as relatively atypical for the child's age and gender; such behaviors raise the suspicion of possible sexual abuse.

Assesses a wide range of sexual behaviors that cover nine major content domains:
1. Boundary Issues
2. Sexual Interest
3. Exhibitionism
4. Sexual Intrusiveness
5. Gender Role Behavior
6. Sexual Knowledge
7. Self-Stimulation
8. Voyeuristic Behavior
9. Sexual Anxiety

The mother (or primary female caregiver) writes directly in the Test Booklet, indicating how often she has observed each of the listed behaviors during the preceding six months.

The CSBI was normed on 1,114 children from a wide range of socioeconomic backgrounds in the general population. The Appendix provides raw score to T-score conversions for the CSBI clinical scales for six age/gender groups.

Carbonless form can be hand-scored and includes a Score Summary box for recording raw scores and T-score conversions.

The three CSBI clinical scales
1. CSBI Total - overall level of sexual behavior the child exhibits.
2. Developmentally Related Sexual Behavior (DRSB) - sexual behaviors that can be considered normative for the child's age and gender.
3. Sexual Abuse Specific Items (SASI) - sexual behaviors that can be viewed as relatively atypical for the child's age and gender; such behaviors raise the suspicion of possible sexual abuse.
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**Trauma Symptom Checklist for Children (TSCC)**

- Self-report measure of posttraumatic stress and related psychological symptoms
- Children who have experienced traumatic events (ages 8-16)
- 54-items, 4-point scale, carbonless test booklet, easy hand scoring
- 2 validity scales: Underresponse and Hyperresponse
- 6 clinical scales: Anxiety, Depression, Anger, Posttraumatic Stress, Dissociation, and Sexual Concerns
- Individual or group administration

**Profile Forms** allow for conversion of raw scores to age- and sex-appropriate T scores and graphing the results.

- Scales are internally consistent and exhibit reasonable convergent, discriminant, and predictive validity in normative and clinical samples.
- Standardized on a group of over 3,000 inner-city, urban, and suburban children and adolescents from the general population.

**Child Behavior Checklist**

- 118 items rated by parents
- Describe specific behavioral and emotional problems, plus two open-ended items
- Parent ratings based on how true each item is now or has been within the past 6 months on a 3-point scale.
- CBCL 6-18 scales are based on new factor analyses from parent ratings of 4,994 clinically referred children; normed on 1,753 children ages 6-18 years.

**Risk Assessments: Risky Business**

- No proven method
- Risk and Needs Assessments do not equal Prediction.
- Low base rates of recidivism (typically 10% or lower)
- Help to:
  - Identify factors associated with risk
  - Identify strengths that decrease risk
  - Develop strategies to reduce risk factors
  - Develop strategies to improve strengths

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**Clinical Judgment**
- Based on clinical experience and individual practices

**Empirically Guided**
- Rate a fixed list of factors which are indicated by research to be associated with offending; review of item ratings leads to an overall determination of risk

**Actuarial**
- Fixed number of statistically derived factors are evaluated using a structured and objective rating system; items summed to yield an overall risk score associated with defined level of risk

One of the first major evaluations based on risk assessments - Parks and Bard (2006).
- Examined differences in recidivism risk factors and traits for three groups of male adolescent sexual offenders (N = 156): offenders against children, offenders against peers or adults and mixed type offenders.
- Data indicated that about 6% of the sample reoffended sexually and about 30% reoffended nonsexually.

Parks and Bard (2006) - Risk assessments using the Juvenile Sex Offender Assessment Protocol-II (JSOAP-II) and the Psychopathy Checklist: Youth Version (PCL: YV)
- Using analyses of variance, they found that mixed type offenders produced higher risk scores than those who offended against children or adults/peers.
- Additionally, they found Impulsive/Antisocial Behavior scale of the JSOAP-II and the interpersonal and antisocial factors of the PCL: YV were significant predictors of sexual recidivism.

The behavioral and antisocial factors of the PCL: YV were found to be significant predictors of nonsexual recidivism.
- Despite this finding, other researchers have found that the JSOAP-II and the PCL-YV assessments are not predictive of adolescent violent recidivism for sex offenders (Viljoen et al., 2008; 2009).

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 Brouil, 1999; McCann and Lussier, 2008).

**Psychopathology**
McCann and Lussier (2008:369) - meta-analysis of 18 studies and a total of 3,189 sex offenders. Established seven categories of risk including:

- Criminal history
- Offense characteristics
- Victim characteristics
- Psychological
- Behavioral characteristics
- Antisociality
- Sexual deviancy

- Deviant sexual interests
- Prior criminal sanctions for sexual offending
- Past selection of a stranger victim
- Past sexual offenses against two or more victims
- Social isolation
- Incomplete offense specific treatment

Promising JSO Risk Factors
- Problematic parent/adolescent relationship
- Attitudes supportive of sexual offending

Possible JSO Risk Factors
- High Stress Family Environment
- Impulsivity
- Sexual Preoccupation
- Male Victim
- Negative Peers
- Environment supporting opportunity to reoffend
- Past sexual assault against a child

Possible JSO Risk Factors
- Threats or use of violence during sexual offense
- Indiscriminate choice of victims
- Unwillingness to alter deviant sexual interest
- Antisocial orientation
- Interpersonal aggression
- Recent escalation in anger or negative mood
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### Unlikely JSO Risk Factors
- History of childhood sexual abuse
- History of nonsexual crimes
- Lack of measured “victim empathy”
- Level of penetration in sexual offenses
  - Denial of the sexual offense

### J-SOAP-II: Examples of Static Items
- Empirically guided risk assessment tool
- Considers both static and dynamic elements
- 28 items, 4 subscales
  - Sexual drive/preoccupation (static)
  - Impulsive, antisocial behavior (static)
  - Intervention (dynamic)
  - Community stability/adjustment (dynamic)

### J-SOAP-II: Examples of Dynamic Items
- Accepting responsibility for offense(s)
- Empathy
- Cognitive distortions
- Quality of peer relationships
- Management of sexual urges and desire
- Stability of current living situation
- Stability in school
- Evidence of support systems

### Juvenile Sexual Offense Recidivism Risk Assessment Tool-II (JSORAT)
- 12 Items
- Validated in Utah & Iowa
- Actuarial approach for male juveniles who have offended sexually,
- Items are behaviorally anchored and scored based on a review of relevant reports in juvenile justice case files.

### Juvenile Sexual Offense Recidivism Risk Assessment Tool-II (JSORAT)
- Can be scored by evaluators with a very high degree of consistency.
- Looks at number of sex offender adjudications, number of victims, length of sexual offender history under supervision at time of sex offense, treatment future
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**Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR)**
- Empirically guided tool
- Considers both static and dynamic elements
- 5 broad factors
  - Sexual interests, attitudes, behaviors (static and dynamic)
  - Historical sexual assaults (static)
  - Psychosocial functioning (dynamic)
  - Family environmental functioning (dynamic)
  - Treatment (dynamic)

**Adolescent Sexual Interest Cardsort: Example Items**
- “I go by the gym at school and look through the girls’ locker room window. I can see several girls in their bras and panties.”
- “I am making an 8 year old boy bend over so I can have sex with him.”
- “My sister and I are lying on the couch. I am rubbing her soft skin, all over her body. I’m feeling her breasts.”
- “I’ve tied a girl down in the park. I’m hurting her, just beating her up.”
- “I’m having sex with a pretty 15 year old girl. We really like each other.”

*Becker & Kaplan, 1988*

**Multiphasic Sex Inventory-Juvenile version: Example Items**
- “I am too shy to even talk to a girl my age”
- “I am too embarrassed and ashamed to even try to have sex with a girl my age”
- “I am [not] sexually attractive”
- “After I date a person, they often do not want to go out with me again”

*Nichols & Molinder*

**MOLEST Scale: Example Items**
- “Sometimes, touching a child sexually is a way to show love and affection”
- “Sexual activity with a child can help the child learn about sex”
- “If a person does not use force to have sexual activity with a child, it will not harm the child as much”
- “Some children are willing and eager to have sexual activity with adults”

*Bumby, 1996*

**RAPE Scale: Example Items**
- “Women who get raped probably deserve it”
- “If women did not sleep around so much, they would be less likely to get raped”
- “Victims of rape are usually a little bit to blame for what happens”
- “A lot of times when women say ‘no,’ they are just playing hard-to-get and really mean ‘yes’”
- “Many women have a secret desire to be forced into having sex”

*Bumby, 1996*

**Wilson Sex Fantasy Questionnaire: Example Items**
- Indicate how often you fantasize about the following themes...
  - Being forced to do something
  - Receiving oral sex
  - Watching others have sex
  - Tying someone up
  - Being excited by material or clothing (e.g., rubber, leather, underwear)
  - Exposing yourself provocatively
  - Having incestuous sexual relations

*Wilson, 1998*
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**Other Adolescent Assessments Frequently Used**
- Hare Psychopathy Checklist – Juvenile (PCL)
- PHASE Sexual Attitude Questionnaire
- Incomplete Sentences
- MMPI-A
- Abel, Becker Cognition Scale

**Assessment of Sexual Arousal, Interest, or Preference**
- Sexual arousal patterns not necessarily established fully for all adolescents
- Validity and reliability of physiological measures may be impacted by age, maturity, and development
- Ethical & Liability Issues Ex. Penile Plethysmograph
- Use selectively and cautiously
  - With older (> =14) male clients with more extensive offending histories and/or self-reported deviant interests and arousal
  - With clients who admit offenses
  - With full informed consent of client, parent/guardian, referral source

**Penile Plethysmograph**

**Assessment of Sexual Arousal, Interest, or Preference (cont.)**
- Generally, should use auditory or visual stimuli designed for the juvenile population
- Not to be used to determine innocence or guilt
- May be useful for identifying juveniles with emergent paraphilic disorders
- May help juveniles to gain awareness of their sexually deviant behaviors and patterns and strengthen their non-deviant sexual interests
- Ex. Abel Screen

**Polygraph Assessments**
- Primary Types:
  - Sexual History – complete excluding victimization
  - Specific – for deniers or honesty during assessment process
  - Maintenance – during on-going treatment

**Polygraph for Assessment**
- Often used to facilitate disclosure of sexual history
- Used more frequently with adults than juveniles
- Little research on its reliability and validity for juvenile offenders
- Research suggests results can be influenced by client’s age and intelligence, physical and emotional state, examiner’s training
- Utilization with juveniles should be selective and cautious, with informed consent of youth and parents
Polygraph Assessments

- **Pro's**
  - Additional assessment tool
  - Helps clients take responsibility and promotes honesty

- **Con's**
  - Less reliable as age decreases
  - Expensive and client typically has to pay for it
  - Male examiner and female client
  - Can be intrusive and anxiety provoking
  - Ethical debate

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**TREATMENT**

Obvious Goal: Reduce & eliminate inappropriate sexual behavior.

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**“Best Treatment” Practices Needed!**

**Early Diagnosis & Effective Treatment !!!**

*My therapy is quite simple: I wag my tail and lick your face until you feel good about yourself again.*

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**Treatment Concerns**

- Reputable providers.
- Therapy is not a fix all or “cure”.
- Proper assessments are critical.
- Specialized, intensive training.
- Interagency collaboration.
- It’s the approach, not the modality.
Psychosexual Assessments and Treatment of Children and Adolescents

Specific Treatment Issues

- Specific, measurable, logical, and progressive goals that assure the readiness of all parties.
- Ongoing and closely supervised contacts between the abuser, victim, and other family members are critical during the process.
- Responsible reunification practices require an ongoing assessment of risk and needs.

Frequent Mistakes

- Reunification premature because placement needed or when participants are not committed to process.
- Reunification delayed, postponed, delayed, postponed . . .
- Children held responsible for adult mistakes.
- Failure to use “Successive Approximation” (i.e., one planned step at a time).

Frequent Mistakes

- Inexperienced and unqualified providers offering recommendations which then guides process.
- Belief that treatment providers have crystal balls.
- Failure to tolerate setbacks and belief that “Everything should be perfect.”
- Lack of focus or emphasis on visitation process.

Adult Reactions . . .

Much of the shame and psychological damage that occurs -- not only with child victims of sexual abuse, but also with sexually reactive children -- stems from the reactionary behaviors of adults.

Most children do not continue to have sexual behavioral problems.

- Treatment outcomes -- No longer have sexual behavior problems after short-term outpatient treatment (3-5 months).
- Children 6-12 years old who have been treated -- only 15% still had problems 2 years after treatment.

Review: IMMEDIATE INTERVENTIONS

1. Safety.
2. Report Incident?
5. Safety Plan & Proper SUPERVISION.
6. Parental/Caretaker involvement, support and guidance.
Review: IMMEDIATE INTERVENTIONS

- Refer for other services (psychiatric, medical, etc.)
- Intervene with school, daycare, or after school care personnel.
- Provide treatment for sibling-victims.
- Support interventions with other siblings.
- Focus on core/underlying issues and avoid chasing symptoms.

Three (3) Goals: Children with Sexual Behavioral Problems

1. Create Environments that Reduce Anxiety and Promote Safety
2. Intervene When a Child is Acting Out Sexually or Inappropriately (not within normal developmental limits)
3. Promote Healing and Correction through Therapy and Education

TREATMENT for Children

COGNITIVE-BEHAVIORAL THERAPY

Directed Play Therapy
Indirect, Family & Group Counseling
Multi-disciplinary Approach
Non-Offending Parent Groups
PCIT – Parent Child Interaction Training

Treatment Goals

Teach healthy sexuality (Good Touch, Bad Touch, Secret Touch) especially children who have been sexually abused.

Teach children specific skills to reduce anxiety

- Help children learn tools for dealing with anxiousness, or arousal.
- Teach a child to take a time out, to repeat a phrase in his head, to engage in a physical activity other than sex, or to draw or write out his feelings.
- Children who experience sexual arousal must be given the tools to channel anxiety, frustration, anger or fear into appropriate, non-abusive activities.

Teaching Goals

- MUST teach and role play self protection skills to prevent future sexual abuse.
- Teach caretaker's behavior management techniques.
- Help children learn about feelings and ways to integrate feelings and thoughts associated with prior victimization.
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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 & Multi-systemic approach.
- Correct mode, level and type of treatment.
- Maintenance polygraphs for moderate to high risk clients. (outpatient and inpatient)
- CBT still seems to be the most effective treatment approaches.

TRAUMA-FOCUSED COGNITIVE-BEHAVIORAL THERAPY
- Psychoeducation
- Stress Management
- Affect Expression and Modulation
- Cognitive Coping
- Creating the Trauma Narrative
- Cognitive Processing
- Behavior Management Training
- Parent-Child Sessions
- Evaluation

Community Safety & The Community as the Client
Psychosexual Assessments and Treatment of Children and Adolescents

**Adolescent Treatment: Research**

- Treatment effective studies - inconsistent results
- Recidivism rates which range between 6-20%.
- Very few evaluations that are methodologically sound
- 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.

**Adolescent Treatment: Research**

- Two noted findings include:
  - Juvenile sex offenders are more likely than adults to respond positively to treatment
  - Juveniles are also less likely to recidivate than adults
  (Association for the Treatment of Sexual Abusers, 2000; Worling and Curwin, 2000).

**Adolescent Treatment: Research**

- Importance of approaching treatment by using a multifaceted approach to behavior change because most studies report higher rates of non-sexual than sexual recidivism
- Some common practices among clinical practices include:
  - Involving families in the treatment,
  - Peer group therapy, and
  - Other cognitive behavioral approaches.
- Some evidence which bolsters support for the Multisystemic Therapy (MST) approach in treating sex offenders
  (See Swenson et al., 1998; Letourneau, 2009).

**Adolescent Treatment: Research**

- Longitudinal studies completed by Zimring and colleagues (2009) offered an analysis based on repeat juvenile sex offenders through age 26.
- Four major findings from their analysis using 221 male and female juvenile sex offenders:
  1. Through the first eight years of adulthood, only 10% of youth were charged with another sex-related offense.
  2. Ninety-two percent (92%) of the males in the sample did not have a prior juvenile sex offense.

**Adolescent Treatment: Research**

3. A male with no prior sex offenses but five or more police contacts were more than twice as likely to have a sex-related offense as an adult compared to those adolescents who had less than five police contacts overtime.

4. Last, multinomial logistic regression showed that being a juvenile sex offender did not significantly increase the chance of becoming an adult juvenile sex offender.
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Safety Plans: Basic Rules
- Should be written and signed
- Need to be reviewed with all family members and caretakers
- Should be developmentally appropriate for client or provided in a modified version

Review: Need to Address:
- Supervision
- Boundaries
- Touching
- Sexual Talk
- Physical Punishment

Review: Need to Address:
- Media Restrictions (V-Chip, Parental Controls, etc.)
- Sleeping and Bathroom Issues
- Appropriate Dress/Clothing
- Privacy

How 'bout some privacy here!

DJJ Safety plans should also 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 online at:
http://www.villagecounselingcenter.net/vcc_forms

TREATMENT GOALS
- Increase client’s understanding of sexual acting out 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 and sexual acting out.
- Integrate feelings and thoughts associated with prior victimization (e.g., Trauma-Focused CBT).

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TREATMENT GOALS
• 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).

VCC SAPT Program: Adolescent Treatment Modules
LEVEL I: Evaluation & Orientation
• Offense Cycle
• Cognitive Restructuring
LEVEL II: Treatment
• Victim Empathy
• Healthy Sexuality
• Impulse Control/Arousal Reconditioning
LEVEL III: Integration & Discharge
• Social/Dating Skills
• Relapse Prevention

Complementary Treatment Modules
• Substance Abuse Issues
• Family Issues
• Communication Skills
• Anger/Stress Management
• Arousal Reconditioning

TREATMENT GOALS
• Cognitive Restructuring
  Identify, Challenge and Replace Irrational Thoughts related to offense, past victimization and everyday thinking/behavior.
  Ex. I won't get caught. This wont hurt her. He has done this before. She wants me to touch her.
• Relapse Prevention Skills
  Precipitating Factors, Triggers, Interventions and Support System

Level 1 Module:
OFFENSE CYCLE: Central Process Model

Level 1 Module: Cognitive Restructuring
• 4-Step
• Self-Talk
• Thought-Stopping
• Changing the Tapes
• Common Irrational Thoughts/Beliefs
• Positive Affirmations
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4 Stepping: Rational vs. Irrational Beliefs

1. I won't get caught.
2. This won't hurt her.
3. This could make my parents mad at me.
4. They should do what I tell them to do.
5. Even if it feels good it probably won't feel too good if I get caught.

6. I don't need anyone else to make my own decisions.
7. This might hurt him later in life.
8. He's only 4 years old and won't remember what happened anyways.
9. It's O.K. to molest her because they messed with her first.
10. Even though I can get her to do what I want it's not right to mess with her because she's only 9 years old.

4-STEP EXERCISE

I went to a party over the weekend with my friends. I didn't ask my Mom if I could go because my mother always says "No!" to everything I want to do. She found out from my cousin that I went to the party and grounded me. I'm sick and tired of not being able to do what I want to do. My little brother never listens to her and she lets him do whatever he wants! She's always on my back about everything! I'm old enough to make my own decisions. I should be able to do what I want and when I want to do it. I'm going to go live with my dad. He'll let me do what I want to without messing with me all the time!

4-Step

STEP 1

Thought 1:

STEP 2

Rational or Irrational?

STEP 3

Thought 1:

STEP 4

Thought 1:

Level II Module: Victim Empathy

- Stages of Crisis
- Short and Long-term Effects of Abuse
- Harm
- Reasons Victims Don't Tell
- Empathy Transference
- Demonstrating Empathy

Apology Letters

The 5 R's of an apology (John Kador)

1. Recognition - injured party needs to know that the offender understands specifically what he or she did wrong.

Ex. I recognize that my lies have messed up our friendship and that you do not trust me anymore.
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### Apology Letters

2. **Responsibility.** The offender must accept personal responsibility for the injury.

   *Ex.* I accept total responsibility for repeatedly lying to you.

3. **Remorse.** There is no substitute for the magic words *"I'm sorry"* or *"I apologize."*

   It’s probably wise to keep this part short and direct. It’s tempting to add words of explanation. Resist the impulse.

   *Ex.* I am so sorry.

4. **Restitution.** Whenever possible, the apology should try to make the injured party whole and include what the offender is doing to ensure that he/she never offends again.

5. **Repeat.** It offers a promise not to repeat the offensive behavior.

### Level II Module: Healthy Sexuality

- Sexual functioning and anatomy
- Masturbation
- Sexually Transmitted Diseases
- HIV/AIDS
- Birth Control Methods
- Appropriate vs. inappropriate touching
- Stages of Arousal (E.P.O.R.)

### Level II Module: Arousal Reconditioning

- Satiation Techniques
- Aversive Conditioning
- Vicarious Sensitization — aversive stimuli are videotaped portrayals of adolescent sex offenders who must contend with the negative social, emotional, and legal consequences of their crimes against young children. Many trials are needed to evoke anxiety rather than deviant fantasies or actual abuse. (Mark Weinrott)

### Vicarious Sensitization

- Sixty-nine teenage child molesters
- 3-month regimen of VS as an adjunct to cognitive therapy
- 300 VS trials over 25 sessions.
- Both phallometric data and self-report measures - significant decreases in deviant arousal for youths who received VS.
- Wait-listed youths did not improve, despite continuing in weekly cognitive therapy.
- When VS was later administered to wait-listed youth, they too showed a significant treatment effect.
- Three-month follow-up data indicated that treatment gains were maintained.
Level III Module: Social/Dating Skills
- Friendships & Partners
- Dating Strategies
- Casual Contact
- Sexual Contact
- Planning the Date
- Rules for Dating: Do's and Don'ts
- Types of Feedback
- Responding to Feedback

Level III Module: Relapse Prevention
- Definition of Terms
- Internal & External High Risk Factors
- Support System
- Motivation
- Cognitive & Behavioral Interventions

Multiple Offenses - M.O. Worksheet
- M.O. = Multiple Offenses & Modus Operandi
- Assessing youth's habits or manner of working, their method of operating or functioning.
- Setting – Location, Time of day, Supervisor
- Victim – Ages, Genders, Relationship, etc.
- Youth Issues – Precipitating Factors, Triggers, Access to victim, etc.

Placement Stability
- Specially trained caregivers.
- Caregiver participation and involvement in treatment is CRITICAL.
- Appropriate & “Matched” placements.
- SUPERVISION.

Placement Stability
- Specialized Juvenile Probation Officers & Dependency Case Managers

Placement Stability
- Appropriate & “Matched” placements.
- Appropriate CBC Policies and Procedures.
- Court and legal support.
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When to Reunify?

- All participants meet guidelines discussed.
- Case by Case Decisions.
- Survey says . . . Everyone's input matters, even when we don't want it to.
- Safety and protection of victims must remain the overriding consideration.

Basic Reunification Concerns

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

**ABUSER (Child or Adult)**
- Ability to Protect Self, Victim and Other Children?
- Readiness, Willingness & Commitment to Reunification Process?
- Little Chance of Collusion?
- Participated Successfully in any Necessary Treatments (e.g., Non-Offending Parents Group)?

**PARENT (Caregiver)**
- Successfully Completed Required Treatments?
- Low Risk of Re-offending?
- Competency Regarding use of Relapse Prevention Skills?
- Accepts Full Responsibility for Abusing Victim/s?
- Readiness, Willingness & Commitment to Reunification Process?
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.
4. Client and/or family not held accountable.
5. Not invested in treatment process.

Common Barriers – Environmental
1. No safety plan or failure to follow one.
2. Frequent placement disruptions or no placements available.
3. Ineffective JPO or Case Manager.
4. Reunification not possible.

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

Juvenile Sex Offender Registry
- Commission of OR Attempt, Solicit, or Conspire to Commit
  - s.794.011*
  - Sexual Battery, *excluding subsection (10)
  - Sexual Battery, where the victim is under 12 or the court finds sexual activity by the use of force or coercion
  - Lewd/lascivious battery where the victim is under 12 or the court finds sexual activity by the use of force or coercion
  - Lewd/lascivious molestation, victim under 12, where the court finds molestation involving unclothed genitals
  - Lewd/lascivious molestation, victim under 16 but more than 12, where the court finds the use of force or coercion and unclothed genitals
- Or A violation of a similar law of another jurisdiction
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.

Common Barrier: Compassion Fatigue

- Also known as a Secondary Traumatic Stress Disorder, is a term that refers to a gradual lessening of compassion over time.
- "The well has run dry".
- Common among victims of trauma and individuals that work directly with victims of trauma.
- It was first diagnosed in nurses in the 1990's.

Common Barrier: Compassion Fatigue - Prevention

- Several symptoms including:
  - Hopelessness
  - Decrease in experiences of pleasure
  - Constant stress and anxiety
  - Pervasive negative attitude
- Can have detrimental effects on individuals, both professionally and personally, including a decrease in productivity, the inability to focus, and the development of new feelings of incompetency and self doubt

Common Barriers: Compassion Fatigue - Prevention

- Reasonable Ratio of Hours Attending to Clients/Others in Need
- Humor
- Stress Reduction
- Boundaries with clients
- Co-Worker Relationships
- Focus on Successes

Compassion Fatigue - Prevention

- Tolerate Setbacks
- Workplace Policies and Procedures
- Rest and Relaxation
- Avoid Negative People
- Limit Unhealthy Substances

Putting it All Together

Role Plays and Case Consultation

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**Resources**
- ATSA & Florida ATSA
- S.A.I.N. – Hillsboro & Broward Counties
- Child on Child Sexual Abuse Prevention Task Force
- DCF Gabriel Myers Workgroup
- Stop it Now!
- The KEMPE Foundation

**Resources**
- National Adolescent Perpetrator Network (NAPN)
- Child Welfare Information Gateway
- Center for Child Welfare
- Office of Juvenile Justice and Delinquency Prevention
- National Child Traumatic Stress Network

**Q&A**