Working with Juveniles with Sexual Offending Behaviors

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Juvenile Criminal Sexual Conduct (CSC)

- Most research is on male adolescents with sexual offending behaviors. Please keep this is mind throughout this training.
- 1st-4th Degree CSC: Felonies. 5th Degree CSC: Gross Misdemeanor.
  - Degree charged considers ages of perpetrator and victim, presence of force or coercion, and specific sexual behavior.
- Only 20-30% of sexual crimes are reported, less go to trial, and less than that result in conviction ("adjudication" in juvenile cases).
  - Reasons for not reporting are many: afraid they won't be believed, the relationship with the person who harmed them, hurting the family, stigma, trauma, blame themselves, etc.
  - False report rate of sexual crimes is 2.1-10.3%.

(CDC, 2022; Lisak, et al., 2010; Orchowski, Bogen & Berowitz, 2022)

Criminal Sexual Conduct (CSC)

- Most CSC is perpetrated by someone known to the person particularly children who were sexually abused (over 90%).
  - "Stranger Danger" Myth.
- More than half of females will experience sexual violence involving physical contact in their life. 1 of 4 females are sexually abused by age 18.
- Almost one third of males will experience sexual violence involving physical contact in their life. 1 of 13 males are sexually abused by age 18.
- About 1/3 (22-40%) of all sexual offenses are committed by juveniles, majority by male juveniles.

(CDC, 2022; DOJ, 2017; Lisak, et al., 2010; OJP, 2009)

Who are they?

- 12-18.
- All socioeconomic classes, races, cultures, religions, genders, etc.
- NOT mini adults!
  - Brain development.
- Different from "children" (under age 12) with sexual behavior problems (see publications by Dr. William Friedrich, Ph.D., for excellent information on this population).

"Why" do juveniles sexually offend?

- **Adolescence is a time of dynamic change! There is a lot going on for youth during this stage. The following are NOT causes, but instead common factors found in research.**

(Bonner, 2009, p. 7; Leversee, 2015)

Why did this happen?

Brain development!

- Experimenting/Curiosity
- Immaturity/Impulsivity
- Frontal Lobe
- Dopamine (rewards NOW, lack consideration of long-term consequences).

Home environment.

- Unhealthy sexual boundaries at home.
- Domestic violence.
- Parental unstable employment.
- Parental substance use.
- Child maltreatment (abuse and neglect).

Sexualized media.

- Human beings are social learners.
- Of note, pornography in and of itself does NOT cause sexual offending according to research!

(Bonner, 2009; Leversee, 2015)

Why did this happen? (cont.)

- **Psychological or Developmental Struggles**
  - Social Skill Deficits
  - Anger/Aggression
  - Depression
  - PTSD (e.g., emotional, physical, sexual abuse)
    - 40-80% (depending on the study) of adult males incarcerated for sexual crimes reported being sexually abused as a minor.

- **Sexual Attraction to Children**
  - DSM 5: at least 16 and more than 5 years older than the child.
  - Very uncommon risk factor.
    - 'The vast majority of youth sexual offenses are manifestations of non-sexual feelings.' – National Center on Sexual Behavior of Youth.

(Bonner, 2009; Leversee, 2015; SURJ, 2011, p. 18)

Family Involvement

- These are kids!
- Behaviors impact the entire family (family system).
- Family support, especially parents are ESSENTIAL!
  - Often both the victim and perpetrator are their children.
  - Blame themselves for their child's actions.
  - Lack support.
  - Feel Angry, Alone, Scared, Powerless (court, probation "in charge").
    - Part of the Team!
      - Validate to help them feel seen and heard. Hope.
    - Therapeutic support!
- Family can be a helpful support and a protective factor that can contribute to a lower risk level!

(Jones, 2015; Worling, 2017)

What starts the process?

- Psychosexual Evaluation.
  - Referrals typically from Court, Child Protection Services, or Probation.
  - Some from parents or other mental health professionals concerned about their child/client's sexual behaviors.
    - Atypical sexual behavior (e.g., pornography use, bestiality, stealing underwear, excessive masturbation, exposure, etc.).

Psychosexual Evaluation

- PSE
  - Focus and purpose?
  - Who is qualified to provide PSEs?
    - Training, Experience, License, Certification (SOTP/CSOTP), Affiliation (e.g., ATSA). No state standards in Minnesota.
  - Who is evaluated?
    - Juvenile vs. Adult Evaluations.
    - Children under 12 undergo a specific type of evaluation, not "PSEs."
  - What does a PSE tell us?
    - Structured Professional Clinical Judgement (SPCJ).
    - Risk, Need, Responsivity (RNR).
      - Evidence based.

A note on how long a PSE and PSE recommendations are valid.

- Because adolescence is dynamic: 6-12 months.
  - Beyond that, if interventions have not started, a new PSE should be completed to assess current RNR.
- Once the mental health professional starts interventions (e.g., boundary psychoeducation, treatment), they assess RNR throughout therefore no new PSE is necessary unless:
    - There is a new sexual offense/boundary violation, major behavior change, or life changing event during treatment where those working with the client feel a new PSE is necessary.

PSE and Risk, Need, Responsivity (RNR)

- Risk: **WHO** should be treated.
- **Need (Criminogenic Needs): WHAT needs to be treated (factors linked to recidivism; treatment targets).**
  - Static vs. **Dynamic**.
    - Static = cannot be changed; ex. number of sexual offenses.
    - Dynamic: stable (enduring over months or years but still changeable) vs. acute (changing over hours, days, weeks).
- Risk Assessments incorporate criminogenic needs (more on this next!)
- Responsivity: **HOW** to treat.
  - Match research-supported interventions to each unique individual (traits, learning styles, personality, etc.).

(Andrews & Bonta, 2010)

RNR: Risk Assessments

- Dynamic Factors
  - ERASOR (validated risk assessment tool per ATSA 2016) adolescents 12-18 who committed previous SO; better predicting SO vs. non-SO recidivism.
  - J-SOAP-II (validated risk assessment tool per ATSA 2016) sexual and nonsexual reoffending, 12-18 male adolescents with sexual offending (SO) history. May be better for older adolescents and SO vs. non-SO recidivism.
- Mix of Dynamic and Static (actuarial)
  - J-SORRATT-II (validated risk assessment tool per ATSA 2016) prediction of sexual reoffending in juveniles, 12 static/historical items.
- Others: SAVRY (Structured Assessment for Violence Risk in Youth), Jesness Inventory (gauges aspects of personality).
- NOT risk assessments but often used: MACI, MMPI-A.

Which is Best?

- (J-SOAP-II, ERASOR, J-SORRATT-II)
  - "Total scores on each of the tools significantly predicted sexual reoffending, with aggregated correlations ranging from .12 to .20 and aggregated AUC scores ranging from .64 to .67. However, in many cases heterogeneity across studies was moderate to high. There were no significant differences between tools."
  - Challenges to developing risk assessments for juveniles are the overall low recidivism rate of sexual reoffending and the dynamic period of development in adolescence.
    - Depending on the research and follow-up period, sexual offending recidivism rates range from 3 to 15%. General recidivism (nonsexual crimes) ranges up to 50%.

(Viljoen, Mordell, & Beneteau, 2012, p. 423)

RNR: Criminogenic Needs

- "Big 4"
  - History of antisocial behavior (not a criminogenic need as it cannot be changed but is an indicator of future antisocial behavior), antisocial personality pattern, antisocial cognition, and antisocial associates).
  - And
    - "Big 8". The following 4 are impactful but less than the "Big 4": dysfunctional family; employment and education; leisure and recreation; and substance abuse.
- Best practice is determining individualized criminogenic needs and using interventions appropriate for that individual (responsivity).

(Andrews & Bonta, 2010)

Criminogenic Needs for Juveniles with Sexual Offending Behaviors

- Empirically supported risk factors:
  - Deviant sexual arousal.
  - Prior convicted sexual offenses.
  - Multiple victims
  - Social isolation
  - Incomplete treatment for sexual offending behaviors
- Empirical support in at least one study:
  - Problematic parent-child relationships
  - Attitudes supportive of sexually abusive behavior

(Rich, 2015, p. 3)

Criminogenic Needs for Juveniles with Sexual Offending Behaviors (cont.)

- Possible Risk Factors:
  - Impulsivity, Antisocial orientation, Aggression, Negative peer group association, Sexual preoccupation, Sexual offense of a male, Sexual offense of a child, Use of violence, force, threats, or weapons in a sexual offense, Environmental support for reoffense.
- Unlikely Risk Factors:
  - History of sexual victimization, History of nonsexual offending, Sexual offenses involving penetration, Denial of sexual offending, Low victim empathy.

(Rich, 2015, p. 3)

Protective Factors

- Protective factors can reduce recidivism!
- PROFESOR
  - Categories reflect level of intensity of service that may be required.
    - Positive Factors
    - Neutral Factors
    - Negative Factors
  - The PROFESOR is **NOT** a risk assessment for sexual reoffending!

(Worling, 2017)

Interventions

- Appropriate level of treatment (RNR) reduces the risk of recidivism.
- (Intensive) Outpatient Sexual Offending Specific Treatment.
  - If recommendation does not use "intensive", it is assumed (i.e., CD assessments).
  - Primary Care and Aftercare components.
    - Primary Care: Involves individual, family, & group therapy. Addresses sexual offending behavior, criminogenic needs, processes the harm they caused, psychoeducation, and decision-making. Can be 6 months to more than 1 year.
    - Aftercare: Focuses on a "new normal" back in the community, psychoeducation, relationships, school, work, etc. May be 6 months to one year.
- Residential ("Inpatient") Treatment for Sexual Offending Behaviors.
  - Primary Care more intense/frequent, longer treatment. Aftercare is typically outpatient.

(Andrews & Bonta, 2010)

Interventions

- Boundary Curriculum
  - Psychoeducation regarding boundaries, wellness, healthy decision-making, etc., and sexual boundary violation (i.e., sexual offense) including accountability, victim empathy, and apology letter.
- Psychoeducation (e.g., social media, laws, boundaries, sex-ed.)
- Individual, group, family therapy.
  - It is essential to work with the whole person and their family, not just their sexual offending behavior!
    - Mental Health Concerns.
    - Substance Use Concerns.
    - Etc.

Providing Interventions

- Providers **MUST** have training, experience, credentials, etc.!!
- Affiliations (e.g., ATSA, MNATSA).
- PSE drives level of intensity to address criminogenic needs and how treatment is delivered (RNR).
- **When youth receive and complete appropriate interventions, the recidivism rate for sexual reoffending is LOW.**
  - 5% sexual recidivism after 10 years; 9% after 20 years (Worling, Littlejohn, & Bookalam, 2010) to 7% sexual recidivism after 59 months (Caldwell, 2010) to 13% sexual recidivism after 59 months (Reitzel & Carbonell, 2006). These youth are more likely to engage in nonsexual offending (stealing, truancy, substance use, etc.) than sexual reoffending.
    - Research varies depending on level of risk assessed and follow-up period.

Registration as an "Intervention"

- Registration (POR)
  - And notification laws "have done little to reduce sexual recidivism or prevent sexual abuse whether applied to youths or adults who have been convicted of a sexual crime."
    - "SORNA does not provide any general deterrence."
    - Restrictions to employment, residence, programming, etc.
    - "Most sexual abuse perpetrated against children (approximately 93%) in the U.S. was perpetrated by someone known to the victim."
    - In the U.S., "children and adolescents adjudicated for a sexual offense, just 2.5% committed an act against a stranger victim."
  - Increases risk for registered juveniles to be victimized and sexually abused.
  - Of juvenile's who commit sexual offenses only occurs in and U.S. and UK. "No other countries register children and adolescents."
  - Labeling Theory.
    - Why label someone with something we don't want them to be?

(ATSA, 2020; SURJ, 2011; Willis, 2018)

Polygraphs

- Used as a therapeutic tool for safety and treatment planning.
- Common types of "postconviction" polygraphs used in sexual offending specific treatment:
  - Sexual History
  - Incident Specific
  - Maintenance
- Check the credentials and qualifications of the polygrapher.
  - Polygraph testing related to sexual offending is a separate certificate.
  - Experience in polygraph testing with juveniles.

(Ralph, 2015)

Polygraphs

- No license is required in Minnesota to administer polygraphs so make sure you check credentials!
  - American Polygraph Association.
  - Completed training through an accredited program.
    - https://www.apapolygraph.org/accredited-programs
  - At a minimum, those administering polygraphs should be a member of the American Polygraph Association (APA).
    - APA requires completion of education through accredited programs and ongoing Continue Education (CEs) is required.
- ATSA strongly recommends not using the polygraph or plethysmograph with juveniles.

(https://www.polygraph.org/)

Polygraphs

- Pros.
  - Treatment and safety planning.
    - Youth can therapeutically process all past sexual offending behavior while a juvenile increasing their ability to release their shame.
  - Disclosing now provides age-appropriate interventions.
    - If a victim comes forward when the perpetrator is an adult and a PSE recommends treatment, adult treatment is VERY different from adolescent treatment and may be inappropriate.
  - Identify unknown victims of sexual abuse who can then get help.
    - Perpetrators of sexual crimes are most often known to the person harmed which makes a report less likely and those harmed are often household members where the juvenile may be destined to return to.

Polygraphs

- Cons.
  - Ethical Dilemma.
    - What is in the best interest of your client vs. bigger picture.
  - Test Misses Happen.
    - As happens in medical tests, psychological tests…reliance on the test/instrument has run correctly and results are valid.
  - Accuracy/Expertise of Polygrapher.
    - Need for standardization and regulation.
    - Polygraphs with juveniles appear to be more complicated than polygraphs for adults.
  - Additional disclosures.
    - Possible additional charges.
  - No current research showing polygraphs improve treatment outcomes.

Reasons for out of home placement.

- Needs more intensive services per the Psychosexual Evaluation.
- Not following the safety plan or adequate supervision is not available.
- Person who was harmed sexually lives in the home or nearby where contact is likely to occur.
- Safety concerns about other behaviors not related to sexual offending.
- Safety concerns at the home not related to client's actions.

Apology Sessions & Reunification

- Client has progressed in their treatment and completed their empathy and apology assignments.
- Therapist of client who harmed collaborates with the therapist of the person harmed sexually to confirm readiness for an apology session.
- Apology sessions do NOT automatically mean reunification! This is an ongoing carefully coordinated process between both therapists.
- Parental/caregiver involvement is essential especially if client and person harmed sexually are related or from same household.
  - The goal is ALWAYS reunification when possible!
- Healing for both the client and who they harmed is important!

Your role in the lives of these youth.

- Consider Person First Language
- Remember these are kids not “mini adults”.
- Shame and secrets.
  - Trauma
  - Home environments.
- The importance of relationships: YOU matter to your client.
- Secondary trauma and the importance of self-care.
- Where can we brainstorm to form a multidisciplinary team to help these youth from start to finish?**


Questions?

Resources

Websites

www.atsa.com/
www.mnatsa.org/
www.smart.ojp.gov/somapi/initiative-home
www.safersocietypress.org
www.ncsby.org
www.rainn.org
www.mncasa.org
www.cornerstonemn.org

- Adolescents
  - Taking Action Support for Families of Adolescents with Illegal Sexual Behavior by Barbara Bronner, Ph.D. available at Safer Society.
- Children
  - Taking Action Support for Families of Children with Sexual Behavior Problems by Dr. Jane Silvosky, Ph.D. available at Safer Society.
  - Psychological Assessment of Sexually Abused Children by Dr. William Friedrich, PhD, ABPP.

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