

Handouts for the Webinar

Working with Sexually Aggressive Youth

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Presented by

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Sample Sexual Aggression Assessment

NEW SEAPORT YOUTH ACADEMY
NEW SEAPORT, CALISOTA

[A proper letterhead can make a report appear more authoritative, but are often neglected. Likewise, page numbers and a header can be useful, e.g., Axehandle Assessment, 5-14-93]

SEXUAL AGGRESSION ASSESSMENT

NAME: Biff Axehandle
DATE OF BIRTH: November 1, 1976
DATE OF ADMISSION: June 10, 1992
PRIMARY CLINICIAN: Raven Desktop, LCSW
DATE OF REPORT: May 14, 1993

BACKGROUND INFORMATION

Biff is a sixteen-year-old Asian-American male from New Seaport, Calisota. He referred to New Seaport Youth Academy by Dimona County Public Schools Office. He is currently in his parents' custody. He is also currently on probation following a December 1992 conviction for simple assault, described below. More recently, he attempted to sexually assault a male peer and aggressively propositioned an adult male staff member. The concerned adults in Biff's life have requested an assessment of Biff's sexually abusive behavior for purposes of treatment planning and placement decisions. This report is intended for these contexts only, and should be used for these purposes only for the next six months to a year. Possible limitations of this report are discussed below. Because Biff's history of sexually abusive behavior contains elements of coercion, this report also discusses Biff's difficulties with interpersonal aggression.

Concerns upon Biff's admission to New Seaport Youth Academy (an intensively supervised residential facility) included termination from his previous educational placement following revelations that he had engaged in a number of acts of inappropriate sexual behavior with other younger, more vulnerable students. Biff has since acknowledged that these acts were coercive in nature. Other concerns included a history of impulsive and aggressive behaviors, reports that he had allegedly sexually abused a five-year-old neighborhood boy (although there was apparently no follow-up), Biff's special education status, difficulties managing anger, and poor social skills. Biff has been diagnosed with Bipolar Disorder, Attention Deficit Hyperactivity Disorder, and Learning Disorders.

RECORDS REVIEWED

This writer interviewed Biff and his parents on three occasions, (insert dates here). New Seaport Youth Academy documents including [insert list of documents here] were reviewed in the preparation of this report.

Pre-placement materials furnished upon admission were also reviewed, including:
[Insert list of pre-placement documentation here]

MOST RECENT DIAGNOSIS/TESTING

A Psychiatric Evaluation Report by Dr. X, M.D. dated ____ provides the following diagnosis:

- Axis I --
- Axis II --
- Axis III--
- Axis IV --
- Axis V --

Biff's medications are monitored and evaluated by X, M.D. His most recent medication review was February 5, 1993. He is currently prescribed:

[List medications here]

Per a Psychological Evaluation dated ____, by Dr. Y, Biff's score's on the ____ were:

Verbal IQ -
Performance IQ -
Full-scale IQ -

The examiner noted that Biff displayed "low self-esteem... he experiences the world as threatening and is prone to lash out aggressively".

PREVIOUS DIAGNOSES AND TESTING RESULTS

[In this section you can list previous diagnoses and past testing.]

LEGAL STATUS/HISTORY

[Describe custody, legal history, and current legal status here.]

FAMILY CONSTELLATION

David and Lisa Axehandle are Biff's parents. His older sister, Linda, currently attends Loogie College in Redbud, Minnefornia. Mr. and Mrs. Axehandle are both employed and live in a suburban area outside of Redbud, Minnefornia.

DEVELOPMENTAL HISTORY

[Key elements include a well-written and comprehensive narrative that includes elements that will be discussed later under risk and protective factor headings. Strengths and weaknesses should both be included. A key aspect is that this is the author's opportunity to lead the reader through the youth's life so that when they come to the "recommendations" section they have likely come to the same conclusions as the author. This is also an opportunity to transmit an understanding of the youth's view of the world as well as the experiences that led to his theories of how things are in the world.]

FAMILY HISTORY

[Relevant information goes here, including any family history of mental health, sexual abuse, or substance abuse problems. Strengths and weaknesses can both be addressed.]

PSYCHIATRIC HISTORY

Biff has an extensive history of involvement with mental health services, with varying levels of response. Primary themes have included his poor peer interactions and physical aggression towards others. Pharmacological interventions have been an important part of his treatment to date, and a history of his medications is provided below.

[A key aspect is what is the young person's history of psychiatric/mental health treatment and how did he respond to interventions?]

PLACEMENT HISTORY

[This is self-explanatory]

Biff lived with his parents until the age of 14, at which time the New Seaport Department of Child Protective Services (CPS) placed him in foster care. After seven months, Biff's foster parents contacted CPS to state that his behavior problems precluded further placement in their home. Biff was subsequently placed at the St. Nicholas Home in Brass River, Calisota. While at Brass River, Biff sexually assaulted his roommate (described below), and upon investigation it was revealed that he had.... Biff was admitted to the New Seaport Youth Academy on ____.

SCHOOL HISTORY

As noted above, Biff began to have social and emotional difficulties at or before pre-school. He was administered psychological evaluations in 1990 and 1993, with both evaluations indicating functioning in the average range of intelligence Biff has spent his school career identified as learning disordered and educationally handicapped. More recently, he has been diagnosed with disorders of _____.

A Psychological Evaluation dated ____ yielded WISC-III scores of _____. A more recent evaluation dated ____ and using the ____ found Biff to be in the low average range, with scores lower than in his earlier years. This report also notes "an inability to maintain satisfactory interpersonal relationships".

MALTREATMENT HISTORY

[Relevant history regarding the youth's own victimization, neglect, and other trauma can go here]

SEXUALLY ABUSIVE BEHAVIOR HISTORY

Biff met with this writer on ____ and _____. He was informed of the limits of confidentiality and the purpose for this report. Upon admission, Biff acknowledged involvement in inappropriate behavior, and a need for treatment in this area. He has since acknowledged that the incidents at his previous placement were coercive in nature. Five conduct reports from the St. Nicholas were provided to this writer, with excerpts included below.

Biff states that the first sexual contact he can remember was when he was seven or eight. This apparently occurred on one occasion in the basement of a neighborhood house with a boy named Scooter who was younger than himself. He says that this included touching the other boy's penis, [describe any self-report here]. He later stated that he and the other boy made attempts to engage in anal sex. Biff states that he made it clear to Scooter that he was not to tell anyone of their activity, but that Scooter told his mother and that the police interviewed him. He does not recall any further actions taken.

Biff further describes engaging in sexual contact with a different younger boy in the neighborhood whose name he does not recall. He describes very similar incidents of rubbing, touching the other boy's penis and attempts to engage in anal sex. As with the other boy, Biff is very unclear on what specific threats he used or actions he took to ensure that this contact remained secret. However, he acknowledges making it very clear to each boy that they were not to tell. He states that the incidents between himself and these boys took place approximately 3 or 4 times with each boy.

Biff states that between the time of these incidents and his admission to the St. Nicholas Home, he had consensual vaginal intercourse with two or three same-age young women who he considered girlfriends. He insists that no coercion was involved and that these were the result of friendly and caring relationships. His parents report no knowledge of these young women.

As noted above, Biff was admitted to the St. Nicholas Home for the 1991-1992 school year, just prior to his fifteenth birthday. The following incidents are excerpted from the record:

August 2, 1991: A student reported that Biff had entered his room and started a conversation. The conversation became increasingly personal, with Biff offering to take him for a ride in his car at the holidays. Biff reportedly began to rub his chest and back, gradually pulling down the student's pants. At that point the student apparently told him to stop and he did. Biff reportedly told the student not to tell. The student reportedly waited two weeks, and expressed a concern that Biff would be angry at him.

February 5, 1992: A staff reported that he found Biff performing oral sex on another student. An addendum dated ___ stated that this incident had been reported to CPS and that an investigation was underway by the Sheriff's Department.

March 2, 1992: A student reported that Biff reportedly tried to hug him and wrestle his pants off. The student told Biff he had to go to an appointment, got out of Biff's grasp, and left the room.

May 8, 1992: A student reported that Biff had entered his room the previous night, pulled down his pants and fondled his penis and buttocks. The student told Biff to stop and Biff left the room.

Biff has since acknowledged the coercive nature of these incidents. He states that in many of these cases, he had considered his actions for months prior to the events, where consideration included selecting someone who wouldn't fight back and who might be willing. He has stated that he was angry with others for various reasons at the time of the latter incidents, and that he had been involved in many arguments with his parents.

According to a letter to ___ from ___, there was a report of Biff sexually assaulting a five-year-old in his neighborhood (no victim gender is provided). Apparently there was no follow-up to this allegation at the time of the report. In conversations, Biff's mother does not recall an incident of this nature, although she acknowledges an awareness of other incidents described above.

COURSE OF PLACEMENT/MOST RECENT INCIDENTS

[An overview of the youth's response to treatment can be inserted here. For purposes of example, we will imagine that he has been involved in incidents of both violence and sexual aggression towards others.]

Biff was recently involved in incidents in which he attempted to sexually assault a younger, more vulnerable peer and aggressively propositioned an adult male staff member... [Include dates and details]

IMPRESSIONS

A possible limitation of this report is that no self-report inventories mapping attitudes and beliefs around sexual behavior were used. Rather, this report is based on Biff's work in treatment and observable behaviors within the milieu. I am concerned that his learning disabilities and cognitive abilities would obscure the results of these scales.

Also, no physiological measures such as the penile plethysmograph, visual reaction time, or polygraph were used. However, in Biff's situation, I feel that each would be of limited utility. Biff is young, and his developmental level could contribute to uncertain results with each measure. Measures such as the polygraph and plethysmograph may also be counterproductive to treatment due to their potentially intrusive nature. Further, Sexual interest and arousal patterns as measured physiologically can be quite fluid and dynamic across adolescence (Hunter & Becker, 1994). Additionally, although Biff targeted younger boys in each recent instance, it can also be argued that his choice was based more on

availability and detection than sexual preference. It is also possible that given Biff's level of functioning, these younger boys are closer to his developmental level and functioning than others of his age. For this reason, along with the fact that his thoughts and contact with them were short-lived, he does not currently meet the criteria for pedophilia.

Even without these measures, however, Biff has a clearly established pattern of willingness to engage in sex with others, potentially of both genders, who are unwilling or appear likely to offer little resistance. His motivation, by all appearances, has been more to establish himself as powerful and engage in sex than to obtain gratification from humiliating others. While he presents himself as streetwise and threatening, and resorts to aggression when he perceives threat, there is very little evidence of his actively seeking to humiliate others in his daily life. Although adults working with sexual abusers will want to screen for sexual sadism in many situations, Biff does not meet the criteria for this diagnosis, or for Paraphilia, NOS, nonconsent, at this time (see Doren, 2002).

Many factors appear to influence Biff's patterns of behavior. The first is his self-reported perception that he is not like others. He is clearly frustrated both by his differences from same-age peers, as well as his skin condition. He feels alienated from the surroundings that he wants to be a part of (including his own family and community). Given Biff's age and developmental status, it is of little surprise that Biff does not experience remorse or empathy in the ways that most adults do. However, there is evidence that these can develop, particularly in the context of treatment, in the future (Siegel, 1999). Biff does, however, experience considerable shame, and expects very little from his own future.

Currently, there is no empirically validated method for assessing Biff's risk for future harmful sexual behavior. However, the following historical risk factors, based on recent research, suggest an elevated level of risk:

- Biff has persisted in coercive sexual contact despite detection by adults, moderate sanctions (removal from his previous program and placement in another) and the first stages of a course of treatment targeting harmful sexual behavior.
- Biff's victims are unrelated.
- Biff has a conviction for a violent nonsexual offense (simple assault).

Also of concern is the early onset of Biff's aggressive behavior towards others, although it is noted that he has not been diagnosed with Conduct Disorder in any of the records cited above.

Dynamic (and potentially changeable) risk factors that suggest an elevated level of risk include:

- *A sense of sexual entitlement evident in his behavior and self-report.* At the time of the above incidents, Biff was apparently not concerned with the impact or consequences of his actions. He reports that he was simply interested in obtaining sexual gratification by whatever means available. His reported consideration of these acts for several months in advance suggests that this sense of sexual entitlement is of significant concern to those working with Biff.
- *Emotional loneliness.* Biff has a lack of emotionally intimate relationships, and a history of difficulty in creating these relationships. This is an area of some salience to Biff, who experiences a sense of loneliness very frequently.
- *Poor problem-solving skills.* Biff is able to solve problems for himself in low-stress circumstances. However, when he is upset, angry, or anxious, it is very difficult for him to anticipate problems or generate alternatives to problem behaviors such as physical or sexual aggression.

Protective factors that may mitigate Biff's risk include:

- His family's support for treatment
- His long-standing acknowledgement of a need for treatment
- His demonstrated willingness to engage in treatment
- His willingness to learn new ways to develop and maintain relationships
- Elements of a pro-social orientation. Although Biff postures and presents himself as threatening, he quickly loses interest in these elements of his life when given the opportunity to work or

enjoy one-to-one time with supportive adults. This is most apparent in pre-vocational education situations.

SUMMARY AND RECOMMENDATIONS

Biff is a sixteen-year-old young man who has faced significant challenges across much of his life to date. These range from ___ to ___ and ___. They also include long-standing behavioral problems, and psychiatric difficulties. Although he states that his primary sexual interests are towards age-appropriate females, he has a historical willingness to engage in sexual contact with males significantly younger and more vulnerable than himself. Although this appears to reflect those who are available to Biff, it is also of obvious concern to future treatment providers. Although he possesses many attitudes tolerant of aggression, he has little demonstrated interest in other forms of antisocial activity, and is easily engaged in pro-social activities under optimal circumstances. Biff is amenable to treatment but displays a pattern of behavior that has persisted despite detection, the threat of sanction, and the beginnings of treatment. He does not meet the criteria for a sexual disorder at this time, although this should be reviewed should he continue to engage in harmful sexual behaviors. At present, he might best be viewed as a young man whose ability to form appropriate relationships based on respect and empathy has gone badly awry due in large part to his life circumstances. Despite these challenges, Biff's behaviors should not be understood as intractable or without amenability to change.

At the same time, Biff remains in need of the intensive level of supervision and structure found in a residential treatment center. Due to his assaults on a _____ and a ___, Biff requires a higher level of care than that available at the New Seaport Youth Academy. It is recommended that he be placed in another setting that can manage his behavior while providing opportunities for carefully supervised education oriented towards vocational skills building.

Raven Desktop, LCSW
Fancy title goes here

Date

REFERENCES AND RESOURCES

[It can be useful and instructive to include references. This can include those provided within the text of the report as well as any additional references or resources that may be helpful to future assessors or treatment providers.]

J-SOAP-II and Treatment Planning

How can I use J-SOAP scores in treatment planning?

The purpose of the J-SOAP-II is to facilitate risk assessment and risk management. J-SOAP-II may be particularly useful for informing and guiding treatment and risk management decisions. For example, if a youth has a relatively high score on Scale 1 but a relatively low score on Scale 2, the youth may require more sex offense-specific treatment interventions and less of a focus on delinquency interventions. In fact, mixing such a youth with more “hard-core” delinquents may do more harm than good.

In contrast, a youth who has a relatively high score on Scale 2 but a relatively low score on Scale 1 may have sexually offended as part of a more general pattern of antisocial behavior. In cases such as this, the sexual offense may not reflect serious issues involving management of sexually deviant or sexually coercive behavior. This type of youth may require delinquency-focused treatment interventions, perhaps with some limited psychoeducational interventions that address appropriate sexual boundaries, nonabusive sexual behavior, impulse control, and healthy masculinity.

Juveniles who have high scores on Scale 1 and Scale 2 may well require more intensive supervision, perhaps in a secure residential placement, and need sex-offense specific treatment as well as delinquency-focused interventions. Low scores on Scales 1 and 2, on the other hand, may suggest that the offending behavior was more situational and requires only limited interventions, such as psychoeducational approaches that address human sexuality, appropriate sexual behavior, social skills training and dating skills. Specific interventions, of course, depend on the overall picture of risk and needs.

Types of Sexually Aggressive Youth

Sexual abuse of children	Rape of peer and adult females
<ol style="list-style-type: none"> 1. Deficits in psychological functioning 2. Poor self-esteem 3. Poor self-efficacy 4. Less aggressive 5. Victims often related 6. Less likely to be under influence of alcohol or drugs 7. Less likely to use weapon 8. More driven by deficits in <i>social competency and self-esteem</i> than those that target peers and adults 9. Sexual offending against younger children may be more compensatory than reflective of underlying paraphilic interests 	<ol style="list-style-type: none"> 1. More aggressive and violent 2. Victims typically unrelated 3. Substance abuse 4. More likely to use weapon 5. More likely to commit a non-sexual offense in conjunction with the sexual assault 6. More likely to target females and strangers or acquaintances 7. Juveniles that target peers and adults demonstrate different offending patterns and perhaps have different motives for their behavior 8. Appear more criminal, violent, and predatory; it is hypothesized that upon further study these youth will show evidence of greater levels of psychopathy and a higher level of delinquent peer affiliation

General Characteristics of Sexually Aggressive Youth

The general characteristics seen with sexually abusive and sexually aggressive youth do not typically separate them out from other juveniles considered to be delinquent or who have non-sexual behavioral problems (Longo and Prescott, 2006; Hunter, 2006). The characteristics seen in clinical practice generally include but are not limited to:

Lack of social competence:	Very high levels of exposure to:	Self perception deficits:
<ul style="list-style-type: none"> • Depression • Anxiety • Pessimism • Loneliness and isolation • Immaturity 	<ul style="list-style-type: none"> • Child maltreatment • Abuse of females (domestic violence) • Male-modeled antisocial behavior 	<ul style="list-style-type: none"> • Socially inadequate • Fear peer ridicule and rejection

Sexual Risk

Sexual risk assessment with youth who have sexual behavior problems is not a precise science. At this time there are no risk assessment tools or scales that can be considered reliable and valid in determining sexual risk. Historically, risk assessment with juveniles with sexual behavior problems, has occurred with little regard for developmental and contextual issues that need to be taken into consideration in determining risk to others and treatability, e.g., deviant sexual arousal.

Risk factors for youth in general that are associated with delinquency, including sexual behavior problems, but not exclusive to sexual behavior problems, include the following:

Individual Factors	Family Factors	Peer Factors	School & Community Factors
<ul style="list-style-type: none"> • Early antisocial behavior • Emotional factors such as high behavioral activation and low behavioral inhibition • Poor cognitive development • Low intelligence • Hyperactivity 	<ul style="list-style-type: none"> • Parenting • Maltreatment • Family violence • Divorce • Parental psychopathology • Familial antisocial behaviors • Teenage parenthood • Family structure • Large family size 	<ul style="list-style-type: none"> • Association with deviant peers • Peer rejection 	<ul style="list-style-type: none"> • Failure to bond to school • Poor academic performance • Low academic aspirations • Living in a poor family • Neighborhood disadvantage • Disorganized neighborhoods • Concentration of delinquent peer groups • Access to weapons

The general characteristics seen with sexually abusive and sexually aggressive youth do not typically separate them out from other juveniles considered to be delinquent or who have non-sexual behavioral problems. The characteristics seen in clinical practice generally include but are not limited to; lack of social competence, depression, anxiety, pessimism loneliness and isolation, and immaturity. The majority, reveal very high levels of exposure to; child maltreatment, abuse of females (domestic violence) and male-modeled antisocial behavior, while having deficits in self perception, are socially inadequate, and fear peer ridicule and rejection.

Risk assessment is no longer a simple act of determining if a young person poses sexual risk, and if that risk can be lowered through the course of sex-offense specific treatment. Rather, risk assessment must take into account several factors that look at the, 1) young person from a developmental and contextual framework, 2) youth’s ability to thrive in the community, and 3) the findings from risk assessment of youth should be considered time-limited.

When assessing youth, risk factors for problem behaviors are generally considered. There are three basic types of risk factors that are considered when assessing the risk of a child to engage in future sexually abusive behaviors, *Static*, *Dynamic*, and *Protective*.

Static Risk Factors

Static risk factors are those historical risk factors and variables which are either unchanging (i.e., gender, number of victims, use of weapon, history of being abused, previous arrests), or not subject to change as a result of treatment interventions (i.e., age of onset).

Dynamic Risk Factors

Dynamic risk factors are those risk factors which are subject to change (i.e., substance abuse) and which, when successfully treated, are associated with lowered recidivism rates. Some of the dynamic risk factors that are recognized include (1) attitudes toward offending, (2) negative peer influence, (3) emotional self-regulation, (4) general self-regulation, (5) intimacy deficits, and (6) resistance to treatment. Risk assessment and treatment models based solely on unchangeable risk factors in the past are likely to over-estimate risk, as well as missing important opportunities in treatment to change what is changeable.

Protective Risk Factors

Protective risk factors are those risk factors that when examined, reduce the risk of delinquency. They are important for identifying interventions that are likely to work. For example, some common protective factors against child delinquency and disruptive behavior are female gender, prosocial behavior (such as empathy) during the preschool years, and good cognitive performance (for example, appropriate language development and good academic performance). The proportion of protective factors to risk factors has a significant influence on child delinquency, and protective factors may offset the influence of children's exposure to multiple risk factors. Although focusing on risk factors is important, examining protective factors that reduce the risk of delinquency is as important for identifying interventions that are likely to work. For example, some common protective factors against child delinquency and disruptive behavior are female gender, prosocial behavior (such as empathy) during the preschool years, and good cognitive performance (for example, appropriate language development and good academic performance). The proportion of protective factors to risk factors has a significant influence on child delinquency, and protective factors may offset the influence of children's exposure to multiple risk factors.

Currently, there is no empirically validated method for assessing the degree of risk for future harmful sexual behavior. However, historical/static risk factors, based on recent research, suggest the possibility for an elevated level of risk.

Facts and Statistics

- While reported statistics vary, in the United States juvenile sexual aggressors (JSA) commit a substantial number of sex crimes, including 17% of all arrests for sex crimes and approximately one third of all sex offenses against children.
- Females under the age of 18 account for one percent of forcible rapes committed by juveniles and 7% of all juvenile arrests for sex offenses, excluding the category of prostitution.
- This translates to approximately seventeen percent of all arrests for sex crimes and approximately one-third of all sex offenses against children are committed by young persons under the age of 18 (females under the age of 18 account for approximately one percent of forcible rapes committed by juveniles and seven percent of all juvenile arrests for sexual offenses excluding prostitution).

Source: www.ncsby.org

The NCSBY notes the following:

- Adolescents do not typically commit sex offenses against adults, although the risk of offending against adults increases slightly after an adolescent reaches age 16.
- Approximately one-third of sexual offenses against children are committed by teenagers. Sexual offenses against young children under 12 years of age are typically committed by boys between the ages of 12 and 15 years old.
- Adolescent sex offenders are significantly different from adult sex offenders. They have different developmental pathways, are heterogeneous, and we should therefore never assume a “one size fits all” approach to assessing, treating, and/or managing these clients:
 - Adolescent sex offenders are considered to be more responsive to treatment than adult sex offenders and do not appear to continue re-offending into adulthood, especially when provided with appropriate treatment.
 - Adolescent sex offenders have fewer numbers of victims than adult offenders and, on average, engage in less serious and aggressive behaviors.
 - Most adolescents do not have deviant sexual arousal and/or deviant sexual fantasies that many adult sex offenders have.
 - Most adolescents are not sexual predators nor do they meet the accepted criteria for pedophilia.
 - Few adolescents appear to have the same long-term tendencies to commit sexual offenses as do some adult offenders.
 - Across a number of treatment research studies, the overall sexual recidivism rate for adolescent sex offenders who receive treatment is low in most US settings as compared to adults.
 - ASO are different from adult sex offenders in that they have lower recidivism rates, engage in fewer abusive behaviors over shorter periods of time, and have less aggressive sexual behavior. Adolescent sex offender rates for sexual re-offenses (5-14%) are substantially less than their rates of recidivism for other delinquent behavior (8-58%).
 - Adolescent sex offenders commit a wide range of illegal sexual behaviors, ranging from limited exploratory behaviors committed largely out of curiosity to repeated aggressive assaults.

Guarding Your Health

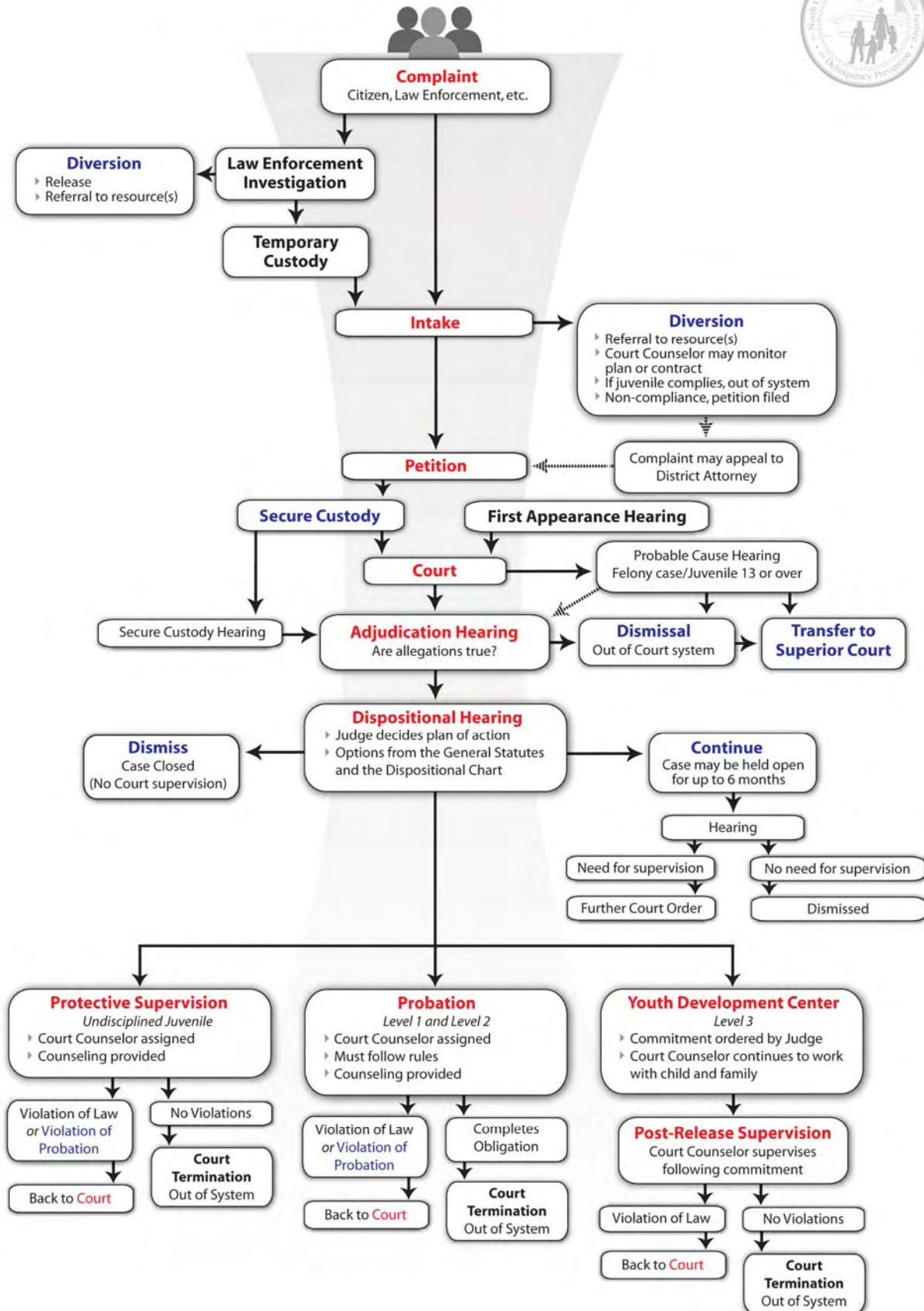
- Regularly take an inventory of the reasons why you chose this work.
- Regularly evaluate your personal relationships.
- Regularly assess the impact of working with sexual offenders.
- Regularly assess your work environment.
- Seek support and regular consultation from colleagues.
- Engage in process and discussion with others who do similar work.
- Maintain a balance between personal and professional time.
- Maintain a sense of humor.
- Engage in regular physical exercise.
- Have fun.

Issues Addressed in Treatment of Sexually Aggressive Youth

For more complete resolution of the sexually abusive youth's healing and prevention of future offending or self-defeating/destructive behaviors, a number of factors should be addressed in treatment, including:

- problems with trust and intimacy
- low self-esteem and peer relationship problems
- developing and maintaining boundaries
- sense of guilt, shame, and self-blame
- compulsions and addictions
- sexual identity confusion
- post-traumatic stress disorder
- recognizing and preventing self-destructive and self-defeating behaviors
- managing arousal to deviant or unwanted sexual fantasies
- depression and anger management
- assertiveness training
- developing a healthy understanding of relationships and sexuality

North Carolina Juvenile Justice Process



Assessor Qualifications

Clinical assessments should be conducted by degreed, mental health professionals and who are licensed appropriate to their discipline and according to local laws. The Task Force recommends that assessors have expertise in the following areas:

- Child development, including typical sexual development and behavior
- Differential diagnosis of childhood mental health and behavioral problems
- Specific familiarity with common problems seen among children with SBP, including non-sexual disruptive behavior problems, learning disorders and developmental issues, ADHD, child maltreatment, child sexual abuse, trauma and posttraumatic stress related problems. Familiarity with conditions that may affect self-control, such as hyperactivity disorder and childhood bipolar may be important.
- Understanding environmental, family, parenting and social factors related to child behavior, including the factors related to the development of sexual and nonsexual behavior problems.
- Familiarity with the current research literature on empirically supported intervention and treatment approaches for childhood behavior and mental health problems.
- Cultural variations in norms, attitudes and beliefs about childrearing and childhood sexual behaviors.

Registration of Adjudicated Juveniles in NC

Registration of juveniles adjudicated for committing certain offenses (GS 14-208.26)

- Only pertains to first degree raps, second degree rape, first degree sexual offense, second degree sexual offense, or attempted rape or sexual offense
- Juvenile was at least 11 years old at time of the offense
- Juvenile is considered by the court to be a danger to the community

Registration information is not public record; access to registration information available only to law enforcement agencies and local boards of education (GS 14-208.29)

Termination of registration requirement (GS 14-208.30)

- Registration requirement terminates on juvenile's 18th birthday or when the jurisdiction of the juvenile court ends, whichever occurs first

Filing of registration with the Police Information Network (GS 14-208.31)

- Registration information shall be included in the Police Information Network and shall be maintained permanently even after the reporting requirement ends.

Resources

- 2009 Annual Report of the North Carolina Department of Juvenile Justice and Delinquency Prevention
http://www.juvjus.state.nc.us/resources/pdf_documents/annual_report_2009.pdf
- Serendipity Healing Arts (Rob Longo's Website)
<http://www.roblongo.com/>
- Helpful Links
<http://www.csom.org/>
<http://www.ncsby.org/>
<http://www.atsa.com/>
<http://www.kempe.org/napn>
<http://www.mnadopt.org/Factsheets/Recognizing%20Healthy%20&%20Unhealthy%20Sexual%20Development%20in%20Children.pdf>
http://nctsn.org/nctsn_assets/pdfs/caring/sexualdevelopmentandbehavior.pdf
<http://www.stopitnow.org/>
- From Report of the ATSA Task Force on Children with Sexual Behavior Problems (<http://www.atsa.com/pdfs/Report-TFCSBP.pdf>), p. 6
- *Juveniles Who Commit Sex Offenses Against Minors* by David Finkelhor, Richard Ormrod, and Mark Chaffin, December 2009 (US Office of Juvenile Justice and Delinquency Prevention. This bulletin presents population-based epidemiological information about the characteristics of juvenile offenders who commit sex offenses against minors.
<http://www.ncjrs.gov/pdffiles1/ojdp/227763.pdf>
- *It's Perfectly Normal: Changing Bodies, Growing Up, Sex, and Sexual Health* by Robie H. Harris and Michael Emberley. Candlewick; 3rd edition (2009). A book that can be useful in explaining sexuality to tweens and teens; contains information on body parts, puberty, reproduction, birth, diseases, Internet safety, and the emotional swings that accompany adolescence.

Child Welfare Workers
working with
Youth with Sexual Behavior Problems
&
Sexually Aggressive Youth

Welcome!

Please click on the colored link below to download the
handouts for today:
12-14-10 webinar handout



Panel Participants today are:
Virginia Pirrello
NC Dept. of Juvenile Justice

Robert E. Longo
Serendipity Healing Arts

Photos of Virginia
and Rob here

Your facilitator is:
Kathy Johnson
Jordan Institute for Families

**Technical support is
provided by:**
Phillip Armfield
John McMahon


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TODAY'S AGENDA

- Characteristics and behaviors of sexually abusive youth
- Overview of the juvenile justice system
- Effective assessment, intervention and treatment
- Safety planning and working with youth and families
- Q & A


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Characteristics and behaviors



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Sexual behavior is considered problematic when it:




- occurs at high frequency
- interferes with child's cognitive or social development
- involves coercion, intimidation, force or emotional distress
- occurs when there is a significant age difference and / or developmental ability
- continues after intervention


(NCSBY, 2003)

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The current research by Hunter (2006) and colleagues indicates that there are two major types of Juvenile Sex Offenders:




- Adolescents who sexually abuse children
- Adolescents who rape peer and adult females



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Characteristics by typology

Sexual abuse of children	Rape of peer and adult females
<ul style="list-style-type: none">> deficits in psychological functioning> poor self-esteem> poor self-efficacy> less aggressive> victims often related> less likely to be under influence> less likely to use weapon> more driven by deficits in social competency and self-esteem than those that target peers and adults	<ul style="list-style-type: none">> more aggressive and violence> victims typically unrelated> substance abuse> more likely to use weapon> more likely to commit a non sexual offense in conjunction with the sexual assault> more likely to target females and strangers or acquaintances

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Three Subtypes

> Life Style Persistent	> 5-10%
> Adolescent Onset Paraphilic	> 5-10%
> Adolescent Onset Non-Paraphilic	> 80-90%



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General Characteristics

- depression
- anxiety
- pessimism
- loneliness and isolation
- immaturity
- lack of social competence



Very high levels of exposure to:

- child maltreatment
- abuse of females
- male-modeled antisocial behavior

Self perception:

- socially inadequate
- fear



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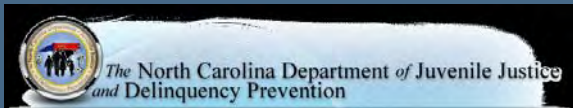
Questions about characteristics or behaviors?



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Juvenile Justice System



The Department offers services for youth by establishing and maintaining a seamless comprehensive juvenile justice system that promotes juvenile delinquency prevention, intervention, and treatment.

<http://www.ncdjdp.org>

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Overview of the System

- Process
- Court process
 - Different than for adult court
- Adjudication hearing
- Comprehensive evaluation
- Disposition hearing



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The importance of language

Juvenile Sex Offender
vs
Child / Adolescent
with Sexual Behavior Problems



Sex Offender – a legally defined term, applies to individuals convicted or adjudicated for a sexual offense

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Did You Know?

- **Detention Centers**
 - Juveniles can be considered undisciplined or delinquent as early as the age of 6.
 - Children can be placed in detention centers at the age of 6.
- **Youth Development Centers**
 - Children can be adjudicated delinquent and committed to the custody of DJJDP at the age of 10 until age 21.

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Detention Centers

<u>State operated:</u> <ul style="list-style-type: none">➤ Alexander➤ Buncombe➤ Cumberland➤ Gaston➤ New Hanover➤ Perquimans➤ Pitt➤ Richmond➤ Wake	<u>County operated:</u> <ul style="list-style-type: none">➤ Durham➤ Forsyth➤ Guilford
---	---



http://www.ncdjdp.org/facilities/detention_centers.html




Youth Development Centers

Dobbs	Kinston
Lenoir	Kinston
Edgecombe	Rocky Mount
C A Dillon	Butner
Samarkand	Eagle Springs
Chatham	Siler City
Cabarrus	Concord
Swannanoa Valley ..	Black Mountain

Did You Know?

➤ Adult Prison System

- Under criminal law an individual is considered an adult at the age of 16 – and will be tried in adult court, not the juvenile system.
- Juveniles as young as 13 can be tried as adults for certain offenses.
- The NC DOC has only one sex offender specific treatment program (in the entire prison system).



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Sex Offender Registration

➤ Registration of juveniles (GS 14-208.26)




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Q & A



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Assessment, Treatment and Intervention



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Assessment

- Characteristics of an evaluation
- Components of a SOSE
 - Overview & reason for referral
 - Legal history
 - Family history
 - Developmental history
 - School history
 - Medical history & medications
 - Psychiatric history/prior psychological testing
 - Maltreatment
 - Sexual history
 - Current offense(s)



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Treatment models & modalities

Research has not supported a specific model; but there are effective treatment options

- > TF- CBT
- > CBT
- > Dialectic therapy
- > Motivational interviewing
- > Narrative therapy
- > Healthy sexuality
- > EMDR

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Strength-based interventions

Identifying Strengths

Reinforcing Strengths

Creating Strengths

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Strengths-based approaches include protective factors

Family

Individual

Community

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Strengths-based approaches focus on:



- Relationships
- Safe Environment
- Emotional Safety
- Pro-social Behaviors
- Resources

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Safety Planning




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What is safety planning?

Safety planning includes:


1. Determining what are the risks?
2. Risk Factors are Red Flags or Warning Signs!
3. Individualized planning
(One size does not fit all)
 - Each child is different
 - Proper risk assessment is necessary
 - Proper risk assessment takes time

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What are the risks?

- > One size does not fit all
- > Each child may be different
- > Proper risk assessment is necessary
- > Proper assessment takes time
- > Family dynamics
- > Developmental issues

HANDOUT 

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Types of risk factors

Static Risk Factors / Historical

- Number of victims
- Number of offenses
- Use of weapon



Dynamic Risk Factors / Changeable

- School performance
- Anger management
- Peer affiliation



Protective Risk Factors / Reduce Risk

- Female gender
- Prosocial behavior (empathy)
- Good cognitive performance



HANDOUT 

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Risk Factors

Red Flags & Warning Signs


- Individual risk factors
- Family risk factors
- Community risk factors
- Peer risk factors

HANDOUT 

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Individual risk factors

- Early antisocial behavior
- Emotional
- Cognitive
- Low intelligence
- Excessive time alone / isolation / withdrawal
- Excessive Internet use
- Sexualized talk/behavior / preoccupation




HANDOUT

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Family risk factors

- Family dysfunction
- Maltreatment
- Poor parenting skills
- Family violence
- Divorce
- Family antisocial
- Family structure



HANDOUT

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School & Community risk factors

- Poor school performance
- Disadvantaged neighborhood
- Poverty
- Access to weapons




HANDOUT

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Peer risk factors

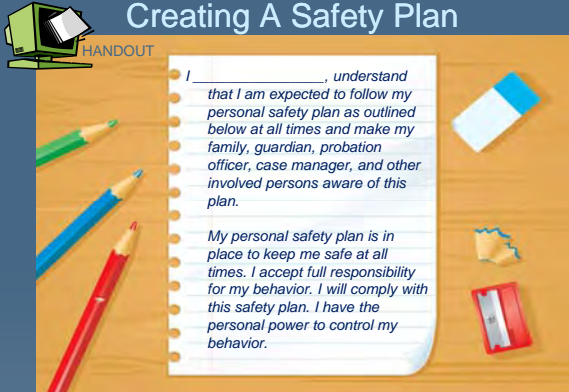
- Affiliation with children who are two or more years younger
- Negative peer affiliation
- Peer rejection



HANDOUT 


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Creating A Safety Plan



I _____, understand that I am expected to follow my personal safety plan as outlined below at all times and make my family, guardian, probation officer, case manager, and other involved persons aware of this plan.

My personal safety plan is in place to keep me safe at all times. I accept full responsibility for my behavior. I will comply with this safety plan. I have the personal power to control my behavior.

HANDOUT 

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Rules for community living:

1. Basic rules for community living
 - I will follow all conditions of my probation.
 - I will attend school as required.
 - I will attend all therapy sessions.
 - I will take all medications as prescribed by my Doctor
 - I will pay attention to my warning signs and talk with someone in my support group if I feel problem sexual urges
 - I will not babysit any children
 - I will not use drugs or alcohol
 - I will avoid associating with negative peers
 - I will avoid being around children who are three or more years younger than me unless I am with an adult who knows about my sexual behavior problem.
 - I will not engage in the use of pornography.
 - I will discuss ALL of my sexual behaviors with my therapist.

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And...

- 2) My list of risk factors and warning signs/problems I might have, and activities I need to avoid:
- 3) My list of interventions and coping responses for my risk factors listed above:
- 4) The consequences I will receive for misbehavior: and or not following my safety plan:
- 5) Positive activities I can engage in
- 6) People I can talk to (my support system/safety-net)

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Monitoring and Supervision

- The Team works together to monitor and supervise the youth while he/she is involved in the system.



- The level of monitoring and supervision depends on the risk of the youth.

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Working with the Team

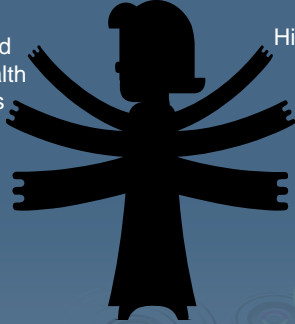


- Family
- Schools
- Therapists
- Probation
- Guardian Ad Litem
- DSS Social Worker
- Doctors
- Others

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Multiple considerations



Co-morbid mental health disorders

History of trauma


Amblyopia

Traumatic brain injury

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Summary

Sexually abusive behavior is often a symptom of a much greater problem.



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Sexual abuse is a multifaceted problem

- Cultural issues
- Developmental issues
- Contextual issues
- Family dynamics
- Community dynamics
- Holistic approach




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Resources

- www.atsa.com
- www.csom.org
- www.ncsby.org
- <http://www.advocatesforyouth.org/publications/factsheet/fsbehdem.htm>
- <http://www.cdc.gov/HealthyYouth/sexualbehaviors/>
- http://www.siecus.org/pubs/Facing_Facts.pdf

Visit **NEARI** Press on line at:
<http://bookstore.nearipress.org/>

<http://bookstore.nearipress.org/index.php/books/featured-products/current-applications.html>




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Implications for Practice

Use your chat pod:
What have learned today that will be helpful ?



 What questions do you still have about working with Sexually Aggressive Youth?

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Follow-up from the Webinar

Working with Sexually Aggressive Youth

December 14, 2010

Presented by

Robert E. Longo, MRC, LPC, NCC and
Vignia Edwards Pirrello, PhD

Produced by

Family and Children's Resource Program, part of the
Jordan Institute for Families
UNC-Chapel Hill School of Social Work

Sponsored by

NC Division of Social Services

Be sure to consult the handouts for this webinar, which contained valuable information:

https://www.ncswlearn.org/ncsts/webinar/handouts/9_Webinar%202012-14-10%20Handouts.pdf

Questions and Answers from the Webinar

1. What are the three subtypes of sexually aggressive youth?

- Lifestyle Persistent (anti-social and aggressive): Individuals in this category typically respond poorly to treatment. They account for approximately 5-10% of all sexually abusive and aggressive youth. Many of these youth have a diagnosis of Conduct Disorder.
- Adolescent Onset, Paraphilic (developing paraphilic interests): *Paraphilias* are mental disorders characterized by sexual fantasies, urges, or behaviors involving non-human objects, suffering or humiliation, children, or other non-consenting persons. Individuals in this category show an increased number of post-treatment arrests for sexual offenses. They account for approximately 5-10% of all sexually abusive and aggressive youth.
- Adolescent Onset, Non-Paraphilic (transient interest in criminal sexual behaviors): The majority (80-90%) of adolescents with sexual behavior problems fall into this category. Sexually aggressive behaviors are considered to have the best response to treatment.

2. What does the research say about how many offenses juveniles are likely to commit before they are identified by the juvenile justice system?

Many of the youth who come to the attention of North Carolina Department of Juvenile Justice and Delinquency Prevention are first offenders who were caught after the first time they sexually abused another person. However, among those who are not initially caught, the average number of prior offenses is 3.

3. What is the thinking about using lie detector tests as part of assessments or treatment?

The current thinking in practice does not favor the use of lie detectors. In addition to its likely negative effect on the therapeutic relationship, there is no research to show that it is effective for assessment or treatment. Until there is proof of its efficacy, it is likely to only be used in rare individual cases where it is warranted by very specific circumstances.

Interested in learning more about use of polygraphs with sexually abusive adolescents? Consult the December 2010 issue of the NEARI newsletter:

(<http://nearipress.org/images/PDF/nearinewsletterdecember2010.pdf>).

4. If an older sibling perpetrates on a younger sibling, can the children co-habitate with one another if a safety plan and mental health services are in place?

This is a case-specific decision that needs to be based on individual, family, and treatment factors. While it is not always possible, it does sometimes happen when the child and family are actively involved in therapy, the parents are conscientious about monitoring the safety plan and have things like motion detectors for bedroom doors, and when everyone on the team agrees that the offender can be at home with victim.

5. Would a safety plan work with a 5-year-old?

Yes, safety plans do work with young children and developmentally delayed children. You have to simplify the language and the concepts in the plan. It helps to work in 3's to aid their memories – identify three main behaviors, three interventions, three consequences, etc.

6. How do we handle cases with children that like to have sex with animals?

The person should be reported to the police as well as being referred to therapy. To protect everyone involved, specific steps should be taken to keep the child away from animals – send pets to live with relatives, monitor the child closely whenever they are in proximity to animals, etc. Include animals in the safety plan and in the behavior plan.

7. What are recidivism rates for youth who have gone through sex offender treatment?

The average rate in looking at a variety of studies is approximately 10%; however, with good treatment it is usually in single digits.

8. Why won't juvenile court counselors accept referrals on children who are 16 if they work with youth up to age 21?

Juvenile court counselors can work with youth until age 18, 19, or 21 depending upon the offense with which they were charged.

9. How many juveniles are currently on the Sex Offender Registry?

It is not known because, unlike the adult registry, the juvenile registry is confidential and available only to law enforcement and local boards of education. Anecdotally, the number is small, as it is not commonly seen on court orders.