



## **202: Working with Adolescents: JUVENILE SEX OFFENDERS:**

**Developed By:  
The Institute for Human Services**

**Revised By  
The Institute for Human Services for the PA Child Welfare  
Training and Certification Program  
Shippensburg University  
Shippensburg, Pennsylvania**

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PENNSYLVANIA CHILD WELFARE COMPETENCY-BASED TRAINING AND  
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## **202: Working with Adolescents: Juvenile Sex Offenders**

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## **202 Juvenile Sexual Offenders: Characteristics, Assessment and Treatment**

### **Training Day Agenda**

#### **DAY ONE:**

<b>Section I 45 Minutes</b>	<b>I. Introductions</b>  A. Introductions of trainer and trainees B. Caseworker Sexual Abuse Training Series C. Difficulty of the Topic Area D. Idea Catcher	<b>Pg. 8</b>
<b>Section II 1 Hour</b>	<b>II. Understanding Sexual Behaviors</b>  A. Introduction: The Story (optional) B. Normative Sexual Behaviors C. Sexual Behaviors that Cause Concern	<b>Pg. 10</b>
<b>Section III 2.5 Hours</b>	<b>III. Definitions and Dynamics</b>  A. Introduction B. Etiology C. Legal Definitions D. Clinical Definitions of Sexual Behaviors E. Who are Juvenile Sex Offenders? F. Discussion of Elements of Sex Offending for Juveniles: The Assault Cycle	<b>Pg. 17</b>
<b>Section IV 1.5 Hours</b>	<b>IV. Confidentiality and Case Planning with JSO's</b>  A. Goals of Case Planning and Investigation B. Understanding the Paradigm Shift C. Ethical Concepts and Dilemmas	<b>Pg. 31</b>

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### **DAY TWO:**

<p><b>Section V</b> <b>2 Hours</b></p>	<p><b>V. Family Assessment and Dynamics</b>            A. Family Treatment: Key Concepts            B. Impact of Sexual Abuse on Family Members            C. Family Dynamics            D. Stages of Family Intervention and Caseworker Roles</p>	<p><b>Pg. 38</b></p>
<p><b>Section VI.</b> <b>2 Hours</b></p>	<p><b>VI. Offense Specific Assessment and Case Planning</b>            A. Introduction            B. Goals of Assessment            C. Content/Components of Assessment            D. Purpose of Prosecution            E. Utilizing the Offense Specific Assessment Report: Case Planning            F. Stages of Family Intervention and Caseworker Roles</p>	<p><b>Pg. 47</b></p>
<p><b>Section VII</b> <b>1 Hour</b></p>	<p><b>VII. Intervention Strategies</b>            A. Introduction            B. Supervision Strategies            C. Sex Offender Specific Treatment            D. Constellation of Services Needed by Family, Offender and Victim            E. Stages of Family Intervention and Caseworker Roles</p>	<p><b>Pg. 55</b></p>
<p><b>Section VIII</b> <b>45 Minutes</b></p>	<p><b>VIII. Reunification and Case Closure</b>            A. Reunification and Paradigm Shift            B. Reunification Issues            C. Process of Reunification            D. Prognosis            E. Closing the Case            F. Caseworker Roles and Tasks</p>	<p><b>Pg. 66</b></p>
<p><b>Section IX</b> <b>15 Minutes</b></p>	<p><b>IX. Closing/Evaluation</b></p>	<p><b>Pg. 75</b></p>

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#### **Overview of Curriculum**

##### **Rationale:**

Child Welfare Professionals require the attitudes, knowledge and skills necessary to provide quality services to children and families who have been impacted by sexual abuse. In working with juvenile sex offenders, Child Welfare professionals must understand the dynamics of normative sexual behaviors as well as behaviors that cause concern in children of all ages. Also, workers must understand how juvenile offending is similar and different from adult offending, as well as know how to work with juvenile offenders and their families, including assessment, case planning, intervention strategies and reunification efforts.

##### **The following competencies are taught in this curriculum:**

- **202-2:** The Child Welfare Professional can correctly assess the behavior of “unruly” adolescents within the context of their development, family, culture and situation, and can recognize family dysfunction and crisis which contribute to the adolescents’ behaviors.
- **202-4:** The Child Welfare Professional can assess a child’s need for specialized residential placement, treatment or other special services, and knows how to refer children to these resources.

##### **Learning Objectives:**

Specific learning objectives are provided for each section throughout the curriculum. Comprehensive learning objectives for the curriculum include:

##### **Participants will be able to:**

- Identify the dynamics of sexual abuse by a juvenile and assess the difference between normal sexual experimentation, sexually reactive behavior, and sexual abuse.
- Describe the importance of his/her responsibility to protect the victim(s) from further abuse; to prevent juvenile sex offenders from re-offending, and carry out the steps necessary to assure that the offender is held accountable for his/her behaviors.
- Determine the differences between female and male juvenile sex offenders and between pre-pubescent and adolescent sex offenders and develop an investigative plan and case plan appropriate to the individual and his/her circumstances.

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- Identify and coordinate multiple services to multiple parties including the victim, the juvenile offender, the juvenile's parents or caretakers and siblings.
- Identify the need for law enforcement and court involvement to motivate the offender and to hold him/her accountable.
- Describe the components of a comprehensive sex offense specific assessment, determine how to obtain the assessment and use the assessment to plan services for the juvenile sex offender.
- Identify various treatment options and understand the complex issues involved in service termination and case closure.

### **Length of Workshop:**

12 Hours

### **Materials Needed:**

Specific materials needed to conduct the training are listed for each section of the curriculum. Handout and overhead sections follow the curriculum.

### **Target Audience:**

Child Welfare caseworkers who work with sexual abuse cases in any capacity.

### **Expectations of Trainers:**

The trainer of this curriculum should possess extensive knowledge and experience in the field of child sexual abuse. Specific knowledge of juvenile sex offending in terms of individual and family assessment, case planning, and treatment is critical. The trainer must understand the role of the child welfare professional and the operation of the child welfare system in Pennsylvania.

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## **SECTION I**

### **INTRODUCTION**

#### **Rationale:**

Group trust and cohesiveness assist in creating a positive environment of learning. To this end, the trainer must establish his/her credibility, give an overview of the training, and begin to get participants to think about the topic at hand.

#### **Learning Objectives:**

Participants will:

- Learn about other available sexual abuse workshops.
- Become acquainted with trainer and each other.
- Review the training agenda and receive the competencies and learning objectives for the workshop.
- Become familiar with the purpose and use of the **Idea Catcher**.
- Be aware of the difficulty of this workshop and its potential emotional consequences.

**Time:** 45 Minutes

**Methods:** Trainer presentation  
Trainee self introductions

#### **Materials Needed:**

- **Handout 1: Competencies and Learning Objectives**
- **Handout 2: Training Agenda**
- **Handout 3: Idea Catcher**

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### **A. Introduction of Trainers and Trainees**

**Trainer:** The trainer will introduce him/herself and ask trainees to introduce themselves, where they are from, their job, and why they chose to attend the Juvenile Sex Offender workshop.

### **B. Caseworker Sexual Abuse Training Series**

As the trainees describe their learning objectives, the trainer will be sure to inform the trainees about the other sexual abuse workshops that are a part of the Caseworker Sexual Abuse Training Series (Overview of Child Sexual Abuse; Sexuality of Children: Healthy Sexual Behaviors and Behaviors That Cause concern; Investigative Interviewing in Child Sexual Abuse; Family Reunification and Case Closure in Child Sexual Abuse Cases;).

The trainer should distribute and review **Handout 1: Competencies and Learning Objectives** as well as **Handout 2: Training Agenda**. Trainers should answer any questions participants have.

### **C. Difficulty of the Training Content**

The trainer will warn participants that the content of this workshop can be difficult; that participants may have uncomfortable emotional reactions to the workshop content; and that they need to be aware of their reactions and take care of themselves. Talking to other trainees, family members or friends, co-workers and supervisors may be helpful. Seeking counseling may also be indicated.

### **D. Idea Catcher**

The trainer will distribute **Handout 3: Idea Catcher** and discuss the importance of its use in the transfer of learning process.

## **SECTION II**

### **Understanding Sexual Behaviors**

#### **Rationale:**

For children of all ages, Child Welfare Professionals must be able to ascertain whether exhibited sexual behavior is normative or of concern and determine what, if any intervention is necessary based on their assessment.

#### **Learning Objectives:**

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Participants will be able to:

- Identify normative sexual development and behaviors for children and adolescents.
- Describe children's and adolescents' sexual behaviors that should cause concern.
- Evaluate children's sexual behaviors in order to determine whether intervention is necessary.

**Time:** 1 Hour

**Methods:** Lecture  
Video  
Small group exercise

### **Materials Needed:**

- **Handout 4: Three Stages of Sexual Development**
- **Handout 5: Behaviors Related to Sex and Sexuality in Pre-school Children**
- **Handout 6: Evaluating Sexual Behaviors of Children and Adolescents**
- **Video: Assessment of the Sexualized Child and Children Who Molest: (Counter #351)**

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### **A. Introduction: The Story (optional)**

The trainer can read: "The Story" to the participants and discuss the fact that working with children who have deviant sexual behaviors is really about helping to prevent additional victims.

#### **THE STORY**

A young man was walking beside a river when he noticed a child struggling half submerged in a series of rapids. He quickly jumped into the water and rescued the child. As he was administering first aid to the child, he looked upstream and saw several other children and a few adults who were also struggling in the swift current. Fortunately, many passers-by noticed what was happening and joined his rescue efforts. As the young man surveyed the suffering that surrounded him, the focus of his attention shifted and he began running upstream. A rescuer, seeing the young man pass several victims in need, shouted over to him, "Where are you going? These people need your help!" The young man shouted back, "I'm running upstream to do something about the person whose throwing all of these people in the river."

Unknown

Before caseworkers can determine if sexual behavior is problematic, they must first know what constitutes normative childhood sexual behaviors. As a society, most people are uncomfortable with the idea that children are sexual beings. Most people deny all sexuality in childhood and attempt to repress sexual behavior in adolescence. They deny that sexual behaviors begin in utero, continue through infancy and adolescence. Instead, many people operate under an illusion that children will miraculously transform from innocent, non-sexual youth to healthy sexual adult without guidance or experimentation. Unfortunately, because of this social denial, most adults are unsure about which childhood and adolescent sexual behaviors are developmentally appropriate and which are not. Caseworkers, in particular, need to be familiar with normative sexual behaviors so they can evaluate referrals and assess risk.

### **B. Normative Sexual Behaviors**

#### **1. Small Group Exercise**

**Goal:** To give trainees an opportunity to fill in any gaps in their knowledge about age appropriate sexual development.

**Trainer:** The trainer should divide the trainees into four small groups and assign each group an age range: pre-school; young school age; pre-adolescent; and adolescence. Each group is asked to brainstorm for about 10 minutes and list, on

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flip chart paper provided by the trainer, a continuum of natural and expected sexual behaviors for each age range. The trainer should ask the trainees to start from the premise that all children are sexual and physically capable of sexual response from birth on. Erection and lubrication occurs in infants, and children have the capacity to have orgasms before they are one year old.

After the brainstorming, the trainer should tape each list on the wall, review each list, and make additions and/ or corrections to the list based on the developmental information given below for each age group.

- a. **Preschool:** As they mature, children become consciously interested in their sexuality. By the age of two, kids have increased interest in touching their genitals. They are intensely curious about sexual differences, voyeuristic and exhibitionistic. They will take advantage of opportunities to look at others' bodies and make comparisons. They initiate games where there is undressing and sexual exploration. Bathroom activities and interests are typical at this age and often associated with sex. By the age of three, most preschoolers have discovered masturbation and learned that it is a private behavior. Unfortunately, some children have even learned that masturbation, public or private, can get them into trouble.

Preschool age children are exploring their world in total. So, unless made otherwise by reactions to their explorations, their interest in the sexual parts of their bodies has the same weight as their interest in Barney, a new toy, a mountain or a molehill. All have intrinsic interest for children. Children are powerful observers. They will act on what they see around them. They often will put the Mom and Dad dolls or themselves into situations which they have observed. Hugging, kissing, being in bed together--are all subjects for imitation. The more a child sees, the more likely it is that the child may act out sexually. In this highly sexualized society, companies use sex to sell everything from cars to jeans. Through television, sexual themes come directly into our living rooms and effect our children on a daily basis. It is not surprising, then, to see an acceleration of sexualized behavior among children. However, there is a continuum of response among children. Some children act out very little, others much more. Some children act out sexually in imitation or reaction to their environments while others act out sexually for the pure enjoyment of the behavior.

- b. **Young School Age:** Masturbation continues as a primary sexual behavior but this age child is more discreet about when and where he/she masturbates. Unlike preschool age children, who take advantage of opportunities to compare themselves with others, primary school children are more likely to create opportunities to view each other and other people. This may take the form of peeking while others are bathing or undressing. They may play doctor or house as a way to create

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opportunities for exposure. Sometimes the exposure will be part of an initiation game; removing all or part of your clothes in a public situation will gain you entry to the club. The play may contain elements of competition of forfeiture: "I dare you to run around the back yard without your clothes on", a game of strip poker with the loser being required to remove clothes as a forfeit. In their sexual explorations, primary school children may touch each other interactively, usually within the context of playing. Touching can involve stroking or rubbing the others' genitals and, for girls, the breast area. We don't usually expect to see young school age children engaging in behaviors that involve penetration, open mouth kissing or simulated intercourse.

The common thread in all the above activities is the game like atmosphere. While there may be peer pressure involved, there are no elements of force or intimidation.

- c. **Preadolescent (10-12 years) and Adolescent (13-18 years)**. These two groups are considered together because we have preadolescent girls who mature by age ten. In our society, we expose young children to cultural messages specifically aimed at their age group--messages (television, radio, magazine ads, and music) that encourage them to behave as if they are older or have already reached adulthood.

The developmental work of this period involves learning to develop close relationships with others. This requires development and refinement of social skills with their peers and others and for the teens to distance themselves from parents during this stage of development.

The most common type of sexual behavior in this age group is masturbation. Because of the physical changes in puberty, teens develop greater purpose and control of their activities. Teens are intensely interested in viewing others' bodies, especially the opposite sex and the bodies of older people. They seek out sexual materials--pictures, magazines, and videos (some of which may be pornographic.) Teens sometimes initiate group peeks at the opposite sex in locker rooms, for example. Teens explore interactive sexual behaviors. This ranges from open-mouth kissing and fondling, or rubbing each other's breasts or genitals, to simulating intercourse, to various types of behaviors that involve sexual penetration. Most often this is with a partner of the opposite sex but same sex activity occurs often as well. Kinsey found one half of the boys he interviewed and one third of the girls reported same sex partner activity. This does not reflect an adolescent's sexual identity--that doesn't occur until early adulthood after accomplishing the developmental tasks of establishing a relationship and practicing intimacy with a peer--of both sexes. That it is with peers needs emphasis. Usually preadolescent and adolescent boys and girls do not meet their social needs

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with younger children. Most teens will not seek out the company of, or voluntarily choose to spend significant amounts of time with younger children. However, there are individual differences in every age group. There are teens, for instance, who truly enjoy the company of young children in a healthy nurturing way.

This is a brief outline of childhood sexual development as understood at this time. Our knowledge base is in constant flux as researchers complete more work in this area. This information is largely based on the work of two researchers in the area of normative sexual behaviors in preschool and young school age children, Toni Cavanaugh Johnson Ph.D. and William Friedrich, Ph.D. Dr. Friedrich is affiliated with the Mayo Clinic. Dr. Johnson is in private practice in Los Angeles, California.

2. The trainer should distribute **Handout 4: Three Stages of Sexual Development** and explain that it is a review of the information discussed so far and can be used as a quick reference by caseworkers.

### **C. Sexual Behaviors that Cause Concern**

#### **1. Overview**

The Trainer should distribute **Handout 5: Behaviors Related to Sex and Sexuality in Preschool Children** and offer the following explanation:

The handouts divide sexual behaviors into three groups:

1. usual and expected
2. of concern
3. abusive, seek professional help

In the course of development, some children may try out a few of these behaviors while other children may be more sexually curious and try out more of these behaviors. Note the behavior in the normative column "puts something in the genital or rectum of self or other due to curiosity or exploration." Friedrich says that this is subjective language and it might read more clearly, "tries to put something in the genital or rectum of self or other." In reality the child is usually putting something against the vulva or between the lips of the vulva, not actually inserting something into the vagina. Young children do occasionally insert objects into their rectums. Friedrich research indicates that, while such acts can fall within the normative range on occasion, it is very unusual. Such an extreme sexual behavior in a young child should always be seen as a red flag requiring further investigation especially if it is an act of attempted vaginal insertion. Children may be exposed to seeing thermometers or suppositories inserted into the rectums of small children, babies, or family pets. It is less likely, but not

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impossible, that the child may see a caretaker inserting a tampon. In these instances the behaviors might fall into the normative range. Nevertheless these two behaviors always require, at the least, monitoring and assessment.

The second column is a group of behaviors that move away from the norm. These warrant attention and require some active intervention usually in the form of verbally prohibiting the behaviors. Keep in mind that some children may show some of these behaviors as they experiment and imitate what they see or hear. Friedrich says that his research indicates that some young children do have intercourse as part of normal sexual exploration although sexual intercourse would be a behavior that required intervention.

The last column lists behaviors that demand immediate professional attention.

### **2. Video Vignette**

Trainer should show the **Video Vignette: Assessment of the Sexualized Child and Children Who Molest (counter # 351-510)**. This segment highlights a discussion of the questions to ask in evaluating sexual behaviors and emphasizes that it is a mistake to evaluate the behavior alone. Other factors to consider are:

- affect
- age
- power
- intent of behavior or culpability
- the meaning of the behavior to the child.

Among the experts featured in this film are: Toni Cavanaugh Johnson, Eliana Gil, and Eugene Porter.

### **3. Small Group Exercise:**

The goal of this exercise is to give trainees some experience in evaluating sexual behaviors and interactions based on information given in lectures and handouts.

The trainer should divide the group into several smaller groups and distribute **Handout 6: Evaluating the Sexual Behaviors of Children and Adolescents**. Assign each group two or more scenarios to evaluate whether the behaviors discussed in the scenarios are: normative, no concern; normative, of concern; or abusive. After about 10 minutes, ask each group to report its decisions about the

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behaviors to the full group. Point out any issues the groups may have missed. Use the criteria listed on the handout to evaluate the behaviors.

The following questions can be used to help process the above activity:

1. What issues did your group identify in coming to your conclusions?
2. How might your determination change if the age of the youth was younger? Was older?
3. What initial steps (if any) would you take regarding this situation?

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## **SECTION III**

### **DEFINITIONS AND DYNAMICS**

**Rationale:** In order to effectively work with juvenile sex offenders and their families, Child Welfare Professionals must understand the legal and clinical definitions of sexual abuse perpetrated by juveniles, the operation of the legal system as it relates to juvenile sex offenders, and the overall dynamics of juvenile sex offending.

#### **Learning Objectives:**

Participants will be able to:

- Describe the current research into the etiology of sex offending and understand that the field does not yet understand the cause of sex offending.
- Define the legal and clinical definitions of sexual abuse perpetration by juveniles.
- Determine the various ways in which the legal system can impact negatively or positively on juvenile sex offenders.
- Describe the dynamics of juvenile sex offending.

**Time:** 2.5 Hours

**Methods:** Lecture  
Brainstorming  
Video  
Small group exercise

#### **Materials Needed:**

- **Handout 7: Sexual Offense Synopsis**
- **Handout 8: Spectrum of Sexually Abusive Behaviors**
- **Handout 9: The Sexual Abuse Cycle**
- **Handout 10: Scenario John**
- **Overhead 1: Theories about the Etiology of Sexual Offending**
- **Overhead 2: The Sexual Abuse Cycle**
- **Video: Assessment of the Sexualized Child and Children who Molest  
(Counter # 124)**

#### **A. Introduction**

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Trainer will open this section by showing a video vignette from **Assessment of the Sexualized Child and Children Who Molest (Counter #124)**. This video vignette shows a foster parent talking about the sexualized behavior of two very young children. However, it may not be apparent to the trainees that the children being described are so young, ages two and three. This is the first point of the training: to get trainees to begin to recognize their stereotypes of juvenile sex offenders as adolescents. The trainer will briefly discuss why it is so difficult to think of young children as acting in highly sexualized or abusive ways.

### **B. Etiology**

The trainer should begin this discussion by making it clear to the trainees that research has not yet determined what causes people to become sex offenders. A common belief is that all sex offenders have histories of being sexually victimized and become offenders because of that victimization. But, while many sex offenders do have a history of sexual victimization, some do not; most children who have been sexually victimized do not grow up to become sex offenders. The simple answer that sex offenders are created by sexual victimization doesn't adequately address the issue of etiology.

Caseworkers need to understand that sex offending is a deviant behavior that is probably caused by a complex variety of experiences that happen to the offender. Developmental timing, parental support and reactions, physiology, family systems, coping mechanisms, and many other factors may influence why one person becomes a sex offender after certain experiences, and another doesn't. The important message here is that the cause of sex offending is complex with many variables probably affecting the outcome.

**Trainer:** The trainer should review the theories about the etiology of sexual offending. **Overhead 1: Theories about the Etiology of Sexual Offending** is available for use.

1. Many theories exist to explain why some individuals express their innate, inborn sexual urges in deviant ways. In some instances it is believed that **physical/medical factors** such as neurological impairment, head trauma, or hormonal imbalances cause sexual deviancy.
2. Many theorists believe that the development of sexual deviance can stem from **developmental and environmental factors** that have their beginnings in early childhood. Such factors include lack of empathic care and physical nurturing in infancy and early childhood, chaotic living conditions with multiple caretakers and/or multiple residences, physical abuse, sexual abuse and neglect. (Ryan and Isaacs, 1991.)
3. Rasmussen, Burton, and Christopherson (1992) suggested that **five precursors** lead to a vulnerability to act out sexually in young sexually reactive or aggressive children. They are: **1) early sexualization; 2) poor**

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**social skills; 3) intimacy issues; 4) poor impulse control**  
**5) lack of accountability in all areas of a youth's life.**

4. Carnes, (1983, 1985) developed an **addictive systems model** of sexual deviancy. He theorized that sexual deviancy is the result of a set of core beliefs developed by the offender during childhood and adolescence. Common core beliefs are: I am basically an unworthy and unlovable person. Only bad things happen to me. I can never get my needs met through other people. Sex is my most important need.

Still, even with all of these experts developing explanations for how a person might become sexually aggressive, the truth is that in similar circumstances, some people develop sexual deviance and some do not. Some develop other dysfunctions, some do not. Continued research is needed to address the possible etiologies of sexual aggression or deviance.

### **C. Legal Definitions**

The trainer should distribute **Handout 7: Sexual Abuse Definitions**. The Sexual Abuse Definitions is the standard for prosecution in both adult and juvenile courts. The trainer should point out that sexual conduct refers to penetrative acts and sexual contact refers to non-penetrative sexual activity. The charges describe the nature of the sexual acts and reflect how seriously the law defines the type of sexual activity.

#### **1. Plea Bargaining**

The adjudication of cases is, at times, confusing and unhelpful. For one thing, the charge originally brought by the police may be lessened by the time it is brought to court. Charges are often plea-bargained or re-negotiated based on: the available evidence, the age of the victim, whether the victim is considered a reliable or strong witness, the juvenile's history in the juvenile system, the family's presentation and desires, etc. The charge itself is important because the more serious the charge, the stricter the probation. Under the terms of probation, the offender can be mandated to treatment. This mandate is critical to keeping the juvenile and his/her family involved in treatment. Historically, without a mandate, many offenders do not complete treatment.

Negotiated charges also create casework nightmares. A lesser charge supports the denial and minimization of the offender and his/her family. A lesser charge means less time on probation, increasing the possibility the offender will not complete treatment. Even worse, sometimes the charge is re-negotiated to a non-sexual offense charge, such as unruly behavior. In that case there will be no treatment at all for the sex offense and probably denial that the youth has a sexual problem.

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### **2. Problems with the Law Itself**

The legal process can also be confusing because the law itself sometimes misrepresents the crime. For instance, a juvenile may be charged with rape or felonious sexual penetration without ever penetrating his victim. Under the law, if a sex offender's victim was under 13 and/or the youth used force during the abuse, the charge can be rape or felonious penetration.

### **3. Recent Changes in the Law**

The law concerning discretionary and automatic bindover to adult court has changed. The age of possible bind-over has been lowered to fourteen years of age. Some offenses may result in an automatic bindover to adult court; others are discretionary. As of January 1996, under certain circumstances, juveniles 14 year of age and older will be presumed to be tried as adults. How this law is interpreted in practice may profoundly effect our ability to treat adolescent offenders. For example, in Ohio, rape is not a probational sentence for adults. This means the adolescent offender would be imprisoned where treatment is not always available. These laws are already being challenged by defense attorneys which may result in long delays for resolution of some serious cases.

Another issue is the result of a case law in a case: "In re: M. D." The effect of this case law is that youth, under the age of fourteen, cannot be charged with rape unless the state can prove that the youth was physically in a developmental stage of puberty, and that there was at least a three year age difference between the youth and the victim. Further clarification of this case law is needed, and, again there may be challenges from all sides.

Caseworkers need to work closely with their legal departments and local prosecutors on a case-by-case basis as these laws are applied and tested. It is important to note that jurisdictions may differ in terms of interpretation of the law, policy, and stance regarding juvenile sex offenders.

### **4. The Young Offenders**

Last but not least, because of their age, young sexually reactive/aggressive children, ten and under, are rarely adjudicated into the criminal justice system. Therefore judicial mandates are not available to keep them or their families in treatment. This increases the burden on the protective service system, (and the workload of the caseworker), as the protective service agency becomes the only agent with the power to keep a child and his/her family in treatment.

## **D. Clinical Definitions of Sexual Behaviors.**

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1. Legal definitions of sexual behavior are different than clinical definitions. Legal definitions only describe illegal behavior. Clinical definitions are much broader and describe legal and illegal behavior that may be tied to the abuse; and, sometimes, the feelings and thoughts that go along with these behaviors. For instance, clinical definitions may look at the grooming behavior that preceded the abuse, how the child felt, how the offender groomed the child, and a lot of other information that may be much broader than the illegal act itself.
2. The trainer should write the underlined definition of sexual abuse on a flip chart for trainees. From a clinical perspective, sexual abuse is any sexual behavior between a child and an adult or between a child and a peer or an older or younger child that occurs 1) without consent; 2) without equality; or 3) as a result of coercion. Sexual interactions involving a child and an adult, a child with a peer, or an older and younger child, are abusive if the relationship is coercive, exploitive or aggressive, or threatens the physical or psychological well-being of either participant.
3. Abusive sexual interactions exist on a continuum from exhibitionism to intercourse. In their history of offending, many (but not all) sex offenders progress over time along the following spectrum of behaviors (Sgroi, 1982). This spectrum was developed in the context of adult-child sexual abuse. It is adapted to be specific to juvenile sex offending, and a new category, sexualized environment, was added.
4. The trainer should distribute **Handout 8: Spectrum of Sexual Abusive Behaviors** and ask participants to briefly review it. Most trainees should be familiar with this material. The trainer should make special note of the last category of "sexualized environments" that has recently been added because we have learned about the harmful effects of the highly sexualized environment on children.

### **SPECTRUM OF SEXUALLY ABUSIVE BEHAVIORS Adapted for Juvenile Sex Offenders from Handbook of Clinical Intervention in Child Sexual Abuse, (1982), Suzanne M. Sgroi, M.D.**

- **Nudity:** The JSO appears nude in front of his/her siblings or other children, usually when there are no adults present.
- **Disrobing:** The JSO disrobes in front of the child, generally when they are alone.
- **Genital exposure:** The JSO exposes his/her genitals to the child. The JSO directs the child's attention to his/her genitals.

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- **Observation of the child:** The JSO covertly or overtly watches the child undress, bath, excrete, or urinate.
- **Kissing:** The JSO kisses the child in a lingering, intimate way and/or with an open mouth or use of the tongue.
- **Fondling:** The JSO fondles the child's breasts, abdomen, genital areas, inner thighs, or buttocks. The child may be asked to similarly fondle the JSO at his/her request.
- **Masturbation:** The JSO masturbates while the child observes; the JSO masturbates the child; the JSO and the child observe each other while masturbating themselves; or the JSO and the child masturbate each other.
- **Fellatio:** Oral-penile contact: Either the victim provides penile stimulation to the JSO or the JSO stimulates the penis of the victim orally.
- **Cunnilingus:** Oral-vaginal contact. Either the victim provides oral stimulation to the JSO's vaginal area or the victim's vaginal area is stimulated through oral contact by the JSO.
- **Penetration of anus or rectal opening by penis, fingers or objects:** This involves penetration of the anus or rectal opening by a penis, finger (digital penetration), or inanimate objects such as crayons or pencils (felonious penetration).
- **Penetration of vagina by penis, fingers or objects.**
- **Dry intercourse or humping:** These slang terms describe either the male JSO rubbing his penis against the child's genital-rectal area, inner thighs, or buttocks, or the male/female offender involving the child in imitating adult intercourse. This may be done clothed or nude.
- **Sexualized Environment:** This refers to a group of materials, activities and situations that may, alone or in combination, have the impact of prematurely eroticizing a young child. In these environments children are exposed to: explicit sexual material, videos, magazines, movies; TV shows with adult sexual content; adults or older juveniles acting sexually or interacting sexually in front of the child; or sexual language, jokes, innuendo. Children exposed to these environments and/or who live in environments where boundaries around body integrity or physical space don't exist or are disregarded, are more likely to act out sexually or be sexually victimized.

As was talked about earlier in the section on normative sexual behaviors, when evaluating sexual interactions, it is critical to apply a standard of intent or culpability to the interactions. For example, the motivation for three and four years old siblings to undress and run around nude while playing house, is not the same as the

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motivation of a fourteen year old who chooses to walk around the house nude in front of his/her siblings for the purpose of arousing him/herself and/or them.

### **E. Who Are Juvenile Sex Offenders?**

The trainer should present the following information. The trainer may want to make a flip chart using the underlined categories below to guide the presentation.

1. Thinking about female sex offenders or child sex offenders is difficult. Many people continue to believe that all sex offenders are adult males, but this is not true. Casework practice and clinical practice are informing the field. While the research can't yet tell how many of whom are doing what to which, we do know that juvenile sex offenders are a remarkably diverse group of children and teens.
2. Female Offenders: Many clinicians feel this is a highly under-reported group because so many males in treatment tell of being offended by females: baby sitters, siblings, mothers and other relatives. It seems that society has accepted that males offend, but continues to deny that woman and girls can be sexually abusive. It is hard for many people to shift their perception or idealization of the female role as the protector and nurturer of the young to include the female who harms those she is charged to safeguard.

From the research so far, it appears that juvenile female offenders are not just mirror images of male offenders. For instance, juvenile female offenders, especially the prepubescent or young adolescent, often disclose sex offenses during treatment for their own victims issues. (Richardson, 1994.) Males, on the other hand, are usually pulled into treatment because their victims disclose. It appears that reenactment of trauma for girls may be more common to the dynamic of their offenses. Also, it seems that females are more overtly shamed by the offense. (Richardson, 1994.)

Is that because our society has defined female as being nurturing and male as being conquering? (This may have implications for prevention of all sex offending. Could it be possible that as long as society defines sex as involving dominance and submission, that violence will leak into sexual relationships? Could society prevent some male offending by redefining maleness and femaleness?)

3. Young Sexually Reactive and Aggressive Children: More and more very young sexually aggressive children are being identified. This makes sense since many adolescent and adult offenders trace the onset of their sexually offending behaviors to childhood. We do not yet have any research about the numbers of young children who become sexually aggressive but the caseworker must not collude with the denial or minimization of young sex offenders. Most researchers

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and clinicians agree that early intervention, before the behavior becomes habituated, is successful at stopping continued abusive behaviors.

4. **MR/DD and Psychiatric Offenders:** Adults with a history of chronic mental illness or adults with MR/DD are highly vulnerable to sexual abuse themselves. Contrary to popular belief, in a small percentage of cases they also manifest offending behaviors. Treatment for offenders with developmental disabilities or MH disabilities can be difficult to find. Few clinicians specialize along these lines.

### **5. Cultural and Socioeconomic Issues**

**Socioeconomic Factors:** Offending behaviors occur at all socioeconomic levels. But, poverty can be a factor that may increase vulnerability of all kinds, including victimization and offending behavior. The fewer resources a family has, and the more economic stress in their daily life, the more difficulty they may experience in accessing services. Resources help a family access services; if a family member has experienced sexual abuse or sexual offending, resources may not be available to obtain care. Furthering the problem is the fact that offender treatment is long-term treatment often involving every member of the family. Accessing and maintaining family members in treatment demands an organized response from the family and represents an ongoing drain on their physical, emotional and financial resources. The fewer material resources a family has, the greater the drain that family will be on the resources of the child welfare agency; the more demanding the casework challenge of keeping all members of the family in treatment, especially if there is no legal mandate backing up the treatment process.

**Cultural Differences:** There is no evidence to suggest that any cultural, ethnic or racial group has greater rates of child sexual abuse than any other. Worldwide, all cultures have codes of behavior for the care and nurturing of children and cultural prohibitions against incest, and the sexual exploitation of children. But, despite these cultural prohibitions, sexual abuse of children is nearly universal. Sexual abuse of children is not, in these cases, an expression of culture; it is an expression of an individual's pathology.

But, while cultures universally prohibit incest and other forms of child sexual abuse, cultural beliefs and values can affect the family's response to a sexual offense, both toward the victim and the perpetrator. (This issue is discussed in other sexual abuse curricula in detail but the trainer may want to provide a few examples: in some cultures fear of the system, a belief that justice can not be obtained; a belief that family problems should not be discussed outside the family; a belief that counseling and other social services are not needed; etc. frames a family's response to sexual victimization and offending.)

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Certainly, ethnic, racial and cultural affiliations have an impact on identification, reporting of offenses and on the treatment of youthful offenders and their families within the social service systems. "Once children and families of color enter child welfare systems, there is evidence which indicates differential treatment with regard to what services are provided, both in terms of quantity and quality" (Harris, 1990). Studies have shown that assessment and intervention are "harsher" for families of color (Close, 1983). There are higher rates of out-of-home-placements for children of color than for Anglo children, different and more restrictive referral and diagnostic patterns for African American children, and a disproportionate number of African American children in less desirable placements (Stehno, 1982). Nationally, 50% of children in out-of-home placements are children of color, although they comprise only 20% of the population (Keys, 1991). These responses from the child welfare systems and the attitudes that create this type of differential treatment, are well known within African American communities. They effect the reporting of abuse among people of color; they have an impact on the willingness of families to prosecute offenders because of concerns that the offender will be unfairly and severely treated by the criminal justice system, or discriminated against by the child welfare system and the treatment community.

"Cultural competence is the ability to share the world view of your clients and adapt your practice accordingly. If that sounds familiar, it should. Cultural competence is, at best, the ideal of good social work practice" (Abney and Gunn, 1993). The Ohio Child Welfare Training Program, authors of this curriculum, defines cultural competence as "recognizing, understanding and valuing cultural differences and diversity and recognizing, understanding, and valuing the commonalties that underlie our differences. Working in a culturally competent way with young offenders and their families, requires acquiring a basic knowledge of the family's culture, i.e. child rearing practices, attitudes toward sexuality and sex roles, family structure, religious belief, the extent the family is involved in larger community, etc. This would mean becoming knowledgeable and sensitive to whether, for example, cultural mores allow or prohibit discussion of sexual issues between the sexes; foster shame or denial; value male children over female children etc. Caseworkers must adapt their practice in order to help all families protect their children in a way that honors their culture whenever possible.

Caseworkers can miss opportunities to support case plan goals by failing to bring critical people into the planning and implementation process. For instance, clinicians reported that some church boards have "mandated" African American adult offenders to treatment--a mandate at least as effective as one from the court system. Extended family members and other community social supports should be evaluated for every family, for the protection of the child, the treatment of the offender, and the comfort and trust of the family.

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Sexual behaviors and sex roles are shaped by cultural norms, family and social messages, and life experiences. All offenders and their families bring these cultural beliefs and values into the child welfare system. To maximize interventions with each offender and each person in the offender's family, a worker needs to be cognizant of the worldview of each parent and child, their attitudes towards sexual behaviors and how they view and act out culturally defined roles. This is a hefty assignment but one critical to healthy outcomes for the families and children.

### **F. Elements of Sex Offending for Juveniles: The Assault Cycle**

The trainer should present the following material as an introduction to the concept of the assault cycle.

1. How do we treat sexual abuse if we are not even sure of its cause? Pioneer practitioners in the 70's and early 80's began to see similarities in the youth they were treating, and of thought, feeling and response to events in their lives. It became apparent to clinicians that sexually abusive acts did not "just happen." They were not unpredictable acts. Rather they were a planned response to unresolved issues and overwhelming feelings.
2. Abuse has purpose. It serves as a coping mechanism, albeit maladaptive, for the child or adolescent in dealing with negative life events, difficult feelings and unmet needs. Further, while the acts and life circumstances leading up to the assault might differ dramatically from offender to offender, the sequence is often repetitive and predictable. Anna Salter (1994) defines these precursors as a cycle with "an interlocking series of thoughts, feelings, and behaviors that culminate in sexual assault." The cycle is not the cause of abuse. It is a sequence based on a general progression of thoughts and behaviors. It explains the process, what comes before, leads up to, and follows abuse. It provides a structure for treatment- a way to help the offender understand the context of his offending behaviors, and to develop ways to protect himself and others from future sexual abuse.

The utility of the cycle model has led clinicians to elaborate on and personalize the elements in countless ways to fit their setting and the population and age of the offenders with whom they work. Children as young as five years old act out in cycles of sexually abusive thoughts, feelings and behaviors.

Despite its popularity, the concept of the sexual abuse cycle is not empirically validated in total. There is supportive research that confirms some of the concepts. More research is needed to validate all the assumptions on which the cycle is based.

**Trainer Note:** In other sexual abuse workshops, you may have learned about Anna Salter's version of the cycle-the "deviant cycle." In this training, caseworkers will look at the Sexual Abuse Cycle in Juvenile Sex Offending Model.

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3. Trainer should display **Overhead 2: The Sexual Abuse Cycle** and distribute **Handout 9: Sexual Abuse Cycle**. This work is taken from the book *Juvenile Sex Offending*, Edited by Gaily Ryan and Sandy Lane (1991). This cycle grew out of work of clinicians in Colorado and is the basis for a chapter on the sexual abuse cycle in the book, *Juvenile Sex Offending*.
4. In order to discuss the Sexual Abuse Cycle Model, the trainer should distribute **Handout 10: Scenario John**. Ask trainees to read the scenario. Then, using the **Overhead 2**, lead participants through the three phases of the Sexual Abuse Cycle, illustrating them with the following scenario.

**Trainer Note:** The following scenario includes information in bold type that is **not** included in the "Meet John" scenario handed out to the trainees. These notations should help the trainer point out examples of behaviors, thoughts or feelings that are important for trainees to understand.

### **Case Scenario: Meet John**

**(The first phase, the precipitating phase, consists of experiencing an event(s), the misinterpretation of the circumstance as having a negative meaning about one's self, and the individual's initial efforts to cope with the situation by avoidance.)**

John is 17 years old. He lives with his mom and stepfather. Also living in the home are his eight year-old-half-sister, Mary, and his six-year-old half brother, Mike. When he was about nine, his parents divorced. He rarely sees his biological father. He has memories of his real Dad drinking a lot and sometimes hitting his mother and his brothers. After his parents divorced, his mother moved the family several times, and since her remarriage, the family has lived several different places. Perhaps because of this, John is a loner kind of kid. He has a couple of casual buddies and a girlfriend, whom he sees mostly at school. When he was younger, he stayed at home afternoons and evenings while his mother worked. His older brother baby-sat him. Mom was easy-going with few rules or demands of the boys. After his brothers left home, he kept the habit of hanging around the house. In a way his mother is his best buddy. She talks with him a lot and they do shopping and other things together. She has always let him do as he wants.

John often feels life isn't fair. Lately things have been especially rough. John resents his mother making him baby-sit his younger siblings. Never a very good student, he is getting into trouble at school. His latest girlfriend just broke up with him. **(Triggering events)** He feels especially restricted by the responsibility of taking care of his brother and sister. He is angry at the school and hurt by his girlfriend dumping him. He thinks, "Things never go good for

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me. No one cares about me. I don't count." (**Victim thinking and misconceptions**) "I might as well give up. I can never do things right. I'm a real loser." (**Negative anticipation and black and white, all or nothing thinking--cognitive distortions**)

Never good at speaking up to his mother or expressing his feelings, John has started going to his room at night, where instead of doing his schoolwork, he draws pictures of army tanks and missiles while listening to music with his headphones. When one of his friends calls, he says he can't talk. (**John is attempting to get control of his feelings about himself and his life through avoidance and isolation.**)

(**In the second phase, the compensatory phase, the youth attempts to increase his/her sense of self-esteem and reduce anxiety through power-based thoughts or behaviors that eventually lead to the molestation.**) Over time, John becomes increasingly resentful about how things are going in his life. He isn't doing well at school. He blames his teachers. He thinks his mother was deliberately making things hard for him by insisting that he baby-sit and do some housework after school. (**Externalizing blame.**) John begins to do little things to annoy his mother, like "forgetting" to give her phone messages. He teases her by hiding things she needed, like bills or her checkbook. After she gets upset, he gives them to her. (**Power based behaviors used to express anger and to give him a sense of power and control in his life.**) John told himself that he was getting back at Mom for being so hard on him. (**Externalizing blame.**)

When John was about six or seven, he fell into a pattern of masturbating when his parents would fight or if his Dad yelled at him. It would take away the bad feelings. By the time he entered his teens, he was masturbating two or three times a day. Sometimes he would have fleeting images of his sister bathing. (**Targeting a potential victim.**) Now, when he masturbates, sometimes he will think about her and about touching her between the legs. (**Fantasy**) In the last couple of years, John found he enjoyed touching her breast area and buttocks. He did this under the guise of wrestling. One night while she was sleeping, he put his hand into her pajamas and felt her genital area. Now John is thinking about touching her in a more adult way and wondering what it would be like to put his finger into her vagina. He thought about how he might go about doing this. (**Fantasy plans**) One night as they were sitting on the sofa close together, he told her he wanted to play a special touching game. In time, this led to digital penetration. When his sister complained he hurt her, he would give her an extra dessert. He let her stay up late with him whenever he molested her. Sometimes he takes her to movies or to the mall. He tells himself she likes it because she wants to sit by him and asks for extra treats. (**Justification**)

(**Finally, in the third phase, the integration phase, the youth tries to support or rationalize this behavior.**) After he molested Mary, John would have some

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feelings and thoughts that were uncomfortable. He dismisses these, telling himself that he didn't really ever hurt Mary. **(Justification)** She likes him to take care of her and touch her. He is her favorite in the family. She even asks to have him baby-sit her or take her places.

**Trainer:** The trainer needs to emphasize that offenders rarely go through a cycle in such a straightforward way. (Some never go through a cycle at all.) They may plateau at different stages and progression will stop for a while. Not every negative life event automatically leads to an abusive act. Sometimes, it is not an event that triggers the cycle. It can be the experience of feelings not directly connected to situations. Adolescents tell clinicians that before they acted out they felt angry for no specific reason, or bored. Some offenders have a deviant sexual arousal pattern, so that a certain age child or child of a particular physical type attracts them sexually. For these young offenders, seeing a child who sexually arouses them can "trigger" an offense.

The factors in the cycle are generic while offenders are individual; thus, each offender situation is unique and the treatment or cycle work must be personalized to the individual offender.

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### **SECTION IV**

## **CONFIDENTIALITY AND CASE PLANNING WITH J.S.O.'s**

**Rationale:** In working with juvenile sex offenders, Child Welfare Professionals must understand who the client is for a treatment provider, and the inherent dilemmas this can present for all parties involved in the helping relationship.

### **Learning Objectives:**

Participants will be able to:

- Recognize that the juvenile sex offender treatment provider's client is the victim.
- Define the duty of the treatment provider in protecting the victim and potential victims.
- Identify the limits of confidentiality when working with juvenile sex offenders and the inherent dilemmas involved for treatment providers.

**Time:** 1.5 Hours

**Methods:** Presentation  
Discussion  
Small group exercises

**Materials Needed:** Flip Chart  
**Overhead 3: Ethical Concepts**

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### **A. Goals of Case Planning and Investigation**

The trainer should present the following information as an introduction to talking about confidentiality and case planning:

1. Keeping the victim safe is the first goal in case planning. To that end, best practice usually recommends that the J.S.O. be removed from the home throughout the assessment and case planning process, if the victim lives in the home. This lessens the risk to the victim, sends a strong message that sexual victimization is wrong, and focuses the responsibility for the abuse on the perpetrator.
2. With very young children who are sexually aggressive, however, it is recommended they be kept at home, assuming adequate supervision for the victim. The young child's sense of security, identity, and coping ability are tied to and dependent on their familial relationships and their home environment. Removal from the home may seriously jeopardize the child developmentally, emotionally, cognitively and physically. Of course, there are always exceptions to any rule. The exceptions depend on severity and frequency of the offending behaviors, the ability of the caretaker to keep the victim safe, and to manage the offending behaviors in the home setting. The safety of all individuals involved with the offender must be evaluated in deciding whether to remove the perpetrator.
3. All offenders and their families (biological, adoptive, foster, and kinship) need to be in treatment. The offender needs to gain control over his/her offending behaviors and the family needs to be supported in dealing with what it means to have a sex offender as a son, brother, sister or grandchild. In intrafamilial abuse, the family has the complicated challenge of having an offender and victim in the same family.
4. All offenders need to be in sex offender specific treatment. This treatment must be sex offender specific; it must identify the antecedent issues; the triggering issues; the individual offender's specific progression through the elements of the cycle; and include work on victim empathy, thinking errors, etc. Treatment has a better prognosis if the entire family is involved in the treatment to support the offender and to work on any areas in their lives that support the offender's use of abuse to cope with his/her life situation.

### **B. Understanding the Paradigm Shift**

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The trainer should lead a discussion which answers the following questions. The questions may be placed on a flip chart. The trainer needs to be aware that many trainees will be surprised at this shift in perspective. The trainer needs to punctuate the paradigm shift during the rest of the training.

1. Who is the client?
2. What is the goal of intervention?
3. How do your personal values affect the work?
4. What are the limits of confidentiality?

1. Mental health providers are typically faced with a significant paradigm shift when working with the forensic population and, in particular, with juvenile sex offenders. Most mental health training programs teach providers that their primary ethical and professional responsibility lies in the treatment of the identified client, in this case the juvenile sex offender.

In working with the sexual offender population, this responsibility changes significantly. In most cases involving sexual abuse (particularly when working with court ordered clients and "system referred" clients), the client is actually the victim or potential victims of the offender. That is, the primary purpose of intervention is to protect the victim and the community from further victimization.

2. Criminal sexual behavior is not necessarily a mental disorder. Although many sexual offenders can be diagnosed with a mental disorder, (a condition identified in the *Diagnostic and Statistical Manual IV*), not all offenders have a clearly identifiable mental disorder. Many offenders do possess developing characterological disorders or other mental health issues in addition to the sexually deviant behavior. Most juvenile sexual offenders can be diagnosed as presenting a conduct disorder, disruptive behavior disorder, or paraphilia not otherwise specified. In spite of the fact that sexual offending is defined criminally rather than psychologically or psychiatrically, mental health providers have a great deal to offer in terms of helping to manage the offender's behavior. After all, mental health providers are, by definition, behavioral scientists. As such, they are equipped to facilitate intervention strategies to modify dysfunctional behavior.

As previously established, sexual deviancy can be defined in a variety of ways including clinically, statutorily, and based on personal values. It is essential to address the case worker's personal value system to prevent decision making from the "heart" rather than from sound clinical practice. Given that most individuals find sexually abusive behavior repugnant, it is essential that personal values both be identified and managed effectively in order to provide effective and safe treatment for the community.

Caseworkers and treatment specialists often either over or under identify with victims or perpetrators and it is essential that they find a balance to this position.

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Adolescent and young offenders in particular tend to affect our personal value systems. That is, it is often difficult for caseworkers and therapists to view young individuals as having the ability to form malice and criminal intent in their actions and therefore tend to underestimate the capacity for young people to perpetrate crimes. Caseworkers and therapists also tend to view younger offenders as purely "reactive" and therefore do not assign sufficient culpability to the abuse. (This is not to minimize the understanding that some offenders have been victimized themselves and this may play a role in their acting out behavior.) Everyone involved with the case must be careful not to view the offender as a victim at the expense of looking at his/her offending behavior. Caseworkers sometimes fail to adequately identify risks and to carry out the primary task of ensuring community safety.

3. Confidentiality Waiver: Given that the primary client is the community and given that one of the primary roles in managing juvenile sexual offending behavior is the coordination of services, the issue of confidentiality must be addressed. In most cases a "confidentiality waiver" is an essential component to providing safe and effective treatment of this population within the community.

However, it is not appropriate to share private perpetrator information with people who are not involved in the treatment or supervision of clients. At the same time, it is essential for everyone who is involved in the supervision of, and who has direct contact with sexual offenders, to have adequate information to carry out their tasks. Without adequately informing the school systems, youth leaders, and primary caretakers of the nature of the offending behavior, an environment can be created which fosters continued acting out behavior. Without a free sharing of information, the offender and the community are placed in jeopardy.

### **C. Ethical Concepts and Dilemmas**

#### **1. Concepts**

The trainer should display **Overhead 3: Ethical Concepts** and discuss the ethical concepts of "beneficence", "non-maleficence", "autonomy", and "least restrictive environment."

**Non-maleficence** - the duty to do no harm.

This is, by many ethicist's reasoning, the most important of all ethical principals in the helping profession. That is, therapists are responsible for preventing further harm, in any form, through their intervention strategies. This ethical dilemma is often raised when therapists are placed in a position to remove people from their

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homes, or impose values and beliefs upon others, or pursue prosecution of individuals. In questioning whether to pursue certain interventions, the therapist must first question their responsibility to do no harm. For example, removing a very young perpetrator from home may cause significant damage to the child and to the family (abandonment issues for the child, or increased hostility/resentment of the "system" by the family, etc.) This duty to not harm others applies to our responsibility to the perpetrator as well as to the victim/family/community and must be considered carefully when weighing the potential cost of re-offending.

**Beneficence** - the ethical responsibility to "do good."

This is usually considered the second most important duty of any helping professional and clearly the one with which professionals feel most comfortable. Helping others includes protecting people's rights and improving the welfare.

**Autonomy** - the duty to help people function independently on their own volition.

Helping professionals tend to want to help people to the point of not allowing them to help themselves. They frequently project their own personal values upon others rather than allowing clients to make choices for themselves. They do not empower others, they empower themselves.

**Least restrictive environment** - the duty to provide services with the least amount of coercion and external structuring, while maintaining safety for the community and providing treatment to the offender.

This concept is closely related to the ethical concept of autonomy. Professionals are responsible for using the least amount of force/structure/coercion necessary to effect the change which is statutorily indicated and to maintain safety. Although the first inclination should be to move an individual from the home or to insist that all perpetrators initially be incarcerated, this is not necessarily in the best interest of the family system and may not be necessary to ensure either the safety of the particular individual or the safety of the community. For example, it may be more beneficial (after an initial period of evaluation) to have a sexual perpetrator placed on probation rather than incarcerated for an offense. In some communities, when an individual has completed a prison term, they are no longer under any direct supervision of the court and therefore are not responsible for pursuing further treatment or maintaining basic coping skills to ensure community safety. By having an individual on probation, caseworkers and therapists can frequently facilitate closer monitoring over a longer period of time, and can often leverage an individual to participate in therapy which produces long lasting impact on the individual, thus helping to ensure community safety over an extended time period. In addressing the issue of "least restrictive environment", it is essential to fully understand the full range of intervention options and be able to apply these options as they apply to a particular individual in a particular context.

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It is important to weigh each of these ethical dilemmas, particularly as they relate to our statutory requirements. Certainly, caseworkers and therapists must always pursue their statutory requirements first; however, frequently administrative rules and legal statutes do not clearly delineate direction in a particular case. It is important to weigh these ethical positions carefully in applying intervention strategies.

(It may be appropriate to use the *Standard of Practice* or *Assertions* established by *The Association for the Treatment of Sexual Abuse* [ASTA].)

2. The trainer should brainstorm with trainee's situations which place them in ethically challenging positions. This brainstorming is initiated by asking the question: "When have you found yourself struggling with the 'right' approach to managing a sexual offender?" If the participants are unable to generate situations, it may be useful to provide them with examples including:
  - a. Should a very young offender be removed from the home?
  - b. Sharing information about a perpetrator with persons who may not manage the information well.
  - c. Pushing for incarceration as opposed to probation when the victim/family have different desires for consequences, etc.

### **3. Small Group Exercise:**

**Goal:** To help the trainees learn critical thinking skills and to use the ethical constructs to find a "balancing" position.

The trainer should then divide the group into smaller groups (three to five people per group) and have each small group discuss one of the identified situational dilemmas using the ethical concepts identified above. The small groups should address the following questions during their discussion:

1. How does my "gut" tell me to respond to the situation?
2. How do the ethical constructs of non-maleficence, beneficence, autonomy, and least restrictive environment relate to this situation?
3. How do these ethical constructs lead me to a different conclusion than the conclusion my "gut" leads me to?

The trainer should ask each group to report their conclusions about the situation assigned to them to the full group. The trainer needs to relate the ethical constructs and the features of the paradigm shift to the discussion of each dilemma.

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## **SECTION V**

### **FAMILY ASSESSMENT AND DYNAMICS**

**Rationale:** Issues of juvenile sex offending present special dynamics for the Child Welfare Professional in assessment and case planning activities, particularly in relation to working with the victim and juvenile offender in the context of the family system.

**Learning Objectives:**

Participants will be able to:

- Identify family dynamics as they relate to sexual abuse.
- Describe the impact of sexual abuse on family.
- Determine when the offender should be removed and the impact of this on family members.
- Describe the impact of victim removal on victim and family.
- Develop a case plan consistent with family dynamics and family treatment needs.

**Time:** 2 Hours

**Methods:** Presentation  
Brainstorming  
Discussion  
Experiential exercises

**Materials Needed:**

- **Handout 11:** As With Offender Treatment, Family Treatment Will:
- **Handout 12:** Circumplex Model
- **Handout 13:** The Juvenile Sex Offender's Family
- **Overhead 4:** As With Offender Treatment, Family Treatment Will:
- **Overhead 5:** Sexually Abusive Youth Should ...
- **Video:** Assessment of Adolescent Sex Offenders (Counter #94)
- **Video:** Treatment of the Sexualized Child and Children, Who Molest (Counter #569-656)
- **Flip chart:** Circumplex Model  
Stages of Family Intervention

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### **A. Family Treatment: Key Concepts**

1. **Video Vignette: Assessment of Adolescent Sex Offenders (Counter #94).** offending issues with his parents. **(This segment can be shown at this point or at the beginning of the second day of training, whichever comes first.)** It is a good juxtaposition to the introductory vignette from Day One as the Day One segment highlights very young sexually aggressive children. Thus the continuum of ages of youth offenders is established: from very young child to older adolescent.

2. After participants watch the video, the trainer should present the following information:

Family or caretaker involvement is an integral part of working with juvenile offenders. Parent/family roles in the process include: providing critical developmental information, participating in treatment, and becoming a partner in the treatment process. Remind trainees that cultural beliefs will play a role in the family's understanding of the role of treatment. Families may need extra help in understanding sexual abuse, the cycle, the need for treatment in order to prevent future offending, etc. This understanding can help families understand and actively participate in treatment and other interventions.

As with offender treatment, family treatment requires a paradigm shift in conceptualization about the goals of intervention and approach. The primary goal of offender family treatment is the same as the primary goal in offender treatment: to prevent re-victimization of a victim or victims or further victimization of other victims. In offender family treatment, the victim is the client and the goal is to protect the victim and others in the community.

3. Trainer should display **Overhead 4: As With Offender Treatment Family Treatment Will...** as well as distribute **Handout 11: As With Offender Treatment Family Treatment Will...** The trainer should ask trainees to reconsider their orientation to family treatment in light of the following statements. (The underlined parts reflect the content of the overhead and handout).

#### **As with offender treatment, family treatment:**

- a. **Will be mandated.** Clinical experience documents that historically families do not stay in treatment without the force of a court or protective service order.
- b. **Will have limited confidentiality.** Sharing of information between agencies and treaters is as critical in dealing with the offender's family as it is in working with the offender.

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- c. **Will focus on offense-specific aspects as well as general dysfunction.** (The offense-specific aspects of offender treatment are discussed in the section on interventions.)
  - d. **Will include a value stance by the therapist on setting limits, and being active and directive.** The therapist operates in accord with the goals of preventing re-victimization and protecting the community.
  - e. **May need to expand concept of family to include extended family members, foster parents, other significant others (for example, girlfriend or boyfriend of perpetrator.)**
4. The trainer should display **Overhead 5: Sexually Abusive Youth Should ...** (Revised Report of the National Task Force on Juvenile Sexual Offending, p. 42.) and discuss.

Removal of the offender needs to take place for the protection of the victim as well as for the protection of others in the home. (Remind the group of the exception to this, which is the young or disabled sexually aggressive child.)

Work with the family requires sensitivity, and understanding of the culture of each family. Awareness of treatment concerns for people of diverse cultures is key.

### **B. Impact of Sexual Abuse on Family Members**

When a member of a family is sexually abused, the repercussions impact all family members. The impact on the family is increased many fold when both the victim and the perpetrator are in the same family.

#### **1. Small Group Exercise:**

**Goal:** To increase trainees awareness on both a thinking and feeling level of the impact of abuse on all members of a family.

The Trainer should divide trainees into four groups and assign each group one of the following identities:

- a. Child sex abuse victim. Ask each group member to be a different age with ages ranging from three to fifteen.

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- b. Juvenile perpetrator (sibling of the victim.) Ask each group member to be a different age with ages ranging from six to seventeen.
- c. Father of the victim. Ask each group member to be the parent of a different age child victim, ages ranging from three to fifteen.
- d. Mother of the perpetrator. Ask each group member to be the parent of a different age youth perpetrator with perpetrator's age ranging from six to seventeen.

Each group member is to complete one of the following sentences depending on the assigned identity:

- a. Victim: "I am a molested child, and my greatest concern is..."
- b. Perpetrator: "I molested my sibling and my greatest concern is..."
- c. Father: "My child was molested by a brother or a sister and my greatest concern is...."
- d. Mother: "My son or daughter molested a brother or sister and my greatest concern is..."

The trainer should give each group time for discussion and then ask them to use the same sentence beginnings and add, "and I feel . . ."

The trainer should ask each group to report the range of concerns and feelings to the large group. The trainer should note the differences in the nature of concerns and feelings based on the age of victim and/or perpetrator and between parents.

Typically, victims feel they are to blame for the abuse and the subsequent disruptions in the family because they disclosed what happened to them. Parents alternate between anger towards the perpetrator and anger towards themselves for not protecting the victim and guilt for the same reasons. Often parents feel torn between loyalty to the perpetrator and responsibility towards the victim. The parents feel pushed to "choose" between two children. Parents may minimize or deny the impact of the abuse thus discounting the victim's issues and pain. This is a parallel process to the minimization and denial of the offender.

The trainer needs to emphasize that the dynamics of denial are found not only within the family but also among workers who deal with the offenders and their families. Denial is systemic. The trainer should ask the trainees to discuss these dynamics both as they see them in families and within the child welfare system.

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(This exercise was adapted from Beverly James and Maria Nasjleti, Treating Sexually Abused Children and Their Families, pp. 108-110.)

### **2. Video Vignette**

Trainer should play the **Video Vignette: Treatment of the Sexualized Child and Children Who Molest (Counter #569 - 656)**.

The discussion in this video segment highlights the continuum of family reactions to the revelation that one child has sexually abused another child and enhances the information elicited during the experiential exercise.

### **C. Family Dynamics**

It is important for caseworkers to understand the factors present in families that set up vulnerability for abuse. **This is not cause and effect but climate setting.**

**1.** Trainer may want to prepare a flipchart of the Circumplex Model in order to aid your discussion. **Handout 12: Circumplex Model** should be distributed to participants. (Olsen, Candyce, Russell, and Sprenkle, 1979, 1980, 1982, and 1983.) and distribute.

Using the overhead, the trainer should lead a discussion of the **Circumplex Model** in terms of assessing and understanding the dynamics of the families of juvenile sex offenders. The **Circumplex Model** may not be new to some trainees as it is used in other trainings. For these people, it will be a refresher and a new application to the juvenile sex offender's family.

#### **Content of Discussion:**

The Circumplex Model illustrates two aspects of family structure and dynamics-- cohesion and adaptability. All families manifest these two characteristics. The more the characteristics are in balance and closer to the middle of the continuums, the more functional the family.

Cohesion: Family cohesion measures the degree to which family members are separated from or connected to each other. It is defined as the emotional bonding that family members have toward one another. The extremes of the cohesion continuum are: disengaged and enmeshed. Specific concepts used to describe the cohesion dimension are: emotional bonding, boundaries, coalitions, time, space, friends, decision-making, interests and recreation.

An enmeshed family would manifest a lack of boundaries, secrecy both within and between family and the outside world, limited privacy, sexual and otherwise, and no self-identity. The family functions under the umbrella of a communal

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identity. There may be anxiety about the child's sexual behaviors reflecting on the whole family.

A disengaged family demonstrates an environment with rigid and extremely high standards. In this climate a child cannot develop her own self-regulation. Family members feel emotionally abandoned. There is tension and/or distance around sexual matters and evasion on sexual issues. Sex is something to be discovered, not discussed.

Adaptability: Family adaptability has to do with the extent to which the family system is flexible and able to change. The extremes of the adaptability dimension are: rigid and disengaged. Family adaptability is the ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situating and developmental stress. Specific concepts used to describe the adaptability dimension are: family power (assertiveness, control, discipline), negotiation style, role relationships and relationship rules.

A chaotically organized family might evidence a lack of accountability for sexual issues, disparity in values and behaviors with inconsistent standards, and consequences among family members. The children have no identity outside of the family and within the family there is little respect for personal space.

Characteristics of a rigid family are:

- "right" or "wrong" thinking
- extreme moralistic orientation
- extreme control with severe punishment for minor transgressions

Interestingly, these families are often intact units.

There are two typical patterns for families of adolescent offenders: the chaotically enmeshed family and the rigidly disengaged family. The first, the chaotically enmeshed, produces a less aggressive type of offender who usually offends against younger, smaller, less powerful children. The second produces the more aggressive offender who tends to victimize peers.

2. The trainer should distribute **Handout 13: The Juvenile Sex Offender's Family** and discuss it with the group.

The following characteristics are areas of concern that need to be evaluated during initial and ongoing family assessment. They are a review and amplification of information offered during the presentation on the **Circumplex Model**.

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The trainer should ask the trainees to elaborate on these points and to discuss how these factors can set up the climate for abuse. Trainer again emphasizes that these factors are not cause and effect, but climate setting.

- a. Over-involvement or Enmeshment: The physical, emotional, psychological, and/or sexual boundaries in the family may be blurred or non-existent. Generational boundaries (who is the parent or who is the child) and family members' personal space are not respected.
- b. Isolation: The outside world may be seen as hostile, and the family has closed itself off. This has led to family secrecy, loss of perception or reality checks, and a lack of support systems in the community.
- c. Extreme External and Internal Stress: The family has a large number of intra- and extrafamilial problems, including debts, illness, legal difficulties, and extended-family conflict. Constant exposure to stress weakens family resources. Coping mechanisms may be poor or maladaptive.
- d. Intergenerational Sexual and/or Physical Abuse: Offenders and other family members may have been victims of abuse or may have been abusive, sometimes dating back generations. It is not uncommon for the offender to have been abused by older family members and for his/her parents to have been victimized as well.
- e. Impaired Communication Styles: Communication patterns tend to be indirect, with feelings and thoughts expressed through behavior or in such obscure ways that family members often misunderstand one another.
- f. Conflicting Parental Relationship Styles: Relations may either be too close or too distant (for example, the father is sometimes emotionally distant while mother is enmeshed). There is often inadequate control and an erratic limit setting.
- g. Emotional Deprivation: Emotional needs for nurturance and closeness typically are not met, and skills in this area are limited.
- h. Abuse of Power: Family members, particularly parents, do not know how to use power, often reacting to external stimuli, instead of responding to an internal value system.

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Source: "The Adolescent Sex Offender's Family in Treatment" by Jerry Thomas, in Juvenile Sex Offending, pp. 340-341.

### **D. Stages of Family Intervention and Caseworker Roles**

The caseworker may not be involved during the entire time of intervention, but, if present, the caseworker plays an important role in the process. Even if not involved during the entire time, it is important to understand the process and phases that the family needs to go through. There are three phases to the family process. They are:

1. Crisis of Disclosure/Panic Phase
2. Assessment -- Beginning Awareness Phase
3. Family Treatment and Restructure Phase

**Trainer:** The trainer should make a flip chart listing the three phases and ask trainees to brainstorm caseworker tasks during the first phase, the Crisis/Panic phase.

- 1. Case work tasks and response to Crisis/Panic phase:** The trainer should underline the importance of the caseworker taking a firm stand around protection of the victim (usually involves removal of the offender), involvement of law enforcement and Court, connection with services and immediate link with treatment. Note that crisis is a golden opportunity to link family members to treatment services. During this period the family defenses break down. Thus the family is more open, than at any other time in the process, to accept treatment interventions.

The trainer should ask the group to brainstorm possible feelings the family may be experiencing such as denial, anger, shame, fear, sadness, disappointment, powerlessness, or shock. (Include an exploration of feelings and dynamics that can occur if either victim or perpetrator is removed.) For example, if juvenile perpetrator was a scapegoat, someone else may get this role. If victim is removed, someone else may get victimized, etc. Discuss the dynamic of denial for offender (and other family members) and recanting by victim (recanting is common and does not negate the validity of the original revelations.)

The caseworker has an important role to fulfill. All family members need support and guidance and an education about the dynamics of sexual abuse.

**Trainer Note:** The trainer should inform trainees that they will revisit this flip chart as the training continues. Trainer places flip chart on wall ready to revisit for phase two

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during section on assessment, and phase three during sections on interventions and reunification.

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### **SECTION VI**

## **OFFENSE SPECIFIC ASSESSMENT AND CASE PLANNING**

**Rationale:** In order to conduct case planning and treatment planning effectively, Child Welfare Professionals must understand the elements, purpose, and utility of an offense-specific assessment. In addition, Child Welfare professionals must be aware of the range of consequences resulting from informal interventions to adjudication, and be able to effectively plan for the safety of the victim and community and the needs of the victim, perpetrator and family.

### **Learning Objectives:**

Participants will be able to:

- Identify the purposes of assessment, key concepts regarding assessment, and main elements of an offense-specific assessment.
- Discuss how to utilize the assessment in an effective manner, including identifying data that needs to be shared with key people, how to use assessment results in case planning and treatment planning.
- Identify the range of consequences/options resulting from informal interventions to adjudication. Trainer will be able to identify how decisions are made to ensure the safety of the community and to address the needs of both the victim and the perpetrator.

**Time:** 2 Hours

**Methods:** Lecture  
Discussion  
Small Group Exercises

### **Materials Needed:**

- **Handout 14:** Juvenile Sexual Offender: Purposes of Prosecution
- **Handout 15:** Sex Offender Treatment Team Assessment Part 1
- **Overhead 6:** Goals of Assessment
- **Video:** Assessment Of Adolescent Sex Offenders  
(Counter #1080)
- **Flip Charts**

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### **A. Introduction**

A sex offender specific assessment provides the information needed to plan responsibly in regard to placement for the offender and treatment needs for the offender and his/her family. The caseworker needs the following information in order to "buy" the best assessment for the dollars he/she has to spend. Note: The trainer needs to emphasize that the paradigm shift continues to be in effect, and will continue to be in effect through every aspect of the offenders movement through all related systems--criminal justice, mental health, etc.

1. The trainer will list on a flip chart the points underlined below. Trainer will go over the points inviting trainees to contribute ideas and ask questions.
  - a. Assessment is comprehensive and usually requires multiple sessions. A sex offender-specific assessment cannot be done in a single session. A typical assessment will require four to six meetings with the assessor.
  - b. Assessment is specialized and offense specific. It will differ from a traditional psychological diagnostic assessment. The assessor's style may be more direct than in traditional types of assessment. (A traditional psychological assessment may be done as an adjunct to the offense-specific assessment, if needed, to gain information regarding cognitive functioning and personality structure, unless this information is available from other collateral sources.)
  - c. Initial assessment is preliminary, and assessment is ongoing. Just as sexual abuse takes place over time, disclosure usually takes place over time also.
  - d. The assessor should have specialized training. In offender dynamics and experience in doing sex offender assessment. Caseworkers need to ask questions about the assessor's training and experience in working with sex offenders.
  - e. Assessment requires collateral information. A blind evaluation will not provide a good assessment. Collateral information needed includes court records, physical examination report of victim (if available), police reports, family history, probation reports (if available), and school records. The Children's Protective Services investigation is especially important. The victim statement is critical because the offender may not be relied upon to give valid information. The caseworker needs to understand how critical it is to obtain the CPS investigation record. Trainer needs to inform caseworkers that the assessor may need to get a Court order for release of the investigatory information. Caseworker may need to support the assessor in this process.

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- f. Assessor will be aware of cultural issues. This can play a role in assessment. Trainer may want to review some of the information from section two. Trainer should ask trainees to suggest ways they see cultural issues aiding or obstructing the assessment process.
- g. Assessor has understanding of meanings of sex and sex offending. While sex offending is a sexual act, the motivation to offend is not necessarily sexual in nature. This refers back to information presented in the section on etiology and cycle of offending.

### **B. Goals of Assessment**

1. Trainer should display **Overhead 6: Goals of Assessment** and discuss each goal using the information given.

#### **Goals of assessment are to:**

- a. **Look at all possible factors** that may be impacting on the offender. These would include :
  1. Socio-environmental factors such as life stressors, relationship problems, and issues within the offender's living situation.
  2. Individual factors such as biological/medical issues, trauma, and choice of abuse as a coping strategy.
  3. Family factors such as the structure of the family (**Circumplex Model**), coercive use of power, presence of or lack of family support system, and history of intra-family abuse.
- b. **Reach a preliminary risk assessment** (Risk assessment refers to the type of risk assessment performed by a sex offender assessment specialist and is not the same risk assessment done by caseworkers.)

Risk assessment depends on clinical judgment and experience. It is a judgment of treatment needs and what type of placement will be appropriate, in order to ensure the safety of the victim and the community. Intensity of intervention and level of supervision needed are important aspects of risk assessment.
- c. **Set Treatment Goals and Plan Interventions.** Assessor will recommend what is judged to be in the best interest of victim, community, and offender, (even if the assessor is not sure if the recommendations can be met within current community resources.) The assessor may also give

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alternatives if the ideal is not available. The goals in treatment always include offense specific treatment and should also include adjunctive treatment components such as substance abuse intervention, educational remediation, pharmacological intervention, etc.

### **C. Content/Components of Assessment**

1. The trainer should list the Components of an Assessment on a flip chart. The trainer can lead trainees in brainstorming the content of each assessment area or divide the trainees into four groups and assign each group one area to brainstorm. Each group then prepares a list of their ideas to present to the larger group.
  - a. **Sexual History:** Gathering the sexual history is essential to begin the process of learning about precursors, past behavior, offense dynamics, arousal patterns, personal victimization, etc. Sexual history includes:
    - Sources of sexual knowledge and education regarding sexuality: the who, what, when, where, and how the youth gained his/her knowledge of sex. This part of the assessment includes exploring the offender's exposure to pornographic materials, videos, adult sexual activity, etc.
    - The actual sexual experience of the youth, thus far, positive and negative experiences and paraphilias.
    - Sexual fantasy life: Assessment seeks to get a preliminary sense of daydreaming, fantasizing about sex, what is arousing, etc.
    - Masturbation practices: This is an area of particular sensitivity. Cultural and religious issues come into play here. However, it is important knowledge for understanding the fantasies and deviant arousal patterns that may be involved in the youth's masturbation practices.
    - Personal victimization: The youth's history of sexual and physical abuse and knowledge of history of intra-family abuse.
    - Feelings and concerns about sexual development and sexual orientation, including how comfortable or uncomfortable youth is with sex and sexuality, physical appearance, etc.
    - Medical/Biological Issues: Assessor should check for any history of hormonal imbalance, organic problems, etc.

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- b. **Offense Specific Information:** This part of the assessment is focused on exactly what happened during and after the abuse, as well as the youth's perception of the meaning of the offense. The assessor should explore:
- Events surrounding offense: What was going on in the youth's life at home, at school, in family, and with friends? What situations or events (illness of parent, school performance, etc.) might the offender see as impactful?
  - Events leading up to offending: Discussion of this with offender helps to track feelings, patterns of targeting and grooming victim, how secrecy was established and maintained, triggers to offending, risky situations, etc.
  - Explore previous offending history, including opportunity and access to other victims.
  - Offender attitudes: feelings about the offense(s) and about victim(s).
  - Impression of offender's current degree of minimization, denial and sense of culpability.

Based on this information, the assessor can offer an impression of the factors or dynamics that drive the offender behaviors. He/she can also form a preliminary sense of the culpability of the offender based on his/her assessment of intellectual ability, developmental level, social status, sexual knowledge and history, victimization, and criminal history.

- c. **Individual Factors and Characteristics:** Gathering this information is important in determining relative strengths, weaknesses and treatment issues. In some cases this information can be obtained from collateral sources. Important information to know includes:
- Intellectual functioning
  - Any learning difficulties/ school adjustment
  - Personality structure/any significant mental illness
  - Developmental status (any significant delays)
  - Social history (family and/or caretaker information)

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- Coping abilities/problem solving abilities
- d. **Parent/Caretaker Interview:** Meeting with the parents/caretakers is crucial in determining their ability to aid or obstruct treatment. Factors that need to be explored include:
- Family's fear of further legal consequences
  - Parent's/Caretaker's desire to protect the victim and/or their ambivalence towards the victim; and parent's confusion about how to support the offender and the victim
  - Response to assessor's educational information about the nature of the offenses and patterns of progressions in offending. Often the parents are ignorant about offending issues (and victim issues) and the assessor educates as part of the assessment process
  - Parent's/Caretaker's levels of denial and minimization
  - Parent's/Caretaker's attitudes/feelings about offense and offender
  - Family's past experience with, and anger towards, the systems involved
  - Parent's identification with the perpetrator
  - Cognitive functioning of family members
  - Current life stressors within the family unit. For example, are there financial pressures, relationship issues, illness, unemployment, etc.?

The assessor may also utilize Attitude Questionnaires, Cognition Scales, and Personality Testing as part of the assessment process.

2. The trainer should play the **Video: Assessment of Adolescent Sex Offenders (Counter 1080)**. This segment is labeled Summary of Risk Assessment Issues. This builds on information offered during discussion. Trainer should suggest trainees take notes because the information will be utilized later in the training.

### **D. Purposes of Prosecution**

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**Trainer:** Trainer should distribute **Handout 14: Juvenile Sex Offender: Purposes of Prosecution** and review it with participants.

### **Juvenile Sexual Offender: Purposes of Prosecution**

1. Prevent further victimization
2. Protect community
3. Assure complete investigation of complaint
4. Demonstrate that sexually abusive behavior is serious, illegal and will not be tolerated
5. Hold offender accountable/responsible for his behavior
6. Determine consequences
7. Support victim's rights and reduce minimization and denial by offenders and others
8. Evaluate the need for treatment
9. Facilitate and/or mandate entrance into specialized treatment and enhance the offender's motivation for change
10. Assure continued treatment
11. Provide for supervision and follow-up (orders for probation/parole, also safeguards/safety plan)
12. Document record of offending
13. Help families who are denying the J.S.O.'s behavior to follow through with treatment.

Source: 1993. Juvenile & Family Court Journal. The Revised Report from the National Task Force on Juvenile Sexual Offending of the National Adolescent Perpetrator Network, pp. 19.

## **E. Utilizing the Offense Specific Assessment Report: Case Planning**

### **Small Group Exercise:**

Written and Revised by The Institute for Human Services for the Pennsylvania Child Welfare Training Program.  
202 Working with Adolescents: Juvenile Sexual Offenders

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**Goals:** Trainees will become familiar with the component parts of a sex offender-specific assessment and utilize the assessment in determining offender risk level.

The trainer should divide trainees into four to six small groups and distribute **Handout 15: Sex Offender Treatment Team Assessment Part 1**. The trainer should ask trainees to read the assessment and complete the last two sections of the assessment, including:

- Areas of Relative Strength
- Positives and Areas of Concern
- Problem Areas for the Offender.

The trainer can then lead a discussion with the groups about their conclusions.

Based on this information, the trainer should ask trainees to make a silent determination of the offender's risk level--low, medium, or high risk.

The trainer then should inform trainees that they will soon have an opportunity to compare their conclusions with the "expert's" assessment of risk level.

### **F. Stages of Family Intervention and Caseworker Roles**

The trainer should refer the group back to the flip chart sheet listing the three phases of intervention, that is hanging in the room. The trainer should ask trainees to brainstorm the caseworker role, tasks, and responsibilities for the second phase of the Assessment--Beginning Awareness Phase. The following should be covered:

The caseworker's role is to make sure that foster parents or other caregivers receive essential information about the nature of the offenses. The caseworker will also support the adjudication and assessment processes and ensure that recommendations are followed. It is the caseworker's responsibility to coordinate treatment and talk to therapists. This role may be shared if youth is on probation- caseworker and probation officer work together.

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## **SECTION VII**

### **INTERVENTION STRATEGIES**

**Rationale:** In order to work effectively with juvenile sex offenders and their families, Child Welfare Professionals must understand the range of available intervention methods and the rationale for when various methods are used, as well as the role of the Child Welfare Professional in the treatment process.

#### **Learning Objectives:**

Participants will be able to:

- Discuss the range of available intervention methods (i.e., incarceration, residential, non-residential treatment) with juvenile sex offenders and understand the rationale for various methods.
- Describe the components and rationale of sex offender treatment.
- Determine their role in the treatment process.

**Time:** 1 Hour

**Methods:** Presentation  
Discussion  
Small group exercises

#### **Materials Needed:**

- **Handout 16:** Supervision Strategies
- **Handout 17:** Components of Mental Health Treatment for the JSO
- **Handout 18:** Sex Offender Treatment Team Assessment Part II
- **Overhead 7:** Intervention Strategies
- **Overhead 8:** Supervision Strategies
- **Overhead 9:** Components of Mental Health Treatment for the JSO
- **Video:** Treatment of Adolescent Sex Offenders  
(Counter #430-587)

#### **A. Introduction: Supervision and Treatment**

Written and Revised by The Institute for Human Services for the Pennsylvania Child Welfare Training Program.  
202 Working with Adolescents: Juvenile Sexual Offenders

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The trainer will lead a discussion which helps to delineate the two primary intervention strategies of supervision and mental health treatment, and the goals of these intervention strategies. Trainer should display **Overhead 7: Intervention Strategies** and discuss with participants.

### **Intervention = Supervision + Treatment**

Goal 1: To reduce opportunities for re-offending

Goal 2: To move offender from external to internal controls

Goal 3: To manage precursor behaviors and resultant behaviors

**Trainer Note:** During this discussion, the trainer should continue to remind trainees of the paradigm shift: the client is the victim and the goal of intervention is to protect the community.

### **Content of Discussion:**

Historically, most caseworkers have viewed intervention with sexual offenders as including primarily mental health treatment (intervention-treatment). The court system has historically viewed intervention as synonymous with supervision strategies (intervention = supervision). It is most beneficial to view intervention as including supervision strategies and mental health treatment (intervention = supervision + treatment). Certainly, it is impossible to alter behavior without supervising behavior and directly attempting to alter the behavior. The primary goal of sex offender intervention is to reduce the probability of an offender returning to previously identified sexually deviant behavior. This deviancy is generally defined as sexual behavior that is coercive or harmful (see discussion at beginning of workshop), and not just personal bias (i.e., homosexuality, sexual contact outside of marriage, etc.).

A secondary goal is to make the transition from externally controlled behavior to internally controlled behavior. That is, the offender must learn how to self manage behavior, rather than relying on others to manage that behavior. This requires the management of "precursor" behavior as well as "resultant" behavior. The sexual offender must learn to manage his/her experiences that lead up to the deviant behavior in order to manage the problematic behavior. As a result of this need to manage precursor behavior, intervention must address all sexual behavior in order to extinguish deviant behavior and to enhance appropriate behavior.

Most research suggests that sex offender intervention and treatment requires two or more years, with more intensive intervention early in the process.

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### **B. Supervision Strategies**

1. The trainer will conduct a brainstorming exercise which identifies the pros and cons of supervision strategies including incarceration, probation, electronic monitoring, residential treatment, group home placement, foster home placement, and placement in the home.

To guide the discussion, the trainer should display **Overhead 8: Supervision Strategies** which outlines the continuum of supervision strategies from most restrictive to least restrictive. (Trainer should wait until discussion is complete before distributing handout.)

#### **Content of Discussion**

Supervision strategies generally are identified as including the following interventions: incarceration, probation, electronic monitoring, residential treatment, group home placement, foster home placement, and placement in independent living. Certainly, not all intervention strategies are equal in terms of the amount of intrusiveness involved and require varying quantities of community resources to implement. We are pragmatically faced with limitations in our ability to intervene, based on limited community resources, availability of supervision mechanisms, statutory limits, and the inability/unwillingness to prosecute. It is frequently not appropriate to use the more intrusive forms of supervision, due to these limitations and the importance of maintaining autonomy for the individual.

In understanding placement options it is important to note that significant differences exist between specific facilities. For example, what is true of one foster placement may not be true of another. The classifications in the **Supervision Strategies** chart are not meant to be exhaustive, or to imply that absolute differences exist from one option to another. Rather, placement options can be thought of as a continuum ranging from most restrictive/intrusive to least restrictive/intrusive. Generally speaking, the more restrictive, the safer for the community, the easier to coordinate immediate services, and the better the community feels about the placement. The more restrictive the placement, the more expensive and disruptive it will be to the family system; and the more difficulty the sex offender will have in generalizing new skills acquired when released from the placement. In determining placement options, it is important to weigh the needs of the community with the particular needs of the sexual offender.

As indicated in the chart, incarceration is generally thought of as the most restrictive/intrusive placement option. It is generally thought that as long as an individual is locked up, they can not re-offend against the community (of course they can continue to offend against other incarcerated individuals.) Generally

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those outside the family system, (and to some degree, depending on the family dynamics, the members of the family) experience some relief when sexual offenders are incarcerated or removed from the community as the community feels a sense of justice from punishing the offender.

At the same time, many families experience significant trauma from this experience (guilt from sending a loved one away.) Many institutions lack adequate treatment for sexual offenders, and therefore offenders may get little or no treatment for their sexual problems. It is often difficult for the local community to maintain management of the offender after release because jurisdiction is often transferred to a state agency, rather than the local agencies. Finally, because incarceration involves placing an offender in a secured environment, the offender does not develop the ability to apply newly developed skills in the "real world." As a result, offenders often find it very difficult to generalize coping skills learned while incarcerated into their home environment.

In most cases, probation is an important element to any placement. In every placement except incarceration, probation becomes the mechanism to ensure compliance with treatment. Unfortunately, this is often costly for the local community who often has an overworked juvenile probation department. It is often difficult to coordinate services with individuals who are on probation because several different agencies are involved in a particular case and each agency has a different agenda.

Electronic monitoring can be an effective adjunct to any placement option. In most cases an electronic monitoring system can be set up for only a few dollars a day. Several electronic monitoring approaches exist including: ankle bracelets to monitor the offender's current location, motion detectors to determine movement within an area, video surveillance to ensure compliance with rules, and alarms to restrict movement within an area. Unfortunately, electronic monitoring can not ensure that a new offense will not occur. For example, an ankle bracelet will alert the supervisor that someone has left an area, but it will not keep the offender from leaving nor prevent him/her from gaining access to a victim who enters the area where the offender is restricted.

In recent years the difference between residential treatment, group homes, and foster homes has become increasingly vague. Generally speaking, residential treatment programs offer increased supervision, more intensive intervention from a multi-disciplinary team, and a more restrictive environment than group homes or foster homes. Certainly this is not always the case. All three of these placement options aid significantly in preventing ongoing abuse within the family system, but at the same time cause a disruption of the family system that may cause other problems. Each of these placement options provide varying degrees of security, coordination of services, and exposure to the community. Any placement away from the offender's long term home situation causes potential problems with generalizing new skills into their lifestyle.

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Eventually every offender will return to some level of independent living. This may occur when they turn the age of majority and are no longer eligible for services, have served their maximum sentence or have successfully progressed through an intervention program. Returning to independent living may mean living on their own or returning to their family system. Independent living implies virtually no external monitoring and should generally only be considered for individuals very far along in treatment, or just prior to mandatory release from intervention programming.

2. After the discussion is completed, the trainers should distribute **Handout 16: Supervision Strategies**. The information collected by the group during the previous discussion should be very similar to this handout. The trainer should tell participants that the handout can be a reference guide.

### **C. Sex Offender Specific Treatment**

1. As an introduction to treatment the trainer will show video vignette, **Treatment of Adolescent Sex Offenders (Counter 430-587)**. This segment shows an interview with an adolescent sex offender who is describing his methods for controlling his sexually deviant urges.
2. The trainer should lead a discussion on offender specific treatment used. This discussion should include a discussion of the pro's and con's of individual counseling, group counseling, and family counseling. To guide the discussion, the trainer should display **Overhead 9: Components of Mental Health Treatment for the Juvenile Sex Offender** and distribute **Handout 17: Components of Mental Health Treatment for the Juvenile Sex Offender**.

The trainer should introduce the discussion with the following remarks:

Effective sex offender intervention also includes a number of mental health treatment components. These include:

- Sex education
- Victim empathy training
- Social skills development
- Relationship skills development
- Fantasy management
- Restitution
- Relapse prevention

The most effective treatment programs incorporate at least some element of each of these components throughout the course of treatment. Ideally every individual participates in multiple groups, each group addressing one of these issues while

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participants also attend an ongoing "therapy group". Pragmatically, this only occurs in large, in-patient programs while most community programs attempt to weave these issues into the treatment of a single ongoing group.

Each of these treatment components must be reinforced and further developed in the offender's day-to-day life and should not be discussed/addressed only in a single weekly group. Caseworkers must be able to recognize good, effective treatment. The following summarizes these treatment components:

- a. **Sex education**--Often offenders lack a basic understanding of human sexuality and therefore must learn this material. Occasionally, juvenile sex offenders begin offending out of a sense of curiosity and exploration. Other offenders have significantly distorted misunderstandings of human sexuality. Developmentally appropriate sex education can confront these distortions and can facilitate a healthier understanding of sexuality. One goal of sex offender programming is to help an individual make the transition from deviant sexual behavior to healthy sexual behavior. This can only be accomplished if people understand basic human sexual physiology. Sex education is usually facilitated through a didactic group and includes a mechanism for assessing the mastery of information.
- b. **Social skills building**--Many offenders lack basic interpersonal skills and therefore find it very difficult and emotionally frightening to interact with their peers in an appropriate fashion. Social skills building teaches basic interpersonal skills and basic communication patterns. This includes basic issues such as personal hygiene, listening skills, and social customs. This is frequently taught in a skills-building approach with a behavioral checklist used to measure mastery of skills. This component is effectively taught in a "hear and now" approach, taking advantage of "teachable moments".
- c. **Relationship building**--Even if an individual is socially competent, they frequently lack the ability to develop lasting and intimate relationships. This component focuses on developing those skills which are essential to dating and/or intimate adult relationships. This includes developing the skills necessary to become vulnerable, to develop intense empathy, and to explore a partner in an appropriate fashion through communication. This component may include basic dating skills, as well as more advanced commitment skills.
- d. **Fantasy management**--Some offenders have a history of deviant sexual fantasy and compulsive masturbation. This component

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focuses on establishing fantasy management skills through thought stoppage, sensate refocusing, "natural and logical consequence" fantasy management techniques, and other imagery techniques. This component often relies on the use of fantasy/masturbation logs in order to help establish a baseline understanding of the current level of behavior, and to monitor the effectiveness of fantasy management skills.

- e. **Victim empathy**--Many theorists believe that offenders would not act out on their impulses if they were able to understand the amount of pain which their victims experienced. Other theorists believe that some offenders (particularly sadistic offenders) offend because of their understanding of the pain they inflict upon their victims. In either case, it is commonly believed that offenders need to establish a basic understanding of and empathy for the impact of their behaviors on others. This is usually accomplished through exercises which increase the offender's understanding of the impact of their actions at various points in the victim's life--ranging from immediately following the abuse, throughout adulthood. Imagery exercises are also frequently used in order to help the offender to experience, in a limited fashion, the experience of being abused. This component may also help offenders address their own issues of victimization as appropriate. One tool frequently used to measure the effectiveness of this element of treatment is the "victim apology letter."
  
- f. **Relapse prevention**--Although relapse prevention is the goal of all sex offender intervention, it is also considered a specific treatment modality. Relapse prevention is a cognitive-behavioral approach to modifying behavior. As a treatment modality, relapse prevention identifies patterns of thoughts, feelings, and behaviors which precipitated the offending behavior and then identifies specific coping skills to intervene with these patterns (cycle). For older juveniles, this is usually accomplished through a series of workbook assignments which break down the offending patterns. Specific mechanisms are established for intervening in these patterns and then these intervention strategies are implemented over a period of time. A critical element of relapse prevention training is the ability to generalize these very specific skills into everyday living. All of these strategies are integrated into a personalized relapse prevention plan. This plan is then shared with all family members or caretakers.
  
- g. **Restitution** -- The final component should be to have the offender make offenses to the victim(s), either concretely or symbolically. Restitution can be in the form of paying for victim treatment,

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supporting victim assistance programs financially or with in-kind support, or by helping other offenders in treatment programs.

Each of these intervention components are typically considered essential for sex offender programming. Some treatment programs include a treatment component labeled thinking errors or cognitive distortions. This component deals with distorted patterns of thinking that support the offending behaviors. Such thinking would include: poor me patterns, objectifying victims, black and white thinking, magnifying or minimizing, etc. Often attention to these dysfunctional thinking styles is woven throughout each treatment component to ensure generalization of new modes of thinking across treatment interventions.

**3. Treatment modifications/issues for different populations:** It is sometimes inappropriate to initiate each of these components to their full extent. It is essential to modify programming to a developmentally appropriate level. Certainly, some offenders with mental retardation or developmental delays will be unable to grasp many of the concepts used in relapse prevention and other elements of sex offender treatment. Therefore, treatment modalities must be framed to match the cognitive/developmental level of the group participants. As indicated previously, it may not be appropriate to use victim empathy as an intervention modality for sadistic offenders. Additionally, some offenders find fantasy management difficult as they either did not have significant fantasy behavior prior to their offense and/or the use of these skills exacerbates their fantasy activities. These are issues which must be addressed by all mental health practitioners.

Very young offenders have some additional needs. In managing very young offenders, it is essential to educate primary caretakers as to the nature of the offending behavior, and aid in establishing management strategies for the child. Caretakers are often participants in parallel groups to very young offenders. Very young offenders generally do not benefit from highly cognitive intervention approaches; therefore, play and expressive therapies are considered primary treatment modalities, often addressing urges to sexually abuse with developmentally appropriate language and concepts. By communicating with the youth at this level, they are able to integrate concepts that are generally beyond their cognitive/developmental level.

**4. Pharmacological Issues:** In addition, some offenders may require pharmacological intervention to help manage their sexual impulses. This is particularly true when significant biological/neurological factors have contributed to the acting out behavior. Some juvenile offenders have benefited from medications such as Clonidine, Fluoxetine (Prozac), and Cyproterone Acetate (Cyproteron). Additionally, research has shown Depo-Provera to be an effective means for managing sexual impulses for a small percentage of adult offenders.

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### **D. Constellation of Services Needed by the Family, Offender, and Victim**

#### **1. Experiential Exercise:**

**Goal:** To give the trainees experience in utilizing an assessment and planning appropriate interventions for each member of the family.

The trainer should distribute **Handout 18: Sex Offender Treatment Team Assessment, Part 2**. Trainer will ask trainees to review the previous case example (**Assessment -1**) and to make recommendations for supervision and treatment for the juvenile offender and the family. The trainer will divide the trainees into small groups and ask them to address the following questions (as listed in Handout 7-3):

1. What intervention components are most critical?
  - a. Was this case appropriate for legal prosecution?
  - b. Can the offender remain at home? If not, where should the offender be placed?
2. What services are needed by the offender?
3. What services are necessary for the non-offending parents?
4. What are the services needed by the victim?
5. What safeguards need to be implemented during assessment and treatment?
6. What do you, the caseworker, need to do now that the assessment is complete?
7. Who needs to know about the results?

The trainer should ask the group to report their recommendations to the full group with the trainer facilitating full group discussion when appropriate.

This section of the training should focus on the integration of the skills previously learned. The caseworkers will need to synthesize their understanding of balancing cost of services, risk to the community, pragmatic limitations, etc. It is good to address this case from both a "best practice" approach and a "what's available" approach. This will also require the caseworker to synthesize materials learned in other sexual offender training as well.

In an ideal situation, it would be possible to involve the juvenile offender and his/her family in a comprehensive continuum of treatment services. For the offender, group treatment is usually recommended with individual treatment as needed; for the non-offending parents, group involvement can offer support and

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opportunities for education around victim and offending issues. Group treatment is usually preferred for the child victim as well, since group offers the victim the understanding that he/she is not the only one to be victimized. The victim will need some individual work, particularly if the abuse has been long standing and the family system dysfunctional. Ideally, family treatment would also be available at some point during the process. In practice, family treatment often begins in dyads: marital work with parents if needed, the offender and one parent, the victim and one parent moving on to the victim and/or offender and both parents. Reunification work is addressed fully in the next section.

**2. Treatment Modalities:** Traditionally, sex offender programming has been conducted in a group format. Most sex offender therapists do not feel that individual treatment is an effective primary modality. The traditional rationale for this is that it is more difficult to manipulate peers than it is to manipulate an individual therapist. Additionally, it is often helpful to hear others' progress through treatment and it gives group participants increased hope in what is often otherwise viewed as an impossible journey. Individual therapy may be a valuable complement to group treatment to address issues that are not appropriate to deal with in group (for example issues which are not directly related to offending for most persons) and to deal with issues which are initially too threatening to deal with in group. Individual counseling is often not as effective as group counseling because therapists can easily become overly enmeshed with their clients and individual counseling does not have the ability to benefit from the group culture as a mechanism for confronting behavior. Some issues simply can not be addressed in individual sessions effectively (such as Social Skills Training). Individual work may be helpful in conjunction with group to support the group work and to begin the work of helping the offender explore family and childhood issues. Ultimately almost all issues from individual therapy must be returned to group.

Although family therapy can be an effective intervention modality, it is quite difficult to implement. The victim is often part of the family system and the family system is so pathological that it is unlikely that the offender will return to the family system. (It is important to note that this decision can be made at any point in the intervention process and will need continued assessment.) If family intervention is implemented, it is important that this be conducted as an adjunct rather than a substitute to sex offender programming. Most therapists cannot deal with both family treatment issues and sex offender treatment issues. It is also unlikely that the family system can address each of the therapeutic components identified above within the family counseling format. For those offenders who will continue to have substantial contact with their family systems or will eventually be reunified with their family system, family counseling should be considered mandatory and may be effectively facilitated by a court order in some municipalities.

### **E. Stages of Family Intervention and Caseworker Roles**

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The trainer should return to the flip chart listing the three phases of family intervention hanging in the room. The trainer should ask trainees to brainstorm the casework tasks for the third phase: Treatment and Restructuring.

Caseworker responsibilities include support for ongoing treatment and understanding of the treatment process (including tough times), dialoguing with and working in concert with the treatment providers to assure that information is shared among all, assisting with implementing the safety plan and relapse prevention strategies from the sex offender-specific treatment, and confronting anyone in the family who attempts to drop out of treatment.

Part of the continuing paradigm shift requires workers to recognize and respond to the need to keep these cases open far beyond the usual time perimeters for most cases in child protective agencies. The trainer needs to emphasize that the average length of treatment is usually two years. Keeping the case open is a way of mandating reluctant families into treatment. The trainer should explore the impact of this shift on caseworkers in terms of extra work and vigilance above and beyond that of other cases.

### **SECTION VIII**

## **REUNIFICATION AND CASE CLOSURE**

**Rationale:** In order for child safety to be ensured, Child Welfare Professionals must understand the nature of juvenile sex offending, and the critical treatment milestones that an offender, family and victim must achieve before reunification can be considered.

**Objectives:**

Participants will be able to:

- Discuss treatment milestones that must be achieved by the juvenile sex offender and family members before safe reunification and case closure can be implemented.
- Describe the risk associated with reunification between a juvenile sex offender and children is risky and be able to assist the parents and siblings in structuring the home and community environments to reduce the risk of re-offending.
- Identify the importance of safety planning and implement a safe process for reunification or for closing a juvenile sex offender case.

**Time:** 45 minutes

**Methods:** Presentation  
Discussion  
Group exercises

**Materials Needed:**

- **Handout 19: Treatment Milestones Necessary for Reunification**
- **Handout 20: Process for Reunification**
- **Handout 21: Prognosis**

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### A. Reunification and the Paradigm Shift

**Trainer Note:** The trainer should remind trainees of the paradigm shift: in sex offender treatment the primary goal is community safety. Family reunification is a secondary goal. As this concept runs contrary to the goal of family reunification, the standard of child protective service agencies, the trainees may need some time to process this issue.

### B. Reunification Issues

#### 1. Individual Exercise

The trainer should ask trainees to make a list of specific concerns they have when thinking about reunifying a juvenile sex offender with his/her family, especially if the victim is in the home. Ask the trainees to record these concerns on their own paper.

The trainer should call on individual trainees asking them to share ONE concern. Trainer records these on flip chart paper and discusses as needed.

#### 2. Treatment Milestones

The trainer should distribute the **Handout 19: Treatment Milestones Necessary for Reunification**. Trainer should introduce the handout by stating that reunification should only be attempted if the following treatment milestones have been achieved. The trainer should explain how important it is that the family and perpetrator understand that reunification is dependent on goal attainment and not on a specific timetable.

The trainer should also explain that this handout delineates the “perfect” recovery process. Rarely, is the ideal attainable in practice. Therefore, the decision to reunify must be a joint decision between all players involved: probation officer, treatment providers, caseworkers, Guardian Ad Litem and CASA workers. The trainer should emphasize that the victim’s needs **always** take precedence in planning for reunification. The safety of the victim and the community is the bottom line in deciding whether to reunify.

The trainer should ask trainees to review the milestones.

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### **Treatment Milestones Necessary For Reunification**

- All family members must have acknowledged the abuse and must understand the importance of holding the young person accountable.
- Adult family members must fully understand the ways in which they failed to protect their children. Examples include if the juvenile sex offender was sexually abused prior to his/her own offending behavior or if the juvenile sex offender offended against other children in the family.
- The victim must have a support system and must be able to talk openly about the abuse with therapist and parent or caretaker.
- The offender must have identified his/her offending thoughts, feelings and behaviors, discussed high risk situations, grooming behavior and safety plans with all family members or caretakers.
- The offender must understand the damage resulting from his/her offenses and make, in the therapist's estimation, a sincere apology to the victim.
- The parents or caretakers must not minimize or trivialize the offensive behavior and must be committed to the supervision necessary when the young offender re-enters the home.
- Parents and caretakers must understand how their own history, sexual beliefs, and experiences impact their child's safety and recovery.
- The family or caretakers must have established physical and personal boundaries for family members.
- Concurrent problems such as substance abuse or psychiatric disorders must have been treated.
- The family must utilize therapy or other community resources freely and be expanding their network of extra-familial support.
- The family or caretakers must have openly developed a safety plan which includes direct instruction for children to report future offending and names extra-familial adults to whom reports can be made. The family should be able to identify possible early indicators of the abuse and be invited to return to treatment if needed.

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- All family members must understand that the potential for re-offending exists.

### **C. Process of Reunification**

1. The reunification process is a gradual one which may occur over a considerable period of time. The length of time is highly variable and may depend upon the length of time the court orders treatment and, the degree to which the court supports treatment recommendations regarding separating the victim and the offender. The process should be managed by the caseworker, the victim's therapist, and the offender's therapist. Each new step should be carefully planned and gradually introduced after the previous steps have been successfully completed.
2. The trainer should address the concern that regardless of how successful the young offender was at managing his/her problems in treatment while living away from home, entry back into the home is a powerful force. Reentry may trigger old behaviors, feelings and thoughts. (Remind trainees of the offense cycle from etiology section of training) and not just those of the youthful offender, but the family's as well. Old patterns of behavior can resurface for every family member, as well as old feelings that family members have not yet resolved. If reunification is to be successful, everyone in the family system, not just the offender, must be ready. This is a difficult and complicated period for the family and requires the maintenance of an open case and careful monitoring by the caseworker and therapists.
3. The trainer should distribute **Handout 20: Process for Reunification**. This material is adapted from Michael A. O'Connell, (1994) concerning recommendations on a procedure for reuniting offenders with their families.

Before going over the handout, the trainer should discuss the nature of a reunification safety plan. This safety plan must be developed by the juvenile sex offender with the help of the therapist and probation officer and family members or caretakers. Ideally, a safety plan is created immediately after the offense is revealed (during the assessment process) and is amplified or modified during the intervention process as more is learned of the individual offender's offense patterns. Then the safety plan is modified again at reunification.

The safety plan is a group of rules developed conjointly with the offender and the family with the focus on keeping the victim, the family, and the community safe. This plan would include prohibition of certain behaviors and situations such as caretaking of younger children, being alone at playgrounds, fairs, etc., avoiding certain types of activities, videos, movies, music; and use of alcohol and drugs, etc. The plan would include specific house rules and structure within the home aimed at keeping the victim safe and the offender out of high-risk situations, etc.

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A plan is also formulated to give explicit permission to everyone involved about how they are to monitor for safety and what they are to do if they believe that the sex offender is not following the safety plan. The young sex offender and the caretaker(s) must give sincere, explicit permission to the victim or potential victims in the family, to disclose any problems to the caretakers and therapist or caseworker. Everyone must see interrupting problems and calling for help as a positive, necessary response, not an attack on the family or juvenile perpetrator. If the perpetrator is reaching the age of majority or otherwise going on to live independently, the safety plan should include as many supportive people as possible to help him or her maintain non-abusive behaviors.

The trainer should ask trainees to look over the points on the handout. The trainer needs to emphasize to the trainees the points in bold print. The trainer will point out specific items that might be included in a safety plan.

### **Process for Reunification**

This material is adapted from Michael A. O'Connell, (1994) concerning recommendations on a procedure for reuniting offenders with their families.

1. The victim and his/her family and the juvenile sex offender prepare to meet with one another through individual work with their respective therapists. Before the meeting is scheduled, the therapists must concur that all parties are prepared and willing to meet with one another. **The needs of the victim have priority; if he/she is not ready, meetings should be postponed until the victim is ready.**
2. Initial visits between the family members, victim and the juvenile sex offender are held with therapist supervision in a therapist's office. The victim and the offender must be able to discuss the sexual abuse, the patterns of abuse, the betrayal of trust, and other issues before moving to the next stage. **Individual therapy should continue between these visits so that the victim, in particular, has an opportunity to discuss his/her comfort and feelings of safety.**
3. Visits outside the therapist's office are arranged with family members who can and will assure that the juvenile sex offender behaves appropriately. The visits should be structured to include interactive activities (such as going out to dinner, or shopping at the mall), should be conducted in a public place, should include activities that interest everyone, and should gradually increase in length, with the first visit being about two hours long. These visits

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should not occur until the offender agrees to rules he/she will observe during the visits. These rules should be established in the safety plan. The offender should understand that his offending behavior, and nothing the child or family did, necessitated these rules. He should accept full responsibility for assuring that the rules are followed. **The visit should be terminated if the victim becomes uncomfortable. No explanation is due to the offender; instead, the victim should tell one of the family members or caretakers that he/she wishes to leave, and the visit ends.**

Typical rules for these visits include:

- The offender will never be alone without adult supervision.
- The offender will refrain from any physical affection towards the victim and other children in the family.
- The offender will have no secrets with the victim.
- The offender will not be involved in any physical hygiene (i.e. taking the child to the rest room).
- Discussions of the sexual abuse will occur only in the therapist's office.
- Any other rules necessary to help the child feel safe and comfortable.

4. When several visits have been successfully completed, when issues arising during the visits have been resolved, (**issues arising during the visits should be discussed and resolved preferably in the therapist's office**), and when all family members are comfortable with the idea, the juvenile sex offender may visit the home. He or she should enter the home as a visitor and must be supervised at all times. The first visit home should be fairly brief, and should include a specific activity, such as a family meal. The visits can then increase in length and frequency, and the young offender must adapt to family dynamics and routines which may have changed in his/her absence. The safety plan should be updated and include the previously mentioned rules and the following:

- The juvenile sex offender should not enter any bedroom.
- The offender should use the bathroom alone.
- The offender and all family members should be appropriately dressed at all times.
- The offender must be supervised all times.
- The juvenile will not buy any presents or gifts or do anything that could be construed as grooming the child.
- The juvenile sex offender will not have any authority over the victim.

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**These rules are typical of those that might be included in an offender's safety plan.**

5. Overnight visits occur only after several extended visits have gone well. Individual therapy continues between these home visits so that any problems with the visits can be identified. Usually the first overnight visit is a natural extension of extended visits. **The safety plan should be updated** with the following rules and everyone should be aware of the rules:
  - Locks should be placed on bedroom and bathroom doors to assure feelings of privacy. Locks should not be put on the doors when quick entry is needed with small children.
  - The offender should be fully clothed at all times, except when he is in his bedroom or bathroom.
  - The offender should not be outside of his bedroom after his parents or caregivers have retired to the bedroom, or before they come out of their bedroom in the morning, except to use the bathroom.
  - Everyone, especially the parents or caregivers will need to be hypervigilant in order to assure the safety of the children and the continued progress of the young offender.
6. Overnight visits should be gradually increased in frequency, until finally, a weekend visit is held. Several successful weekend visits should precede reunification with therapeutic sessions in between these visits to identify problems.

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### **D. Prognosis**

The trainer should distribute the **Handout 21: Prognosis** and review the important indicators with the group:

Juvenile sex offenders who exhibit the following behaviors have a poor prognosis and have not mastered earlier therapeutic tasks. The caseworker should delay reunification until the issues are resolved (adapted from Hedges, 1994.)

1. Failure of the family or juvenile sex offender to recognize the continuing and permanent potential for re-offending and the need for ongoing intervention.
2. The family and/or the juvenile sex offender minimizes or trivializes the abuse.
3. The family is unable to develop a specific and/or realistic safety plan.
4. The offender places him/herself in situations previously identified as high risk for re-offending.
5. The family can not make a commitment to helping the young offender or to ensuring safety.

### **E. Closing the Case**

Trainer should summarize the following information:

The decision to close a sexual abuse case is always difficult, and should be made with the assistance of the caseworker's supervisor and the therapists involved in the case. Prior to case closure, the worker should review all the risk factors associated with the abuse; the case should be closed only when the risk associated with all of the factors are considered low. In addition, the following must be in place in order to close the case:

- The young offender must consistently implement the relapse prevention plan (i.e.: stop sexual thoughts about potential victims; remove him/herself from events, situations, and objects that triggered the sexualized thoughts and feelings, etc.)
- The juvenile sex offender and any family members must be committed to seeking help when they identify early indicators of sexual abuse, and must be willing to implement the safety plan if necessary. The safety plan should have been developed in a family meeting with all family members and their support people present.

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- The worker should include the following activities in the process of closing the case:
  1. The number and intensity of caseworker contacts with the juvenile sex offender should gradually decrease over a time period of several months prior to case closure.
  2. The family should be helped and encouraged to function autonomously, or with the assistance of support people in their environment.

### **F. Caseworker Roles and Tasks**

The trainer should return to the flip chart showing the three phases of family intervention and casework roles. The trainer should ask trainees to add the following to the list of casework tasks for Phase Three: Family Treatment and Restructure Phase.

Casework tasks include monitoring the reunification process, and making sure critical information gets disseminated to all professionals. A willingness to keep the case open continues to be a primary casework responsibility. This places caseworkers in a sensitive and difficult position within their agencies since, as mentioned before, agency policy usually supports early case closure and family reunification. The trainer needs to offer an understanding of these difficult agency issues and to support the caseworker taking an educational and advocacy position within his/her agency around the need for a paradigm shift in the handling of sex offender cases. The trainer suggests using information and handouts from this workshop to support the advocacy and education in sex offender cases.

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## **SECTION IX**

### **CLOSING/EVALUATION**

**Objectives:**

Participants will be able to:

- Review important information they have learned during the training
- Develop an action plan to help transfer the training to the work place.

**Time:** 15 Minutes

**Methods:** Individual work with Idea Catcher and Action Plan  
Large group discussion  
Individual work on evaluation

**Materials Needed:**

- **Handout 22:** Action Plan
- **Handout 23:** Bibliography

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### **A. Idea Catchers**

The trainer should ask the trainees to review their notes, handouts, the flip charts hanging in the room, and the overheads that the trainer will re-display for a minute each during this exercise. The trainer should ask the trainees to think about what they have learned that was especially useful to their work on cases with juvenile sex offenders. Trainees should be asked to take five minutes to record these ideas on their **Idea Catcher**.

### **B. Action Planning**

The trainer should distribute **Handout 22: Action Plan** and ask trainees to write down what procedure they should take when they return to work that will improve their work on cases involving juvenile sex offenders. After about 10 minutes, the trainer should ask 3 or 4 individuals to share one of their thoughts with the group. Trainees should be encouraged to record any pertinent ideas of other trainees.

Trainer should distribute **Handout 23: Bibliography** and inform participants that the resources on the list were used to write this curriculum and may be of interest to them in their own work.

The trainer should then thank the group for their participation and distribute the Competency-Based Training Program Evaluation.