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Sexually Abusive Juveniles: From Tertiary to Primary Prevention

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Master of Public Health Thesis

SEXUALLY ABUSIVE JUVENILES:
FROM TERTIARY TO PRIMARY PREVENTION

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The Problem of Juvenile Sexual Perpetration

During the 1970's, an increasing number of adult males were incarcerated and/or placed in treatment programs for their sexually abusive behaviors against children and other adults. As these men were "interviewed" regarding their sexual perpetration, it became clear that these behaviors had not spontaneously developed at the onset of adulthood. Sexually abusive behaviors represented conduct that most of the perpetrating adults had engaged in for years during their pre-pubertal and pubertal youth (Groth, 1979; Groth & Laredo, 1981; Groth, Longo & McFadin, 1981; Abel, Mittelman & Becker, 1985; Bengis, 1987). In fact, research on sexually abusive adults, found that in clinical studies with over 1,000 subjects, the "typical age of inception of sexually aggressive acting out was between 12 and 17 years of age," (Bengis, 1987; Davis & Leitenberg, 1987; Groth & Laredo, 1981).

Juveniles are estimated to be responsible for 50 percent of the reported child sexual abuse cases and 20 percent of all rapes committed each year (Barbaree, et al., 1993; Becker et al., 1993; Finkelhor, 1996; Ryan, 1998; Sickmund et al., 1997; Showers, et al., 1983), and the US Department of Justice's Uniform Crime Report (1990) indicates that the number of sex crimes by males younger than 18 grows by 10 percent each year. Most incidents of
sexually aggressive behavior by juveniles are perpetrated by males, though females and pre-pubescent youth are also known to engage in such behavior (Sickmund et al., 1997). These statistics affirm that juveniles are responsible for a significant number of sex crimes each year (Weinrott, 1996), yet it is known that juvenile sexual aggression is severely under reported (Knopp, 1985a; Ryan, 1997b).

Defining the Problem of Sexually Abusive Behavior

Sexually abusive behavior is defined as any sexual interaction with a person(s) of any age that is executed against a person's will; or executed without consent (See explanation, p. 4); or executed in a manner that involves threatening, exploitive, aggressive or manipulative behavior (Ryan, 1997a). Sexually abusive behavior may involve one or more sexual behaviors or behaviors that are considered to be aberrant and sexualized. Molestation may include touching, rubbing, disrobing, sucking, penetration of bodily orifices and/or exposure to sexual materials. The term molestation is most commonly used to describe sexually abusive acts perpetrated against pre-pubertal children.

In most states, rape typically implies penetration of a bodily orifice (mouth, anus or vagina), by some object, and may or may not include force or violence. In other states, rape may be any sexual act that involves violence or force, regardless of whether penetration occurs (Ryan, 1997a). The
term rape is most commonly used to describe sexual violence toward females of consenting age. Sexual behaviors that do not involve manual (literally, the placement of hands on the victim), contact with a victim, but which may be abusive, include frottage (the rubbing of one's genitals against another, typically in crowded areas); exhibitionism (the exposing of one's genitals); voyeurism (watching another in his or her private domain, without their knowledge); obscene communication (verbal or written harassment or denigration); and fetishism (the taking of another's garments for their use during sexual stimulation) (Ryan, 1997a). Engagement in any of the above acts does not necessarily constitute sexually abusive behavior, as the relationship, the power differential and the impact of the behaviors on those involved, must be considered. The factors to be assessed in determining the presence of sexual abusiveness are equality, consent and coercion (Ryan, 1997a).

Equality considers the physical, emotional and cognitive development of those involved, as well as their levels of passivity, assertiveness, power and control, authority and situational roles. For example, if older siblings are typically in charge when the parents are out, the older siblings have greater authority relative to the younger siblings, even though they may be shorter and only one year older or weaker than their siblings closest in age to them.
Consent, is legally considered to be beyond the competence of juveniles. In the area of sexual relationships, states have defined arbitrary ages as the standards by which juveniles are judged to be able to give consent (Ryan, 1997a). The National Task Force on Juvenile Sexual Offending (1988, 1993), defined the elements of consent to include all of the following:

1. Understanding what is proposed based on age, maturity, development level, functioning and experience;
2. Knowledge of societal standards for what is being proposed;
3. Awareness of potential consequences and alternatives;
4. Assumptions that agreements or disagreements will be respected equally;
5. Participation is a voluntary decision; and
6. Mental competence.

Ascertaining the presence of consent may be further complicated, as cooperation and compliance may result in persons engaging in behavior that may otherwise seem consensual. Cooperation denotes active participation, however unlike consent, this participation is without concern for one's personal beliefs or desire. Compliance may mean passively engaging without resistance, despite opposing beliefs or desires (Ryan, 1988). Even in situations in which the parties involved seem to have equal amounts of power, the importance of discerning consent from cooperation or compliance cannot be understated.
The following case illustrates this point:

Raul (age 14) and John (age 15) are two boys that live in a residential facility together. They are of equal size and intellectual functioning, though John is more outgoing and assertive and Raul more shy and withdrawn. One evening after a shower, Raul wrapped a towel around himself and went to get his laundry out of the dryer. John then entered the laundry room, pulled Raul's towel off and attempted to anally penetrated him. Raul told John to stop and pushed him away, but upon John's continued effort, Raul allowed John to penetrate him. Staff soon walked in on the situation and stopped the encounter.

When interviewed, Raul initially disclosed that John had forced him, but once the police became involved, he recanted. Staff then assumed that the contact had been consensual and that Raul's claim that John forced him to have sex was due to his embarrassment and homophobia. A month later it was found that Raul had been involved in multiple sexual contacts with another boy, Peter (age 16), upon whom he was performing fellatio. While this contact was also determined to be consensual, it reinforced the staff's belief that Raul's previous disclosure of forced sexual contact by John, was due to his unwillingness to openly acknowledge his attraction to males. A few months later, Raul was due to begin visits to his mother's home. Due to knowledge of his prior sexual contacts, concerns were raised that Raul might be a sexual offender (staff's homophobia), which prompted the request for a psychosexual assessment. Upon evaluation of Raul and discussion of the incident with John, he disclosed that on multiple occasions John had overtly exposed his penis to him in the shower. In addition, on the day prior to the incident of sexual contact, John told Raul that he wanted him to go into the bathroom, so that he could "stick it in your [Raul's] butt." Raul stated that he "went along with John's doing sexual things to me [anal penetration] because I just ignored him and I didn't tell staff [about his exposing himself and his threatening statement], so John probably thought I liked it." Raul stated that, "John didn't force me, but I didn't want him to do it." Raul also said he recanted with the police, because "John's older and I didn't want to get him into big trouble."

Raul differentiated between his desire to participate in the sexual contact with Peter and not with John. Raul also readily acknowledged his sexual contacts with Peter and expressed comfort with his attraction to males. Both of these points were important: The first spoke to his compliant rather than consensual participation with John; the second, featured Raul's willingness to discuss his consensual contact with Peter, which eliminated concern that Raul's initial description of the incident with John, as "against his will," was based on an attempt to deny a same-sex sexual contact.

Coercion, which may be employed with various amounts of subtly, is the pressure one may feel to act in a particular manner without free choice. Whereas consent implies similar knowledge, understanding and choice between the people involved, power and authority differentials may coerce
cooperation from an unwitting participant in a relatively subtle form. Similarly, disparities in the size and/or strength between two people, may coerce compliance from the smaller or weaker person who imagines the bodily harm that could occur from resistance. A less subtle form of coercion involves the promise of secondary gains or losses as a result of participation in an interaction. The gains are typically emotional or material and often manipulate a victim's fear of rejection. The most overt form of coercion involves threats of harm or actual violence (Ryan, 1997a).

**Reporting & Counting**

While it is believed that juveniles account for a significant proportion of the sexual assaults that occur, accurate statistics regarding these behaviors have been difficult to ascertain for various reasons. The problem of under reporting juveniles' sexual abusiveness is primarily responsible for the inaccuracy and has been a recognized concern since the field of study was nascent. In the early 1980's, Groth and Laredo (1981), delineated various reasons for the under reporting of all of the types of sexually abusive behaviors perpetrated by youth, from rape and child molestation to exhibitionism and voyeurism.

The victim, who is usually the only person other than the perpetrator to know about the abuse, is often reluctant to disclose the abuse, due to feelings of shame and
humiliation. Given the secrecy that surrounds the subject of sexual behavior, victims often fear of the reactions of the parents and siblings, as well as, concern for her or his reputation amongst peers. The disparate levels of power and/or threats made by perpetrators, often instill a fear of retaliation in victims, thereby effecting their silence (Deisher, et. al, 1982).

The age and familiarity of the perpetrator are common explanations for under reporting. A combination of the youthful age of the perpetrator and his or her typical familiarity with the victim and the victim's family, often prohibit the victim's caretakers from making a formal response to either protective services or the police. The disbelief and fear of both the perpetrator's and victims' parents and families reinforce the denial and minimization of the abusive behaviors as serious and serve to reduce the numbers of sexually abusive acts reported to appropriate authorities (Deisher, et al., 1982).

Further, juvenile justice or mental health agencies regard the sexual behaviors reported to them as incidents of normal sexual development, curiosity or experimentation. A lack of training for these and other types of human service providers regarding issues of normal sexual development, and/or recognition of sexually aggressive adolescents, not only perpetuates the problem of sexual abuse by juveniles,
but a reduction in the known amount of sexually abusive behaviors perpetrated by them (Deisher, et. al., 1982).

Not surprisingly, sexually aggressive youth rarely refer themselves for treatment services, due to the legal and social consequences that may result, and/or the belief or feeling on the part of the youth that he or she has done nothing wrong, hurtful or inappropriate. As well, if youth believe their sexual thoughts and/or impulses may be indicative of more serious problems, they may decide to keep their fears to themselves.

Beyond the socio-emotional influences that inhibit reporting and skew the numbers regarding sexually abusive behaviors by youth, Gail Ryan (1997b), details the factors that contribute to the likely inaccuracy of current statistics that do get reported. The primary obstacle being the absence of a data collection system that identifies all reported cases of child sexual abuse. Each of the multiple systems that capture a portion of the information regarding sexually abusive acts by juveniles are circumscribed due to the various weaknesses of each system.

For instance, the National Adolescent Perpetrator Prevention Network (NAPN) collects data from treatment providers in many states. However, the data collected is not from all treatment providers or all states, so the numbers collected do not capture the full picture of juvenile sexual perpetration. Similarly, the National
Center on Child Abuse and Neglect (NCCAN), provides annual statistics on the number of reported cases of child sexual abuse. NCCAN's statistics do not fully define incidence and prevalence, however, as its data are limited to incidents reported by child protective service agencies. The actual incidence of sexual abuse perpetrated by juveniles is lost if the victims are extra-familial, because they are not accepted by protective service agencies, but referred to law enforcement or criminal justice (Ryan 1997b).

The Federal Bureau of Investigation (FBI) is also an inaccurate source of statistics on the incidence and prevalence of juvenile sexual offending. Despite the fact that the FBI Crime Index does identify rape and other sexual offenses for juvenile perpetrators, it only collects statistics for only those cases that are charged, prosecuted and successfully convicted (Ryan 1997b). Because many cases of juvenile sexual offending are referred to social service agencies without charges being filed, or are unprosecuted or are not successfully convicted, these statistics do not get captured. Further, through plea bargains and other criminal and juvenile justice practices, sexual assault charges are habitually dropped and ultimately presented as mere assaults or nonsexual offenses (Bureau of Justice Statistics, 1981).
Societal Responses

Adults generally do not think of children as sexual beings. This is often seen in the great difficulty adults have communicating sexual information to youth and the actuality of juvenile sexual perpetration, as being out of the range of cognitive possibilities for most adults. As such, sexually exploitive behaviors by juveniles have long been denied and minimized. The punitive responses that children received for any acknowledgment of their sexuality, promoted sexual abuse both by and against them. Children learn very early that sexual behavior is a secret, not to be questioned or discussed. While more juvenile sexual interactions are now being evaluated, historically sexualized behaviors were either ignored, excused or simply disapproved of without intervention (Ryan, 1997). Ryan (1986) pointed out that until the mid-1980s, boys behaving in criminal sexual behaviors were simply judged with a 'boys will be boys' attitude.

Child Protection Agencies

Since the 1920's, the state has been charged with the responsibility of general supervision over those children who required care, protection or discipline, including dependent, defective, abused or neglected children (CT Dept. of Justice). If a report of child abuse or neglect is made to state protective services, an investigation ensues which
could lead to the removal of a child who has received maltreatment or been abusive to another minor child who also resides in the home.

In 1974, Connecticut became the first state to consolidate child protective services, a statewide juvenile court and juvenile justice programming and children's mental health in a single executive agency, the Department of Children and Youth Services (DCYS). DCYS had the mandate of protective services for all dependent, neglected and uncared for children, as well as, the psychiatric and other mental health services for children, and the care and custody of adjudicated juvenile delinquents. As such, the Connecticut Department of Children and Families (DCF), formerly DCYS, may remove children who have been abused or abusive to other minors in the home and mandate that they receive psychotherapeutic treatment and/or make referrals to the police and juvenile justice system if they have engaged in abusive criminal behavior. In Connecticut, child protective services account for a great number of the juveniles that receive treatment for their sexually abusive behavior.

**Mental Health**

Due to the lack of scientifically based theories or model programs to guide the development of the first programs in the early 1980's, most clinicians developed their own understanding of sexually abusive youth and
designed treatment approaches through trial and error (Knopp, Freeman-Longo & Lane, 1997). Treaters of sexually abusive adults began to describe juvenile sexual perpetrators and to suggest specialized assessment and treatment strategies for them. Not surprisingly, most of the treatment approaches used with sexually abusive juveniles were influenced by the previous work and experience that treatment providers had with adults. It was a relatively short time before there was consensus among treaters regarding the need for specialized treatment (Groth, et al., 1981; Knopp, 1982, 1985; Bengis, 1986, 1997), though there were various ideas as to what should constitute that treatment.

Today, specialized treatment programs continue to play a major role in the services available for sexually abusive juveniles in most parts of the country. Presently, there are more than 800 specialized treatment programs for juveniles and most of them exist in the community (Pithers, et al., 1995), with a diversity of program models and modalities employed by treatment providers. Most clinicians treating this population, encourage collaboration between the juvenile courts, parole or probation officers and court supervision of their clients in order to mandate successful compliance with treatment and increase safety to the community.
Juvenile Justice and the Role of the Court

The debate over the effectiveness of treatment versus incarceration for sexually abusive juveniles has been continuous since awareness of this problem began to increase in the 1970's. Poor prognosis for sexually abusive adults receiving treatment pushed the bias toward incarceration for juveniles, though a relative few of those identified as sexually abusive were actually adjudicated (Speirs, 1989). It was increasingly recognized that some juveniles could be safely treated on an outpatient basis, while those that represented a risk to the community should be incarcerated, though optimally, not without concurrent treatment (Heinz & Ryan, 1997).

The Combination of Court and Mental Health

In the mid-80's, the necessity of a continuum of court and therapeutic involvement was formally recognized (National Task Force on Juvenile Sexual Offending, 1988), and conjoint incarceration and treatment began to be understood as being complementary means to protecting victims and reducing recidivism. For all practical purposes, however, court dispositions regarding incarceration and treatment were determined most often by the availability of therapeutic services and not by consistent legal, clinical or safety measures (Heinz & Ryan, 1997).
The dramatic increase in violent offenses committed by juveniles over recent years has promulgated legislation intended to amplify public safety and ensure the accountability of juveniles to the criminal justice system (Hunter, 1999; Hunter & Lexier, 1998). Hunter (1999) notes that the statutory and regulatory amendments enacted have drastically increased accountability to the criminal courts in various ways, including the: 1). Increase of juvenile cases waived to adult criminal courts by 71 percent between 1985 and 1994 (Szymanski, 1998); 2). Reduction of the age at which juveniles may be tried as adults; 3). Increases in the potential that once convicted of a crime in the adult court, that some amount of the imposed sentence will be served; and 4). Increased access by the public to the criminal records of juveniles. Currently there is no federal mandate requiring states to register juveniles adjudicated for sexual offenses (D'Amora, 1999). However, juveniles convicted in adult criminal court must have their names on the register per federal guidelines (Department of Justice, 1998).

For the past decade, treatment providers for this population have recommended concurrent intervention by juvenile justice systems and clinicians (National Task Force on Juvenile Sexual Offending, 1988). Treatment mandates by the court system have been successful in ensuring compliance with treatment and provisions for supervision. The most effective for adults that have sexually offended include,
"intensive supervision, sex offense specific treatment, interagency collaboration, multi-disciplinary teams, the specialization of supervision and treatment staff, the use of the polygraph to monitor therapy and compliance with supervision conditions, program monitoring and evaluation" (English et al., 1996).

Thesis Objectives

The objectives of this thesis are six-fold and begin with a contrast of normative and non-normative development of childhood sexual behavior versus abusive sexual behavior. The second objective is to identify the etiological factors that contribute to sexually abusive behaviors by juveniles. Thirdly, this thesis will discuss the theoretical models of behavioral sequella that lead to sexually abusive conduct and the treatment models and techniques that support the specialized treatment of this population. The fourth objective of this paper involves a discussion of the continuum of care, which was developed to provide consistent treatment and adequate restrictiveness for sexually abusive juveniles, in order to maintain safety in the community. A specialized community-based treatment program for sexually abusive juveniles will then be considered relative to the recommended continuum of care and the treatment services available in Connecticut for this population. The significance of this case review lies in the picture its
presents regarding the paucity of services available in the state at the level of tertiary prevention. The implications of this deficit and the need for primary and secondary prevention will be then be considered.
Normative Childhood Sexual Development

A critical facet of discerning abusive from non-abusive behavior in the area of sexuality, lies in acknowledgment and understanding of normative childhood sexual behavior. Too often, people assume that children are not sexual beings. In assuming such a perspective, all childhood sexual behavior is typically classified at extreme ends of a continuum: The behavior must either be abusive or the behavior requires absolutely no consideration. The most definitive knowledge about childhood sexuality is that it consists of increased curiosity, interest and experimentation, the and behavior is progressive with age (Gil, 1993). As well, the variables specific to each child's culture, familial influence, organic and cognitive capacities, and intra-psychic influences, determine the pace of one's sexual development (Martinson, 1991). The ability to discern between the sexual behaviors that are normal and harmless and those that are abusive and hurtful along the continuum of childhood sexuality, is essential to assisting children in the development of a healthy sense of their sexual selves, as well as keeping them safe.

The sensory capacity for erotic experience begins to emerge during intrauterine development, as seen in fetal
responsiveness to pressure and touch. It is believed that fetuses engage in purposeful autostimulation, as seen in thumb sucking and the grasping of toes, fingers and penises (Martinson, 1991). Involuntary penile erections have been observed and orgasm is known to occur during fetal development (Reinisch & Beasley, 1990). After birth, the infant continues to develop the erotic capacity that emerged in utero and a gradual progression in sexual activity is seen with increased age. Very young children discover that when certain parts of their bodies are touched, poked or rubbed, it feels pleasurable. As pleasant sensations are experienced they are repeated, though the younger the child, the more likely the repetition is accidental. Genital play for boys generally begins around seven months; and for girls around eleven months (Galenson & Riophe, 1974). Many infants also develop a pattern of rocking that may provide intense genital pleasure (Levine, 1957), and for some results in orgasm (Kinsey, et al., 1948).

During the second year of life, children's exploration of themselves, others and their genitalia becomes increasingly organized. Masturbation is a common experience in the development of normal infants and children, and is considered to be nearly universal (Martinson, 1997). At three years old most boys masturbate manually by rubbing the penis or by wrapping their fingers around the erect penis and moving the hand; some boys lie on their stomachs on a
flat surface and rub their penis against the surface while engaging in other activities. Girls often place a soft toy between their legs and rub their clitorises (Levine, 1957).

By three year of age, some child's play with peers may be sexual if left unsupervised and there is nothing else around that stimulates their interest more, though interest in sexual play tends to be episodic (Ilg & Ames 1955). Spiro (1955) found that of affectionate and erotic gestures between young children, hugging was the most common, followed by stroking and caressing, kissing and touching of the genitals. Young children appear to prefer sex play with peers, as long as it is not coercive (Constantine & Martinson, 1981), and such play is seen as a normal and a generally innocuous experience by experts on childhood development (Martinson, 1991).

Three year olds also play house and use dolls to represent their parents in situations in which they kiss, lay in bed, argue and make babies. This is mostly imitative behavior, the specificity of which depends on what they have observed and rarely progresses beyond what a child has actually experienced. Children of this age group also experiment by sticking their fingers in all of the various orifices of their own and peers' bodies. They may discover vaginal or anal openings and attempt to penetrate, however, most children will not persist if the activity produces pain (Gil, 1993). By the age of four children engage in
exhibitionistic and voyeuristic behaviors with peers and adults (Gallo 1979) and tend to initiate activities that involve undressing and sexual exploration. Bathroom activities of interest are consistent with bowel control and toilet training and the use of bathroom words is done with amusement.

School age children have increased peer contact, go through periods of inhibition and have a broad range of experimental interactive behaviors (Gil 1991). During this time demands for privacy develop, often seemingly overnight. This older range of childhood is less self-exploratory as a result of spending more time with peers and includes greater exposure to new sexual behaviors. Masturbation may occur in a less random manner and questions regarding where babies come from are of concern. Interest in seeing nude pictures is frequently present, as is giggling when observing adults kiss on television; children are both repulsed and drawn to overt sexual behaviors (Martinson, 1991). Though it varies, some children may hold hands and kiss. Though most parents do not permit this, some are amused by it. Most children will mimic or practice behaviors they have seen or experienced. There may be fondling of genitals, but usually it does not include penetration.

Latency, the years between ages eight and twelve, has long been considered a time of reduced interest in sexuality. It is now realized that these years are the
beginning of one's awareness of the self as a sexual being and of others as affectional and erotic partners (Martinson, 1997). This is a critical period of sexual, psychological and social change that effects the transition to a healthy adulthood. Bodies are preparing for puberty; and sexual development varies greatly with regard to time and rate for each child and is different for boys and girls.

Pre-pubescence of peer comparisons with some boys engaging in ejaculation contests to see who can ejaculate first or most; and some girls comparing breast sizes. Masturbation is much more common for boys during this period than interactive sexual activity, as erections occur more often, due both to erotic and non-erotic stimuli. Ramsey (1943) indicated that masturbation occurs at some time in the sexual histories of almost all males, with 75% reporting their first masturbatory experience between 10 and 16 year of age.

Most children go through stages of heterosexual involvement in relationships, which may or may not be characterized by overt sexual involvement in puberty or later. Children begin having crushes and/or forming attachments to people outside of the family. The feeling of love is expressed in ways that vary depending on the child's sexual and social maturity, and the permissiveness of the supervising adults. Affection may be expressed by teasing, writing notes, walking home, etc. Most 10 to 11 year olds
request activities that would allow both boys and girls to participate. Dating may begin as early as the fourth grade and consciousness regarding grooming and dressing increases. At this age, children may experiment with tongue kissing, petting over and under clothes, touching each others genitals, dry humping and digital or penile intercourse (Martinson, 1991). First experiments with coitus typically occur between the ages of 10 and 14; and one in four boys has attempted copulation with a girl by age twelve (Kinsey, et al., 1948). For girls, the highest incidence of heterosexual sex play seems to occur pre-puberty, rather than later (Kinsey, et al., 1948). This may be due to the increased pubertal restraints placed on girls by their parents (Martinson, 1973).

Adolescence is a time of transition physically, physiologically, emotionally and socially. This period includes a clearer emphasis on sexuality and sexual behavior takes on new meaning to themselves and others. Pubertal changes are both physiological and structural and related to both physical maturation and reproduction. Puberty brings changes in body image, as well as self-concept. While early- and late-maturing girls view their bodies more negatively than those in the norm (Tobin-Richard et al. 1983), post-menarcheal girls see themselves as more womanly and reflect more on their future reproductive roles (Koff 1983). Some girls experience greater clarity regarding
their sexual identities (Rierdan & Koff, 1980), while others lose self-esteem and perceive boys as gaining in power at this point (Grief & Ulman, 1982).

For boys, the consequences of physical maturation are generally positive, with early-maturing boys tending to feel more positive about themselves and late-maturing boys more negative (Tobin-Richards et al. 1983). First ejaculation is usually associated with positive feelings, compared with the ambivalence that girls experience with menarche (Gaddis & Brooks-Gunn, 1982, 1985). For most teens there is a progression from having sexual desires and urges, to feeling a sexual attraction to other persons. This is followed by going on dates, holding hands, kissing, and touching or fondling another person. These behaviors typically lead to attempting to, and ultimately engaging in sexual intercourse (Simon & Gagnon, 1969; Gagnon, 1972).

Individual differences in adolescent sexual behaviors are traced to both hormonal and social processes (Udry, et al., 1985 - 1987). Socially, the sexual behavior of peers is a strong predictor of sexual activity among adolescents, especially for girls. As a teenager's relationship moves through the transition from dating to courtship to commitment (e.g., dating someone who would be considered a marriage partner), sexual experience tends to develop rapidly. The level of commitment also determines the range of sexual experience that is acceptable in the relationship,
for as teens gain experience with intense emotional involvement, they become prepared for more intensive sexual involvement. Cultural, moral, religious and health limitations, may lead many children to avoid penile to genital contact and instead, encourage engagement in cunnilingus or fellatio (Martinson, 1991).

**Etiology of Sexually Abusive Behaviors in Juveniles**

There is no definite theory to explain abusive sexual behavior by juveniles, though there are multiple factors that have been identified as contributing to non-normative abusive behavior and two etiological models have been developed in order to explain the sexually abusive patterns in youth. The two factors that have been identified as strong correlates of the development of sexually abusive behavior by juveniles include, the youth's experiences of primary physical and sexual abuse and exposure to aggressive role models (Hunter & Becker, in press; Hunter, 1998; Kahn & Chambers, 1991; Stagg, et al., 1989).

**History of Abuse**

Sexually abusive adolescent males have been found to have histories of being physically abused in more than 50 percent of cases and histories of being sexually victimized themselves, in approximately 60 percent of cases (Hunter & Becker, in press; Becker & Hunter, 1997; Kahn & Chambers,
Samples of sexually abusive juvenile females and pre-pubescent males show even higher rates of physical and sexual victimization (Gray et al., 1997). The experience of physical and sexual abuse by youth is related to Post Traumatic Stress Disorder, which is characterized by recurrent and intrusive thoughts regarding the abusive events; the avoidance of stimuli associated with the trauma and numbing of one's general responsiveness; and an increased arousal state, including increased anger and irritability (APA, 1994). Symptoms of Post Traumatic Stress Disorder have been seen in juvenile sexual abusers younger than 14 years of age and females. Youth that have been sexually abused or witness to sexual abuse may imitate the behavior their perpetrator in their interactions with others (Hunter, 1998).

**Exposure to Violence by Significant Others**

Exposure to aggressive role models appears to have a more significant influence on male children who witness domestic violence in terms of increasing their subsequent participation in aggression toward others (Hunter, 1998; Johnson-Reid, 1998; Stagg et al., 1989). Witnessing domestic violence also increases the likelihood of sexually abusive behavior as a juvenile and negatively impacts the psychosexual development of those juveniles who observe it (Fagan & Wexler, 1988; Smith, 1988). Hunter (1998) points out that the effects of exposure to such violence may be
cumulative and/or interactive in the face of other abusive experiences or neglect (O'Keefe, 1994). The link between exposure to violence experienced in the community and the increased likelihood of violent and antisocial behavior by those witnessing the violence, has been suggested by recent research (Johnson-Reid, 1998).

Other Factors

Hunter (1998) notes that frequent attributes of sexually aggressive juveniles include the presence of other diagnosable behavioral problems such as substance abuse and conduct disorder (Kavoussi et. al., 1988), which is characterized by regular aggression to people and animals, destructiveness, deceitfulness and oppositionality (APA, 1994). These youth have also been observed to have difficulties controlling their impulses to engage in behavior that may be harmful to themselves or others and judgement (Hunter, 1998; Smith et al., 1987). As well, up to 60 percent of identified sexually aggressive juveniles have learning disabilities and academic dysfunction (Hunter 1998; Awad & Saunders, 1991).

Models for Non-Normative Sexual Behavior by Juveniles

The Sexual Abuse Cycle was developed by Ryan, Lane, Davis and Isaac (1987), and represents the dominant model for understanding sexually abusive behavior by juveniles.
Though this model has not been empirically derived or validated, it offers juveniles a framework upon which they can gain an understanding of their abusive behaviors, in order that they may intervene in their abusive pattern and processes. The sexual abuse cycle was generated via clinical observation with incarcerated adolescents with histories of sexually abusive behavior (Lane, 1997).

In clinical observation of sexually abusive adolescents, it was found that most all of them had similar patterns of thinking and affective responses to the abusive behaviors in which they had engaged. From the juveniles' retrospective descriptions of their abusive behaviors and associated thoughts, the sexual abuse cycle seemed to represent "a dysfunctional coping response to problematic situations," which led to the youths' misinterpretations about "power and control as it related to self-perceptions of adequacy" (Lane, 1997).

The sexual abuse cycle's originators found the concept to be consistent in its representation of the compensatory and repetitive nature of sexually abusive behavior in over three thousand juveniles regardless of age, gender, developmental capacity or type of sexual offense. The sexual abuse cycle is appropriate for work with juveniles with lower cognitive capacities as well, though use of the cycle with this population should be illustrated using a more concrete and simplified approach. The concept of the
sexual abuse cycle represents the process of cognitive, affective and behavioral patterns that are antecedent, concurrent and subsequent to the abusive behavior(s) and is based on the experiences described by youth in specialized treatment for sexual abusiveness.

The originators of the cycle concept describe the cycle as beginning with the juvenile's response to a circumstance or interaction that the juvenile perceives as problematic. This event stimulates feelings of helplessness. Based on past life experience, beliefs and ideas of how the world works, the juvenile assumes the world will be similar and thus precarious. The negative anticipation by the juvenile provokes feelings of hopelessness and subsequent attempts to avoid the issue itself, as well as the hopelessness and the anticipated negative outcomes. The avoidance, naturally does not work or at least for long, and subsequently the juvenile feels resentful and defensive and seeks to exercise power over others in non-sexual ways. The perception of power and control that the juvenile gains is fleeting, so the juvenile begins to think of other ways in which to feel good (e.g. sex). The fantasy of things that will make the juvenile feel good, including the further thoughts of power and control, are ultimately enacted. Following the sexual abuse, the youth attempts to cope with his or her abusive actions and fear of being caught through distorted thoughts of having control of the situation. Such fugitive thinking
ultimately leads the juvenile to re-frame the behavior in such a way as to suppress the problem (Lane, 1997).

The second model, also not been empirically derived or validated, was developed by Becker and Kaplan (1988). This model advanced the idea that an adolescent's first sexual offense is the result of a confluence of individual characteristics (e.g., poor social skills and anti-social behavior), family variables (e.g., familial relationships), and social-environmental variables (e.g., social isolation and exposure to anti-social behavior by others). Subsequent to the commission of the first sexual offense, the juvenile may follow one of three paths, as described by the authors. The first path is the path of no further delinquency, sexual or otherwise. The second path is the path of delinquency, on which the juvenile commits other sexual offenses, as well as, other types of destructive and illicit behaviors. The third path is that of continued engagement in sexually abusive behaviors and the ultimate development of a pattern of paraphilic interests (Becker, 1998). A paraphilia is characterized by recurrent, intense, sexually arousing fantasies, sexual urges or behaviors that involve non-human objects, the suffering or humiliation of oneself or partner, children or non-consenting persons (APA, 1994).
Overview of Treatment Models

The models discussed below vary in their approaches to treating sexually abusive behavior, though all of them are similar in their agreement that sexually abusive acts have precursors that can be identified and addressed, and thereby include cognitive elements in their methods. Cognitive behavioral treatment (CBT) is based on the learning - and unlearning - of sexual behavior through the tenants of social learning theory. The premise being, that reducing abusive sexual arousal patterns to pro-social and normative sexual stimuli will reduce motivation to be sexually abusive. Relapse Prevention is a containment model, based on the idea that there is no permanent cure for sexually abusive behavior. Those that have been sexually abusive must continue to practice intervention strategies in order to avoid re-offending sexually. The psycho-educational model teaches juveniles about various topics related to their sexually abusive behavior, based on the idea that greater understanding will reduce abusive behaviors. Lastly, multisystemic therapy uses an ecological approach to the problem, implementing some of the cognitive behavioral strategies described in the models below.
Cognitive Behavioral

CBT uses cognitive restructuring methods and behavioral techniques to reduce arousal associated with sexually abusive behaviors and increase pro-social skills (Knopp, et al., 1997). CBT for sexually abusive juveniles is based on a model that was initially developed for sexually abusive adults (Abel, et al., 1984). The original model has been modified to be appropriate to the developmental and emotional needs of juveniles. Cognitive behavioral treatment is usually done in peer group therapy, though it may include individual sessions. Cognitive behavioral treatment programs typically includes the topics of assertiveness training and social skills development in addition to the techniques described below. The following techniques are those most commonly used in the treatment of juveniles in residential settings, though they are also be used in community-based treatment.

Verbal satiation a technique that teaches the juveniles how to use sexually abusive thoughts in a repetitive manner to the point of fatigue or boredom with the stimuli that previously aroused them sexually. This technique begins with the juvenile being shown a slide of a naked person that corresponds to his or her victim in terms of age and sex. While viewing the slide, the juvenile is requested to repeat a phrase that describes the nature of the sexual behavior engaged in during his or her sexually abusive act. Clients
are typically required to complete a proscribed number of satiation sessions for minimum amount of time, usually at least 30 minutes. Juveniles are shown a different slide and repeat a different phrase for each satiation session. This technique is done in individual sessions (Becket & Kaplan, 1993).

*Cognitive restructuring* attempts to change cognitive distortions. This technique involves confronting juveniles with the maladaptive beliefs that supported their abusive sexual behaviors (Becket & Kaplan, 1993). This technique may be used either in a group or individual sessions, though the former is more productive due to the potential for peer confrontation. The juvenile is instructed to discuss all of the things that he or she told him or herself to make the abusive behaviors seem okay. Group member pairs then take turns in the roles of the abuser using his or her cognitive distortions to justify their abusive behaviors to the peer in the role of a therapist, judge, parent of the victim, etc. The juvenile in the role of the authority figure must choose to agree or disagree with the juvenile in the role of the abuser. Afterward, the group discusses the rationalizations or distortions and why they were wrong (Becker & Kaplan, 1993).

Over the course of a few sessions, abusive interactions ranging from child molestation, to date rape, to non-date rape to voyeurism, are role-played and the distortions
discussed. Issues relative to consent, equality and coercion are raised throughout the discussions. When in the role of the authority figure, juveniles typically respond differently to situations than they did when they actually abused their victims. This exercise allows the juveniles to see how their peers react to their behaviors, as opposed to their own narrow perspectives of their abusiveness (Becker & Kaplan, 1993).

Covert sensitization is a technique used to teach juveniles to recognize the thought processes and behaviors that put them at risk to abuse someone else; and to then interrupt these fantasies by substituting negative consequences for the positive ones that drive their abusive fantasies. Juveniles first write down their own fantasy scripts of 'risk factors' and the negative consequences. An example of how this exercise works is as follows: Risk: I get home; no one else is there; I feel lonely as I sit watching the young kids playing at the swing; they look so happy; I think I'll go and play with them. Switch -- Consequences: I'm sitting in jail wondering what the judge will do; I'm really scared; all because I went down to play with young kids at the swing. From these scripts, each juvenile makes 8 to 10 number of tapes outside of group and reviews them with the therapist. Feedback is given on each tape prior to beginning a new one. Once they are reviewed, the tapes are erased (Becker & Kaplan, 1993).
Thought-Stopping is an aversive technique that is used to intervene in abusive sexual thoughts or fantasies. Juveniles first think of negative consequences which they put into a sentence or phrase. An example might be, "I will be arrested in front of my parents and friends." The juvenile then follows that thought with another thought that counters the distorted thinking involved in the fantasy, such as, "Sex is the farthest thing from her mind." The technique involves having the juvenile wear a sturdy rubber band around his or her wrist. Upon commencement of an abusive sexual thought or fantasy the juvenile snaps the rubber band in such a manner that it stings, thereby interrupting the thought or fantasy. The juvenile then tells him- or herself to "Stop," followed by the aversive thought; which is then followed by the counter to the distorted thought.

The CBT techniques that are used to increase cognitive control, such as Thought-stopping and Covert Sensitization, have received predominantly positive reports from clients in terms of their helpfulness (Hunter & Lexier, 1998; National Task Force on Juvenile Sexual Offending, 1993). Empirical data regarding the efficacy of these techniques has been limited however, and given their use among various other methods in a comprehensive treatment plan, their individual effectiveness is not clear (Hunter & Becker, 1994). The techniques used to reduce abusive sexual arousal, such as
Verbal Satiation and Arousal Reconditioning, have generated concerns among clients and clinicians, while empirical data on their efficacy has been inconsistent. The concerns focus around whether it is ethical to subject juveniles to physically or emotionally aversive stimuli (Hunter & Lexier, 1998).

**Relapse Prevention**

The relapse prevention model was originally developed for use with people that abuse chemical substances, and was later modified for use with sexually abusive adults. Relapse prevention is a three dimensional, multi-modal strategy, specifically designed to help clients maintain behavioral changes by anticipating and responding to personal cues in order to avoid relapse. The tri-modal approach of relapse prevention teaches juveniles: 1) Internal self-management skills; 2) How to plan for an external supervisory component; and 3) A framework, the cycle of abuse, within which various behavioral, cognitive, psychoeducational and skill training approaches are utilized to teach sexually abusive youth how to recognize and interrupt the chain of events leading to relapse (Knopp, et al., 1997).

The relapse prevention model requires a high level of personal accountability for thinking and personal choices, recognition of high-risk factors, both internal or external, and avoidance of the abuse cycle (Ryan & Lane, 1997). From
the commencement of specialized treatment for sexually abusive behavior, the juvenile is learning about his or her own sexual abuse cycle or patterns, ways to interrupt that cycle, high risk factors and high risk situations, and methods for coping with lapses in order to avoid relapses (Thomas, 1997). By examining the choices and decisions that support the client's being in a high-risk situation and cognitively rehearsing methods to interrupt progression into the cycle, the client learns to use more responsible thinking and foresight throughout the vicissitudes of daily life (Ryan & Lane, 1997).

Integration of the relapse prevention model with the concept of the abuse cycle can be supportive of the juvenile's awareness of continued risk of reoffense, as relapse prevention calls for external monitoring of the juvenile after treatment (Ryan & Lane, 1997). It is in the final phases of treatment and following formal treatment that relapse prevention is most important. The abusive youth's family or caretakers are an important part of the youth's support and prevention team. Based on this premise that the potential for a youth to reoffend exists even upon successful completion of treatment, relapse prevention must be applied by both the individual and his or her family if it is to be successful.

It will be important for the family to understand that high risk situations can occur internally for the child or
externally in the family. Parents must learn to identify the dynamics within the family that contributed to their child's progression into sexually abusive behavior and be willing to work on changing those dynamics (Thomas, 1997). The juvenile must be willing to share awareness of the dynamics related to his or her abusive behaviors, discuss the various coping skills that assist him or her in preventing a lapse and be agreeable to having his parents or caretakers intervening at points where there is a progression into the abusive cycle (Thomas, 1997). The expectation of the need for ongoing support and reminders of things learned during treatment should be consistently expressed throughout the treatment process, as long-term follow-up and support protects both the juvenile's investment in treatment and the community's investment in treatment resources (Ryan & Lane, 1997).

**Psycho-Educational**

The psycho-educational approach uses a combination of group and individual modalities, in order to teach clients about various areas related to sexually abusive behavior. Groups are often used to teach juveniles about topics regarding human sexuality, victim awareness, interpersonal social skills, self-esteem, responsibility and empathy, anger management, and appropriate sex role expectations versus sex role stereotyping. In this type of model, the
group dynamic is often structured like that of a classroom, with the clinicians employing didactic techniques, followed by group discussion. This model does not employ behavioral methods, though it draws from a variety of counseling theories (Knopp, et al., 1997).

**Multisystemic Therapy**

Multisystemic Therapy (MST), is an intensive ecologically oriented, family and community-based treatment model that addresses the multiple factors of serious antisocial behavior in abusive juveniles. Treatment can involve any combination of individual, family and extrafamilial persons significant in the juvenile's life. The premise behind MST is that creating behavior change in the youth's natural environment, via capitalization on the strengths of those people significant in the youth's life, is the best way to engender lasting change (Bourdin, et al., 1990). MST is not widely used in the treatment of sexually abusive youth at this time, however, a recent study (Swenson, et al., 1998), comparing the correlates of serious juvenile non-sexual offenders with those of sexually abusive juveniles, and the positive outcomes with the former, speak to its potential promise.

The MST model seeks to maintain an ecological approach, while integrating the conceptualizations found in the literature on sexually abusive youth. As such, MST will conduct
a comprehensive evaluation of the juvenile and family; as well as use targeting thinking errors and abusive fantasies (described above); and the cycle of abuse model (described below); the clarification and family reunification processes (described below). MST is delivered in places that are convenient to the family and the juvenile such as in the home, school and church, in order to reduce barriers to access and encourage treatment generalization. Additional characteristics of MST that vary from traditional therapy, include frequent, intensive contacts and round-the-clock availability. MST therapists also carry smaller caseloads than traditional therapists (Swenson, et al., 1998).

Conclusion

The four models of treatment discussed above all rely on internal cognitive inhibitors to varying degrees. The psycho educational model is completely dependent on the use of information by individuals, to be employed as deterrent to sexually abusive behavior. Psycho-education is rarely used as the primary model on which treatment of this population is based, and is more commonly integrated as a component into other models. Cognitive behavioral treatment of this population also relies heavily on the internal deterrents developed through the restructuring of cognitions. CBT techniques are commonly used to treat both
juveniles and adults, though most often in the context of another model.

The relapse prevention and multisystemic therapy models are the most comprehensive in their approach, providing components of both internal and external resources and monitoring. The relapse prevention model places greater emphasis on individuals to take responsibility for their internal cues and creation of support networks. While the multisystemic model includes use of cognitive techniques and the abuse cycle, its primary approach to treatment involves inclusion of the family and the significant individuals in the youth's daily life.

A difficulty with relapse prevention, and a potential difficulty of MST, is the reluctance of the juvenile and the parents to tell others outside of family, especially those in schools and jobs, of the sexual nature of the problems. Another frequent concern with using family-oriented models is the lack of participation by family members. This is due to shame, denial and the often unstable nature of residential situations for youth in treatment. Maintenance of confidentiality is a significant reason for a focus on individualized techniques discussed earlier.

**Psychosexual Assessment**

The process of specialized treatment for a sexually abusive juvenile begins with a comprehensive psychosexual
evaluation. The initial psychosexual evaluation indicates the juvenile's behavior patterns, potential to sexually reoffend and amenability to treatment. The assessment must also define an appropriate treatment setting, the type of treatment, community safety issues, risk factors, monitoring considerations, the potential risks to the victim and vulnerable others, the psychiatric and individual needs of the juvenile, as well as, the family's treatment needs (Lane, 1997).

Pre-Assessment Preparation

It is essential that clinicians performing psychosexual assessments have a thorough understanding of the sexual abuse and the dynamics of sexually abusive behavior. It is also imperative that collateral records and/or reports, such as police reports, victim's statements to the police, reports from the victim's therapist, diagnostic interviews with the victim, investigative reports, as well as, the school reports, placement and mental health records of the juvenile, be reviewed prior to commencement of the evaluation (Lane, 1997). Review of these records will aid the evaluator in determining the juvenile's honesty, ability to take responsibility, level of denial and manner of sexual abusiveness. These reports will also offer information regarding the juvenile's social and psychiatric functioning, individual and family stressors, and concurrent social and
Assessment of the Abusive Behavior(s)

Evaluation of the sexually abusive behaviors for which the juvenile was referred, includes gaining information on the thoughts, feelings and behaviors involved in the offense(s) from the juvenile. Comparing the information regarding the referring behavior with that of the additional information garnered, will offer information about behavior patterns, progression of the behaviors and the severity of the habituation (Lane, 1997).

Information to be obtained during the evaluation includes, the **types and frequency of the sexually abusive behaviors** committed. Generally the more intrusive the behaviors, the greater the concern, however, given that many sexually abusive youth progress from less to more intrusive behaviors over time, less intrusive behaviors should not be minimized. Frequency of sexually abusive behaviors should include the number of repeated behaviors with same and other victims, as well as the frequency of attempted and successful incidents.

The use of **aggression and fear-inducing tactics or harassment** with the victim of the sexually abusive behaviors, must also be accounted for, as it relevant to assessing the level of dangerousness of the youth, as well
as, the progression of abusive behaviors (Lane, 1997). Juveniles who commit repeated sexual abuse behaviors over time, may exhibit some degree of progression in the behaviors, the associated thoughts, increased intrusiveness or coercion and the risks the youth is willing to take.

Insights regarding the abusive juvenile's victim preference, that is, similar or preferred characteristics among chosen victims; the juvenile's arousal assessment, that is, the amount of sexual and internal arousal experienced before, during and while reminiscing about the abusive behavior; and the juvenile's intent and motivation, that is, the anticipated goal that the youth had for engaging in the abusive behaviors, offer information that is critical to the assessment. The combination of the three offer facts as to whether the juvenile has a more predatory or opportunistic style of victim selection, as well as, offering details about the juvenile's triggers and high risk situations. Such information is significant in determining risk and treatment interventions.

Among different programs, there are various means of assessing arousal, including self-report, tests that prioritize sexual interests and physiological measures. Sexually abusive behavior may be motivated by an attempt to control or dominate and compensate for non-sexual issues. While this awareness is not typically conscious, the way that the youth justifies the abusive behavior, the
anticipated goals of the behavior and how they relate to the juvenile's life experience are important to understanding the needs of the juvenile in terms of treatment and safety planning (Lane, 1997).

The level of denial, amount of honesty and the juvenile's ability to discuss the abusive behaviors and/or allegations of such non-defensively, speak not only to the risk of relapse, but of the juvenile's amenability to treatment and the likelihood that the juvenile will be able to consider the appropriateness of engaging in sexually abusive behavior without external prompts. The greater the amount of responsibility juveniles are able to take for their behaviors, the greater potential for the juvenile to be able to address the abusive behaviors in treatment.

Risk factors may be internal thoughts or feelings, triggered by an external stimuli or circumstance which increases the likelihood that the juvenile will engage in sexually abusive behavior. All of the factors related to the sexually abusive behavior(s) and the environment of the juvenile must be considered in ascertaining what the risk factors are or may be during the assessment. A review of all known sexually abusive incidents by the youth should look for similar situations of victim access and opportunities for sexually abusive behavior. Such situations should be addressed when suggesting safety plans and supervision for the youth (Lane, 1997).
Developmental-Contextual Assessment

In addition to the acquisition of details specific to the sexually abusive behavior(s), the psychosexual evaluation must also provide information integral to understanding the juvenile's comprehensive social functioning and the sexually abusive behavior in the context of his or her life (Lane, 1997). Significant factors related to social functioning include the *coping ability* and *social competencies* of the juvenile. Identification of the juvenile's stressors, perceptions of the stressors, affective and cognitive reactions to the stressors and his or her style of managing the reactions to the stressors, are critical to understanding the juvenile's triggers, internal risk factors and antecedents to abusive behavior (Lane, 1997; Thomas, 1997). The juvenile's social competencies are also critical to understanding how he or she manages in the world. The amount of social difficulty or ease, healthy peer group support and participation in appropriate peer group activities, speaks directly to social functioning.

Exposure to past trauma, self-concept and level of school and employment stability are also factors to be considered in determining social functioning. The lower the sexually abusive juvenile's ability to adequately problem-solve and manage social situations, the greater the likelihood that she or he will rely on a misuse of power to
compensate for the feelings of powerlessness generated by these deficiencies (Lane, 1997).

The amount of empathy demonstrated by the juvenile with regard to his or her sexually abusive behavior and its impact on the victim(s), is of import in considering the youth's social functioning and potential to reoffend. Empathy "provides the highest level of deterrence for abusive behavior" (Ryan, 1997), and assessment of whether the youth expresses genuine remorse for the pain caused to the victim, and/or displays an understanding of signs or cues that show an ability to identify how another might feel are significant, not only in terms of estimate of risk of reoffense, but prognosis over the long term.

Evaluation for treatment, both the juvenile's attitude toward it, as well as past success in treatment, if applicable, speak to the juvenile's ability to benefit. The youth's willingness to participate in treatment, desire to stop abusive behaviors and ability to acknowledge that a problem exists for which she or he needs help are tantamount to initial acceptance of responsibility and successful engagement. Previous treatment offers information regarding amenability to mental health treatment. If the youth has already had specialized treatment for sexual abusive behavior, it will be important to determine what the juvenile thinks contributed to the relapse (Lane, 1997).
Cultural issues must also be considered in the course of evaluation and treatment. The likely differences in norms and values between juveniles from affluent and poor areas may offer youth differing beliefs about the need to engage in violence. As well, there must be consideration of the effect of overt and covert racism (Broad-field & Welch, 1999; Lane, 1997), classism, sexism (Minasian & Lewis, 1999), heterosexism, homophobia (Broadfield & Welch, 1999), and the effect that previous experiences, with both individuals and systems (Broadfield & Welch, 1999; Cullen & Travin, 1999), related to these types of biases, will and have had on a juvenile's level of trust and self-perceptions relative to the evaluator. Further, it is necessary to appreciate that sexual behaviors may be interpreted differently among various cultures. As such it will be important to ask youth their interpretation of the behaviors that have been perceived as abusive. It is critical to acquire an understanding of the juvenile's behavior in the sociocultural context in which it occurs (Jones et al., 1999; McIntyre, 1993).

Concurrent psychiatric or physiological disorders are sometimes present with sexually abusive youth and consideration of these possibilities is necessary throughout the evaluation. Such disorders may impact the benefit a youth is able to gain from treatment, as well as, the juvenile's interpersonal relationships and self-concept.
Identification of psychiatric disorders may have ramifications for the juvenile's placement, amenability to treatment, risk levels and ultimate prognosis. Awareness of either psychiatric or physiological disorders is crucial to a comprehensive understanding of the juvenile and accurate assessment of his or her needs.

**Family Assessment**

The acquisition of details specific to the juvenile's social functioning would lack comprehensive understanding without information regarding those who first informed the juvenile of his or her values and perceptions of the world. As such, *family assessment* is a critical component of the juvenile's psychosexual evaluation. It often provides an understanding of the juvenile and his or her engagement in sexually abusive behavior and represents the first phase in the treatment of the family. All members of the juvenile's immediate family and extended family who either live in home or who are significant in the juvenile's life, should be included in the assessment. The initial assessment of the family should include an evaluation of the following questions related to the abusive behavior(s) (Lane, 1997; Thomas, 1997; Steen, 1989):

Understanding family members' perceptions of the sexually abusive behavior is critical. Specifically, it is important to gain understanding of if and how family members
believe the abuse happened, as well as, their thoughts as to what the consequences ought to be and why. Also significant is knowing the extent to which family members externalize blame, minimize the allegations and/or support the child's denial.

It is necessary to gain an understanding of the reaction of the family to the disclosure of abuse. It is important to know who the family supports and why, as well as, the extent to which the parents/guardians hold the youth accountable for the alleged abusive behavior. Comprehension of the extent of understanding by the parents/guardians of the negative impact of the abusive behaviors for victims and their families is meaningful relative to the level of empathy of the juvenile. Necessary to ensure that the family is taking adequate steps to support and protect the victim and get help for the sexually abusive youth. Also need to ensure the family is protecting against any persons who are potential victims of the youth. The parents/guardians must be able to provide supervision of abusing child around all younger children and to support the child regarding community safety.

The reaction of the extended family and/or significantly involved others will also offer information as to how supported and/or stigmatized the family will feel. It is important to know who they offer their support to and why, as well as, the ways in which they offer the support.
The strength and nature of their relationship with the juvenile and family should be assessed, as well as, their potential to be a treatment resource or unhealthy influence for the family. The level of their support for treatment, willingness to participate in the therapy and provide supervision of the juvenile must also be obtained from both the parent/guardians and extended family members.

A familial psychosocial history, which will provide more general information about juveniles and their families, must also be a part of the psychosexual evaluation and include information regarding the general functioning of the families (Thomas, 1997). The physical, emotional, psychological and sexual boundaries within families and the extent to which they may be ambiguous or nonexistent must be explored with families, as this may offer clues to the juveniles' thinking regarding the abuse. The extent to which families have closed themselves off from the supports and perceptions of the outside world and the child, offers information about the coping strategies of families, as well as, the juvenile' sense of belonging both within the family and the outside world.

In order to understand the internal and external stressors affecting families, the number and extent of the intra- and extra-familial problems, including financial, health and legal difficulties and internal conflict must be considered. Awareness of intergenerational sexual or
physical abuse, the amount of violence juveniles have been exposed to, and abuses of power within families, are critical to understanding the behaviors or beliefs that supported the youths' sexually abusive behaviors. Assessment of families' ability to communicate clearly and directly in ways that are understandable to other members, regarding sensitive issues, such as intergenerational abuse, sexuality, drugs, infidelities, offer information regarding treatment planning and potential difficulties in terms of families' willingness to look at their children's abusive sexual behaviors.

Familial understandings and attitudes toward the sexual development of their children, particularly that of their abusive juveniles, is meaningful. It is important to know what or who has been the model and/or influence for the juveniles' sexual understanding, as well as, whether there have been incidents of sexual "acting out" within the families. The level of comfort in the family regarding the topic of sexuality is also significant in terms of families' willingness to confront the issues of the treatment. Any history of mental health services received by families' members in the past and their experiences in receipt of those services, will offer information regarding both past problems and the attitude of family members and their willingness to participate in therapy currently.
Collecting psychosocial, sociodemographic and developmental information regarding the family and the juvenile, establishes a shared understanding of the family's organization. Material that offers clues to abusive familial patterns and maladaptive coping skills, will also provide insights into the juvenile's abusiveness. All of this information will assist in the development of a treatment plan for the family and the juvenile (Thomas, 1997).

Disposition and Placement

The information gathered during the assessment process is now to be examined and put in the form of recommendations. These recommendations will specify: 1). Needs for specialized treatment of sexually abusive behaviors for the juvenile and the family; 2). Treatment setting, intensity and type; 3). Risk potential; 4). Risk factors and safety plans; 5). Intensity and nature of supervision; 6). Placement considerations; 7). Adjunct treatment and concurrent disorders; 8). Family's treatment and educational needs; 9). Victim's protection, resolution and treatment needs.

A determination of the risk of continued sexually abusive behavior is the first consideration in determining recommendations. Factors regarding the juvenile, the abusive behaviors and the family are collectively factored into an assessment of risk. It is important to note, that
offering judgements on the risks of a juvenile to reoffend sexually, must be done cautiously. This is particularly true in situations in which the recommendations will play a significant role in a court disposition. Recommendations should state that they "reflect the best clinical opinion on these issues, but that empirical support for risk models have not been clearly established," (Hunter & Lexier, 1998).

An example, a juvenile who has committed multiple offenses with increased progression in behaviors over an extended period of time, who denies any responsibility for the behavior, who is socially isolated, who has no motivation for treatment and whose parents are substance abusers and support the juvenile's denial, this juvenile will be considered to be at high risk to reoffend sexually. The recommendation for this youth will likely be placement in a specialized residential treatment facility that provides intensive supervision and structure for an extensive period. Reduction in the supervision and structure will be dependent on the youth's progress in treatment.

A juvenile who has committed multiple offenses over an extended period of time without a progression in behaviors, who denies any responsibility for the behavior, who has some motivation for treatment, and whose parents believe their child has been sexually abusive and are supportive of treatment for the child and themselves, will likely be considered at moderate risk to reoffend sexually. The
recommendation for this youth will likely be placement in a residential treatment facility that either has a specialized treatment program for sexually abusive youth or has access to a community-based treatment program. This youth will likely require supervision around peers and other children and in the community. Reduction in the supervision and structure will be dependent on the youth's progress in treatment.

A juvenile who has committed one or two sexually abusive acts against a younger cousin, who admitted to the behavior when confronted, who appears remorseful and expresses empathy for his victim, who is close to his parents and has a few close friends, and whose parents increased supervision of the juvenile upon disclosure of the abuse and are supportive of treatment, will likely be considered at low risk to reoffend sexually. The recommendation for this youth will likely be continued placement with the parents and specialized treatment for sexually abusive juveniles in a community-based treatment program. This youth will likely require supervision around younger children in the home and in the community. Reduction in the supervision and structure will be dependent on the youth's progress in treatment.

For each level of risk presented by various juveniles, another concern is limiting access to potential victims. If the abuse occurred within the nuclear family, the juvenile
and the victim should be separated, at least during the beginning phases of treatment. Regardless of how compliant the parents are with supervision, and acknowledgment of the abuse, if the power differential continues to exist, it is best that the abusive juvenile be removed from the home, even if temporarily until the issues regarding the power differentials can be resolved (Lane, 1997). Removal of the abusive juvenile from the home is in the interest of removing the potential for both, further sexual and emotional abuse to the victim. However, as difficult as it may be for the abusive juvenile, the parents and the victim to comply with this recommendation, it is in the best interest of all of them.

Treatment

Following a comprehensive psychosexual assessment and placement in the appropriate treatment setting, treatment may formally begin. The modalities typically used are a combination of group, family and individual. Various techniques may be implemented within the context of these modalities.

Group

Group treatment is the recommended modality for all sexually abusive youth (National Task Force, 1988, 1993), as many of the characteristics of sexually abusive behavior are
"most effectively addressed in a group setting," (Ryan & Lane, 1997). This belief is based on the reported observations of many of the clinicians treating sexually abusive youth. Group membership models and advances relationships with both peers and the adult clinicians. The experience of hearing peers take increasing amounts of responsibility for their abusive behaviors, may reduce the juveniles negative self-perceptions and promote increased responsibility amongst others. Being in a group with peers who have also engaged in sexually abusive behaviors also reduces the shame that is associated with the juvenile's thinking that he is the only one to engage in such behaviors. This reduction in shame is likely to reduce resistance to taking responsibility and confronting the problem of his sexually abusive behavior (Ryan & Lane, 1997).

As the youth hears the distortions and minimizations of his or her peers, it becomes easier for him or her to recognize the "lack of logic or objectifying aspects without defensiveness," (Ryan & Lane, 1997), which allows for more self-appraisal of his or her own thinking. Witnessing peers take risks regarding self-disclosure and feedback may enhance others' willingness to take such risk. Youth that engage in sexually abusive behavior are ofttimes better at identifying denial and minimization in their peers based on their own abusive behaviors. Confrontation by a peer in such situations or in general, is less likely to bear the
resistance that a clinician may engender. Male - female co-therapy teams are recommended, as they model healthy heterosexual dynamics, the experience of which may be limited in the lives of sexually aggressive youth.

Individual

In addition to the group work, individual therapy can also be used to supplement the juvenile's treatment, though "it is imperative that the individual therapies also be conducted by specialists who are trained in sexual abuse issues and part of an integrated team approach." Individual sessions can provide settings for the experiences of empathy and disclosures of victimization and perpetration, the initial revelations of which may be too difficult for some youth to do in a group environment. These type of sessions are conducive to addressing destructive group behavior with individual members (Ryan & Lane, 1997). Further, while the focus of treatment for sexually abusive youth is on their abusive behaviors, clinicians are also interested in the youth as a whole person. As such, individual treatment can support work on the concurrent issues that the juveniles need to address and as appropriate, bridge them to both, the juveniles' abusive behaviors and enhancement of their coping skills.
Family

Family therapy (Thomas 1997) is a significant aspect of the treatment of sexually abusive youth and depending on the situation of the specific juvenile, it may mean working with the biological family, a foster family, the institutional family or all of these at various points in the course of the juvenile's treatment. As with the individual and group therapists, the family therapist must also be specially trained in the applications of working with sexually abusive youth.

When the juvenile and the family make initial contact with the evaluating clinician, knowledge of the sexually abusive behavior is new or not yet acknowledged. In either case, the clinician must treat the allegations as true in order to assure safety to the accused juvenile, as well as, vulnerable others. This creates the need for the clinician to negotiation of the "crisis of disclosure" of the sexually abusive behavior by the juvenile and the associated feelings of shame, anger, guilt and depression by the family and particularly the parents; and/or the resistance and distrust of the parents and family regarding their mandate to participate in the evaluation and subsequent therapy (Thomas, 1997). Mandated treatment for their child and themselves often increases the resistance to therapy and distrust toward the clinician and juvenile justice, child protection and mental health systems involved. Parents are
likely to feel they are failures and anticipate the negative judgement of professionals. Addressing these issues in the beginning of family treatment is essential to establishing trust with the parents and family members.

Once the psychosexual evaluation is complete and specific treatment issues relative to the juvenile and the family have been identified, treatment can commence. There are multiple issues common to most of the families with sexually abusive children (Thomas, 1997). Denial, a problem often faced with sexually abusive juveniles and their families, may be partial or total; and may be due to either intentional deception or activation of a psychological defense mechanism. Minimization is partial denial, intended to lessen the seriousness of the abusive behavior. The projection of blame is also a common psychological defense of these families, as it serves to place blame or responsibility on another in order to avoid internal conflict or anxiety.

Another issue that the family needs to deal with may be a lack of empathy for the juvenile's victim(s), especially if they were extra-familial. Given the shame, anger and guilt experienced by family members, it is often extremely difficult for families to acknowledge that the abusive behaviors truly affected the victim negatively. However, even if the victim is a family member there can be difficulties with empathy, as it is easier to believe that
one of the children is a liar, than that one of them has been sexually abusive (Thomas, 1997).

Abuses of power on the part of family members other than the identified juvenile, and the consequent feelings of powerlessness experienced by the recipients of those abuses, are issues integral to confronting the sexually abusive behaviors of the juvenile and vice-versa. Tackling such concerns often leads to the uncovering of intergenerational physical, sexual and emotional abuse, as well as other family secrets. As Thomas (1997) points out, in situations like this, anger, distrust, isolation and depression are part of the family dynamic.

A related issue of concern for families of abusive youth, is the needs and issues of the abusive youth's siblings, even if they have not been directly victimized. Families often try to protect the other siblings, however, siblings typically share the feelings of anger, shame and guilt that the parents and older siblings experience. There may also be divided loyalties, if a sibling has been directly abused, but other siblings have not. The victimized sibling may not want contact with the abusive sibling for a much longer time than the other siblings. The other siblings may be quite resentful and see the victimized sibling as the cause of the abusive sibling's removal.

In families in which there is abuse and dysfunction, there is often the occasion for role confusion between
parents and children, with each taking each other's roles at various times. This may be supporting the juvenile's distorted beliefs regarding his or her feeling deserved of sexual contact, given his or her role as "the little adult of the house." Confusion and misunderstandings about human sexuality are common in the families of abusive youth. This is particularly true due to the incidence of sexual abuse that has occurred in many of these families and the distorted views of sex that this can create.

Family Reunification

For situations in which the juvenile has been out of the home, whether the juvenile is to return home or not, family therapy may address the issues regarding reunification. Among professionals there exists a continuum of opinions regarding whether sexually abusive youth should be reunified with their victims. The appropriateness of such intervention is most often considered on a case by case basis, depending on the situation of each family. Depending on the needs and issues of the juvenile, the victim and the family, reunification may range from full reentry into the family, to partial re-entry, to limited or no contact (Thomas, 1997). It should be noted that this portion of the treatment is not likely to be constructive unless the previously afore mentioned family therapy issues have been successfully addressed.
The process of reunification involves the "systematic restoration of the family relationships within the various subsystems of the family" (Thomas, 1997). It begins with clarification, which takes place between the sexually abusive juvenile and the victim. The juvenile's and victim's therapists are present, and other family members may be, as well. If the victim is not a member of the family or someone who the family knows or has contact with, this step may occur between the abusive juvenile and his or her family. During this step the abusive juvenile takes full responsibility for the abuse and should be able to demonstrate empathy for the victim. The additional goals of this process include resolution and reconstruction, and occur concurrently. The first of these, resolution, occurs as supportive alliances are created in the various subgroups of the family. These alliances are those that support safety, problem-solving, reduce resistance, strengthen the family unit, and prevent relapse and revictimization (Thomas, 1997).

**Parent Groups**

Additional modalities (Thomas, 1997), that may be used to help parents and families gain support and education regarding the issues of their child's sexually abusive behavior, may include: 1). Multifamily Education Groups, which offer an opportunity to address treatment issues such
as those named above, to be discussed and explained in a informative manner that may be less personal and threatening to participants; 2). Parent Support Groups, which offer parents an opportunity to reduce their feelings of alienation and isolation and gain support from other parents who are likely experiencing similar feelings; 3). Multifamily Therapy, which brings multiple families together to address issues of mutual concern. Similar to support groups, they reduce alienation and isolation, however, they also address the familial isolation, rigidity, enmeshment, internal and external stressors, poor coping mechanisms, ineffective communication patterns, lack of closeness and nurturance, powerlessness, feelings of parental failure and disapproval by others for their deficiencies as parents (Thomas, 1997).
In her first review of the early programs, Fay Honey Knopp (1982), found many similarities among the twenty treatment programs that existed nationally at the time. Specifically, the programmatic structure of treatment program tended to increase commensurate with the seriousness of the offense and/or the level of violence expressed during the offense and most all used some combination of family, group and individual modalities. In both residential and community-based programs, a psycho-educational model which taught juveniles sexual education, anger management, empathy, victim issues and social skills, was most commonly used. Various techniques, such as role plays, psychodrama, rational emotive therapy and the use of specific skills (Yochelson & Samenow, 1976) were used to counter thinking errors (Knopp, et. al., 1997).

In a comprehensive 1994 survey of adolescent treatment programs, the Safer Society Foundation asked respondents to define the model of treatment with which their program most closely identifies, from a choice of nine provided in the survey (Freeman-Longo, Bird, Stevenson & Fiske, 1995). Forty one percent (281 providers) of respondents indicated use of a cognitive-behavioral model; thirty six percent (247 providers) identified relapse prevention as the model employed; fourteen percent (94 providers) use a psycho-
educational program design; five percent (37 providers) use a psycho-therapeutic [psychodynamic] model; two percent (16 providers) use a family systems approach; one percent (four providers) each use either a sexual addiction or psychoanalytic approach; point five percent (1 provider) use a strictly behavioral model; and zero percent of juvenile providers indicated use of a biomedical paradigm as their primary method of treatment (Knopp, Freeman-Longo & Lane, 1997).

Program Treatment Standards

The following guidelines (Bengis, 1997), which were later confirmed by the National Task Force on Juvenile Sexual Offending (1988, 1993), were developed by clinicians as a standard by which to treat sexually abusive juveniles: 1). Treatment of sexually abusive youth must be specifically directed at preventing further victimization of innocent members of the community. The promotion of treatment for sexually abusive juveniles is specifically focused on the prevention of further sexually abusive behavior. It is the reason that specialized treatment for sexually abusive persons exists; "that there be no more victims of sexually abusive behavior." It is now realized that in the treatment of habituated behaviors, the insight and education typically received from general therapy, do not always translate into behavioral change. In specialized treatment, specific
cognitive and behavioral interventions are often used in approaches targeted to sexually abusive behaviors and thoughts, that support decisions regarding continued engagement in the behavior. The need for specialized training, diagnostic methods and treatment techniques, reflect the expectation that professionals must be accountable and competent in their work (Ryan, 1998).

2). Legal accountability for sexually abusive behavior is part of an overall treatment approach. Legal accountability and treatment are not mutually exclusive principles. Legal accountability for sexually abusive juveniles as part of an overall treatment approach, is based on the fact that sexually abusive behaviors are accompanied by such strong physiological reinforcers that individuals are not typically motivated to stop engaging in the behaviors until they are compelled by external mandates. The collaboration between the court and the clinical arenas is what characterizes behavioral disorders that violate others, from those that do not. Use of the court's mandate enables increased compliance and involvement in rehabilitative programs, as well as, provision of controls that will reduce access to the reinforcers (e.g., potential victims), of the sexually abusive behaviors. Further, sexually abusive youth rarely seek counseling without external coercion from parents, schools, social services or the courts. Once a juvenile is involved in specialized
treatment, the accountability provided by the court is typically helpful in reducing denial and assuring the juvenile's eventual participation in treatment (Ryan, 1998).

3). Client evaluation must include a diagnostic assessment by a specialist trained to work with sexually abusive youth. Evaluation of juveniles suspected of, or with histories of sexually abusive behavior, should be evaluated by a trained specialist in the area of sexually abusive behavior, is based on the desire to reduce the risk of further sexually abusive behavior to the community. A person with expertise in this area, is best suited to assess the level of risk that the juvenile presents to the community, as well as, the youth's amenability for treatment in a more or less restrictive setting.

4). Treatment in peer groups designed specifically for youth who have been sexually abusive is the treatment of choice. The choice of peer group treatment designed specifically for youth who have been sexually abusive, is based on the multiple benefits provided by use of such a modality. For work with a population that is undersocialized, mired in shame over its engagement in the most socially taboo behavior and resistant to change, no modality could offer more possibilities than treatment in homogeneous peer groups. Groups offer these juveniles the potential for resocialization, connectedness and the experience of support and trust. Groups offer sexually
abusive youth a safe environment in which to discuss their socially taboo behavior, while being challenged by peers - who understand their denial, rationalizations and limited empathy better than anyone - in a constructive manner. Finally, for abusive juveniles to experience each other taking responsibility for their behavior, as well as, confronting their own victimization offers courage and the most effective type of role modeling available for them (Ryan & Lane, 1997).

**Treatment Outcomes**

The specialized goals of treatment for sexually abusive youth, as defined by the National Task Force on Juvenile Sexual Offending (1993) are to: 1). Stop all sexually abusive behavior; 2). Protect members of society from further victimization; 3). Prevent other aggressive or abusive behaviors that the youth may manifest; and 4). Assist the youth in developing more functional relationship skills. Ryan and Lane (1997) declared that these broad goals are expressed in specialized offense-specific treatment, which focuses on the areas related to the sexually abusive behavior and the improved social functioning for each juvenile. The specific goals of the treatment for sexually abusive juveniles include their (Ryan & Lane, 1997):
1). Creating a psychologically and physically safe environment in the treatment setting. Each juvenile is responsible for the psychological and physical safety of the group in terms of the juvenile's actions and statements. The more consistently that juveniles experience themselves as expressing their ideas and feelings in a responsible manner, the more the self-concept of these juveniles will mirror pro-social identities.

2). Operationalizing communication, empathy and accountability. Through the treatment process, specifically in the context of groups, these youth have the opportunity to learn and actualize the experience of healthy communication and expression, even regarding topics that are provocative and sensitive to them. As discussed earlier in this paper, juveniles are able to experience empathy, particularly in group modality, and are expected to increasingly relate to others in a manner consistent with empathic consideration. Whether it be regarding an empathic response or choices they make that put them closer to high risk situations, juveniles are held accountable for both their internal and external processes.

3). Consistent definition of abusive interactions. Juveniles learn the dynamics of abuse and are expected to be able to apply them to the situations in their daily lives. This involves their being able to understand and recognize the various ways in which power differentials may manifest
and their need to be accountable to the ways in which they negotiate situations in which there exist differences in power between themselves and others.

4). Acknowledgment of risk. Juveniles learn that their abusive behaviors are the culmination of coping responses, used to help them in times of stress. In the process of treatment they learn adaptive and pro-social means of coping. A part of this learning is based on awareness and recognition of the situations that place them at higher risk for engaging in abusive behaviors; these situations or triggers, are known as high risk factors. Some of these high risk factors may be avoided (e.g., spending time at playgrounds), and some require use of coping skills (e.g., taking a five minute time-out when angry). Juveniles learn that without consistent use and support of the use of their new coping skills, there is greater potential for them to return to their abusive ways of coping. As such, it is important for these juveniles to be diligent; part of what maintains their diligence is awareness of the potential for re-offense. Acknowledgment of the potential risk is related to not denying that they could re-engage in abusive behavior if they are not accountable.

5). Recognition of the dysfunctional cycles. Juveniles learn about their own patterns, to identify their triggers and the onset of such patterns and dysfunctional cycles. Juveniles are supported and ultimately expected to be
accountable for the choices they make in terms of coping with their patterns.

6). Ability to interrupt the dysfunctional cycle. In learning about their patterns of abusive behavior, juveniles are expected to implement the coping strategies they have identified in order to avoid relapse.

7). Demonstrating changed patterns of functioning. Over time, it is expected that use of pro-social coping skills and the efforts of the juvenile and family to improve their skills of interaction, that the youth will develop more positive identities, and reject those based on the abuse of power.

8). Increased empathy in the treatment setting and in daily life. In treatment, juveniles initially learn of the concept of empathy and specifically about how it relates to their victims. Through the process of treatment, it is expected that youth will expand on this concept of consideration of how their behavior may impact others, in a more general.

The Continuum of Care

In order for these philosophical tenets of specialized treatment of sexually abusive youth to be successfully practiced and effective in their avoidance of further harm to, or the creation of other victims, it is essential for them to be executed consistently throughout a service system
that provides a continuum of care (Bengis, 1986, 1997). A continuum of care with regard to the treatment of sexually abusive youth, consists of the optimal range of treatment services needed in order to allow placement and service delivery to be variably restrictive and treatment to be variably intensive, depending on the level of risk that the individuals present to the community and their progression through treatment.

The most restrictive end of the continuum should provide a locked, secure, specialized treatment facility for adolescents who have committed physically violent sexual assaults and displayed lengthy and highly habituated patterns of sexually abusive behavior. The following levels of care should be less restrictive, with the next tier being unlocked, staff-secure residential treatment units. This level of restrictiveness would be appropriate for youth that have engaged in some amount of violence in their sexual behaviors or have an extensive history of sexual offending behaviors. The next less restrictive step of care should consist of alternative community-based living environments, ranging from group living homes, foster homes, mentoring homes and supervised apartments. Youth residing in these types of situations should be concurrently involved in outpatient groups, day treatment programs, diagnostic centers and services specifically designed to provide specialized treatment to sexually abusive youth (Bengis, 1997).
The continuum of care paradigm advocates that the placement facilities, or at the very least specialized units within those facilities, be exclusively for sexually abusive youth (Bengis, 1997). This recommendation is based on concerns that treatment in mixed populations would necessarily be less intensive and less focused; that sexually abusive clients may present a risk to other youth within the residences; and the higher demands for specialized knowledge of staff working with this population, will require increased training of all staff, if all are working with the population.

Working within the continuum of care and the components outlined above, it is recommended (Bengis 1997) that each youth acquiring services along the continuum consistently receive specialized treatment for sexually abusive juveniles, regardless of the level of restrictiveness or treatment intensity at any particular point. It is also advocated that client-staff-peer relationships be maintained as youth transition from one level of care and restrictiveness to another. This recommendation would allow a client to continue working with the same therapist and peer-group throughout his or her entire time in specialized treatment.

When Knopp conducted her first study in 1982, there were twenty-two programs nationally that offered specialized programming for the treatment of sexually offending youth (Knopp, Freeman-Longo & Lane 1997); in 1986 there were 410
identified programs (Knopp, Rosenberg & Stevenson 1986) and by late 1988 there were 645 specialized programs for sexually abusive adolescents and pre-adolescents (Knopp & Stevenson 1989); and in the 1994 Safer Society Foundation survey of programs there were over 800 programs.

The most recent survey (Knopp, et al., 1997), of identified programs in the United States, shows that services remain unevenly distributed. The eastern North-Central, south Atlantic and Pacific states offer the greatest number of juvenile services, while the eastern South-Central states have the have the fewest available. New York and Ohio offer the highest concentration of all services nationwide and New Mexico and Alabama have the least number of programs serving sexually aggressive adolescents and youth.

In New England, treatment programs exist in every state with the highest concentration in Massachusetts and the lowest concentration in Rhode Island. There exists in each New England state, numbers of private providers who are qualified to provide treatment to sexually abusive youth. However, most private providers offer only individual and family treatment and not group treatment with peers, which is the recommended modality (National Task Force on Juvenile Sexual Offending, 1988, 1993). It is unclear how many of the programs that currently exist actually follow the guidelines outlined in the above discussion of the continuum.
of care. However, given the dearth of services in some states and certain areas of the country, it is unlikely that such a continuum is able to exist in many states.

Conclusion

The continuum of care and the optimal progression of services to most safely and effectively treat sexually abusive youth have been presented. As noted earlier, there are a relative few states that provide a full continuum of services for this population. Treaters of this population use an eclectic variety of techniques and typically do not exclusively follow any particular model. In considering individual programs, the integration of various models may be in part due to the limited amount of outcome research and the absence of controlled and long-term follow-up studies to inform treaters of the specific and/or combinations of models, modalities and techniques that are most effective.

In considering the modalities offered by individual programs, however, the resources available to programs, as well as the resources allocated in the state for the provision of a continuum of services to ensure appropriate treatment and community safety, must also be appraised. One of the realities of working with a population that stimulates the most negative visceral reactions of the public, is that there is little societal or governmental willingness to allocate resources, in the form of money,
Thus in evaluating treatment programs of this nature, one must consider the resources made available to it, both as an individual program, as well as, in the context of the resources available statewide and the policy and treatment gaps the program may be attempting to fill.
Clinic Structure & Organization

The Juveniles Opting for Treatment to Learn Appropriate Behavior (JOTLAB) Program is a part of the Clifford Beers Child Guidance Clinic, located in New Haven, Connecticut. The Clinic was established in 1913 by Clifford Whittingham Beers and was the first child and family community-based mental health clinic in the United States. The clinic is dedicated to the prevention and treatment of mental illness and dysfunction in children and families. The clinic has multiple specialized treatment services, including a crisis service, treatment for families affected by HIV and AIDS, sexual abuse victimization, domestic violence, juvenile offenders, school based clinics and a substance abuse prevention program.

Services provided by the Clinic include comprehensive diagnostic assessment, psychiatric evaluations, psychological testing, pediatric consultation, individual, group and family therapy, psychopharmacological consultation, medication and supervision, and specialized parent training and counseling. Clients include children displaying non-compliant, aggressive or disruptive behaviors, poor academic performance, depression, anxiety, adjustment difficulties and parent-child conflicts, and their families.
Referrals are accepted from schools, residential facilities, hospitals, professionals and parents.

The clinic has multiple programs that address specific needs of the Greater New Haven community, including the Sexual Abuse Treatment Team, Project Hope, CAMPES, and JOTLAB Program. The Sexual Abuse Treatment Team (SATT), consists of a multi-disciplinary team of mental health professionals who treat children and adolescents who have been sexually abused and their families. All of the clinicians of the JOTLAB Program are members of the SATT. Project Hope is a culturally-responsive program for African-American and Latino children and families that have a parent who is HIV-positive or living with AIDS. The aim of Project Hope is to reduce behavioral and emotional problems of these youth, who are reacting to their parents' illness and impending death. CAMPES is a mobile emergency psychiatric service which provides intensive time-limited crisis stabilization services for children deemed to be at imminent risk of injuring themselves or others and are in immediate need of intervention. The Domestic Violence Treatment Team (DVTT) is a multi-disciplinary team of mental health professionals who are sensitive to the needs of children and families that have been physically victimized and/or witnessed domestic violence within their homes and communities.
History of Treatment for Sexually Abusive Juveniles at the Clinic

Community-based programming for sexually abusive youth has been provided at the Clifford Beers Clinic since 1986. The initial program, known as the Alternative Program for Adjudicated Youth (APAY), was initially developed in collaboration with the Juvenile Probation Department of the Superior Court for Juvenile Matters in New Haven, Connecticut. The New Haven Regional Office of the Department of Children and Families (DCF), then the Department for Children and Youth Services (DCYS), funded the program. Juveniles that committed sexually abusive acts for which they were adjudicated, were referred to the APAY Program via the probation department of the New Haven's Juvenile Superior Court. The timing of APAY's development coincided with the increased awareness and concern seen in other areas of the country, regarding juveniles' sexually abusive behaviors, as described in previous sections of this thesis.

From 1986 to June 1994, the APAY Program provided treatment services to males from the ages 13 to 16, who were adjudicated for sexual assault for the first time. The program served no more than eight clients at a time. At that time, all APAY clients lived in the city of New Haven or adjacent towns with their families and were on probation and court ordered to attend the program. APAY employed a positive-youth development model, that consisted of weekly
recreational groups for basketball and weight lifting, a weekly psycho-education group and occasional individual and family therapy. The APAY's activities and therapy took place at a facility that had access to a gym, rather than at the Beers Clinic. There was little or no direct discussion of the adolescents sexually abusive behaviors, and no direct sharing of information between program clinicians and other agencies involved with the youth. The philosophy of the program was based on that of traditional therapy, in which confidentiality between the client (juvenile) and the therapist was strictly observed.

In the Spring of 1994, the two clinicians/co-coordinators of APAY left the Clifford Beers Clinic within two months of each other. The program was subsequently non-functional and out of operation for a period of four months. During the months prior, both the New Haven regional office of DCF and the probation department of the New Haven Superior Juvenile Court, expressed their concerns regarding the deficits that existed in the programming being offered for sexually abusive juveniles in the APAY program. This author was hired as the new coordinator for the APAY program in October 1994, and charged with the responsibility of developing a specialized clinical treatment program for sexually abusive adolescents.
Developmental History of Program

The first task of the author was to do outreach to those clients and families who had been involved with APAY prior to the disruption in service, as well as those juveniles that had been newly referred to the program over those same months. One of the first changes executed by the author was renaming the program from APAY to the Juvenile Offender Treatment (JOT) Program. This change was meant to signify a more direct approach to the treatment and programming. The name purposely did not provide information about the types of offenses committed in order to reduce stigmatization of program participants. An additional change was the operation of the JOT Program from the clinic, rather than another site. This change was made in order to provide the juveniles access to psychiatrist and/or pediatric services.

The parameters of who the JOT Program served also changed, in order to increase access to those in need of specialized treatment services for sexually abusive behaviors. The JOT Program now accepted referrals for adjudicated and non-adjudicated adolescents, and both males and females. The JOT Program restarted with four adjudicated male adolescents who had been receiving treatment in the APAY Program, however, within months referrals for both adjudicated and non-adjudicated youth commenced. Not long into the JOT Program's first year, the program was accepting
referrals for pre-adolescents and cognitively-impaired youth, as well. The JOT Program was now receiving referrals not only from Juvenile Court and DCF, but from public schools, local and surrounding police departments, community social service agencies, and local residential facilities and group homes. Referrals were soon to come from Connecticut youth placed in specialized residential treatment facilities of other states. These youth have received some amount of treatment and were now returning to Connecticut in need of less restrictive services.

The JOT Program took a very different approach from APAY in terms of inter-agency communication and collaboration. Consistent with the relapse prevention model, the JOT Program saw such collaboration and communication as integral to each juvenile's treatment and the safety of the community. The author met with the judges of the Superior Court for Juvenile Matters in New Haven, as well as the probation and the DCF program supervisors of the New Haven regional office. Subsequent to the meetings with these administrators, larger meetings were held with the regional office social workers and the probation officers of the New Haven Superior Court. These meetings were held to increase the agencies' awareness that treatment services for sexually abusive youth were again available in the JOT Program, offering greater accessibility to the various subgroups of this population. The information gathered from
these meetings helped shape the referral and communication process between the JOT Program and these agencies.

Over the first year of the JOT Program's inception, the author became increasingly uncomfortable with the term "offender" in the Program's name. Technically, the term "offender" was a misnomer for some of the youth in the JOT Program, as the word, "offender" is a legal term used to refer to a person convicted of a crime. Given that the JOT Program was also working with non-adjudicated youth, this term was not appropriate. However, a stronger impetus than the legal definition was behind the name change. The stigmatizing effect of the word, "offender" classified the youth in a negative manner, even in the absence of the qualifying word, "sexual."

The more general stigmatization of these youth was evidenced in the labeling done by both the professional and non-professional communities that directly or indirectly interacted with these juveniles in the provision of services to them. The term "sex offender," with all of its negative associations and the objectification that it evokes, was being constantly used as the predominant descriptor for these youth. That was particularly troubling; given the effort that was being put into having these youth take more responsibility for their behavior, negative labeling was counter-productive. As such, the intent in changing the name was to remove the word "offender," while maintaining
the acronym "JOT," which had become familiar to agencies and referral sources over the past year. During a SATT meeting, the author asked the clinicians to brainstorm about the idea and a name for the Program, Juveniles Opting for Treatment to Learn Appropriate Behavior (JOTLAB) was born.

The Provision of Services

In October 1994, the JOTLAB Program began with one group for adolescent males that met twice a week for one and three quarter hours. Within six months, a group for pre-adolescent males, ages 9 to 12, commenced meeting once a week for one and a quarter hours. This was followed by a second group for adolescent males, in April 1995, which also met twice a week for the same length of time. In October 1995, a group for cognitively-impaired adolescent males began to meet once week for one and a half hours. In April 1999, a sufficient number of adolescent girls were in need of treatment services to begin a group for them. While there have been a number of pre-adolescent girls involved in treatment in the JOTLAB Program, there have never been sufficient numbers at any one time to begin a group. Whenever there are not sufficient numbers of youth of a similar age and gender to form a group, they receive individual and family therapy.

In addition to the groups that juveniles attend, they have family sessions at least once or twice a month, and
more often if possible. Juveniles also participate in individual sessions with their primary clinicians on alternate weeks. In the first year of the Program's functioning, parent education/support groups were held twice a month for a period of six months. However, attendance by parents was poor and the limited resources of the JOTLAB Program restricted the amount of outreach that could be done. The parent groups were stopped in order to allocate the author's resources into family therapy, which was better attended by parents.

The first year of the JOTLAB Program, services were provided by the author, a full-time Master's level clinician; and a part-time consultant (6 hours/week), who co-facilitated the first adolescent group and furnished sagacious clinical suggestions and support. Since that time, Program staffing has increased at the rate of approximately one new person per year. Currently there are three Master's level clinicians and one Bachelor level counselor providing treatment services. This year the Program also began training a Doctoral-level psychology (14 hours/week) and a Master's-level social work (4 hour/week) intern to work in the with the juveniles and families in the JOTLAB Program.

In March 1998, the author was promoted from Coordinator to Director of JOTLAB Program. Concurrent with this promotion, was the expansion of the author's
responsibilities, as the Department of Children and Families requested that the JOTLAB Program enlarge its mission to include the training of DCF's clinicians and staff at their state facilities on the evaluation and treatment of sexually abusive juveniles. The author began work in April 1998 as a consultant to DCF's clinical facilities, including Long Lane Reform School, The Connecticut Children's Place (formerly known as the State Receiving Home), which is a short-term diagnostic and treatment facility; and High Meadows, a long-term residential treatment and short-term emergency placement facility.

The author, and occasionally the other Program clinicians, travels to the residential facilities of DCF-involved juveniles, on a daily basis to provide education, regarding all areas of childhood sexuality and development, sexual abuse victimization and sexually abusive behavior. The author also evaluates DCF youth that have received specialized treatment in facilities, both in and out-of-state, to determine when they are ready for transition to community-based treatment. In addition, the author and Program clinicians supply psychosexual evaluations and facilitate pre-treatment groups, as necessary, for the youth residing in DCF facilities, as well as, DCF-involved youth residing in other residential facilities all over the state of Connecticut. The pre-treatment groups were developed for the purpose of providing treatment services to those youth
in need of specialized residential treatment for sexually abusive behavior, who are temporarily residing in the DCF facilities awaiting out-of-state placements. Because there are insufficient resources in Connecticut for youth who present more than a low risk for re-engaging in sexually abusive behavior, these youth often languished in DCF residential facilities until there was an opening in an appropriate facility in another state. Ultimately, these juveniles may need to be placed as close as Springfield, Massachusetts or as far away as South Carolina, in order to get the specialized residential treatment they require.

Despite the diversity and extensive amount of services furnished by the JOTLAB Program to juveniles, the majority of the services provided by the Program, are supplied at the Beers Clinic. At the same time that the author staff traveling around the state as needed to evaluate, treat, testify, train and consult on youth and their situations, juveniles also travel from around the state to receive services from the JOTLAB Program.

**Funding**

Like the Alternative Program for Adjudicated Youth (APAY) from its inception, the JOTLAB Program, has received the majority of its financial support from the Department of Children and Families. However, despite the increased numbers of youth in need of services over the years, the
Program has never received an increase in funds to support its ability to keep pace with the demand. The Program also receives a small amount of financial support from a Community Development Block Grant from the city of New Haven. The addition of the consulting, training and treatment services to the Department of Children & Families residential treatment and detention facilities, increased the amount of money received from DCF for the Program, however this money was to provide new services, not to increase the community-based services the JOTLAB Program was originally charged with developing. In 1998, with the program overflowing, the JOTLAB Program secured a grant from a private foundation, for the purposes of hiring a third full-time clinician.

Demographics of Juveniles & Families Served***

The JOTLAB Program officially serves juveniles and families from the Greater New Haven area. However, as the only comprehensive Program in the state, it also serves juveniles and their families from Bridgeport, Hartford, Meriden, New London, Stamford, Torrington, Waterbury, Willamantic and the communities in between. The numbers of juveniles and families receiving treatment services from the JOTLAB Programs has consistently increased. The first fiscal year of service, the JOTLAB Program provided psychosexual assessment to 18 juveniles and treatment services to 23
juveniles. In the last fiscal year, that of 1998-99, 40 juveniles were evaluated and treatment services provided to 48 youth and their families. All of the statistics provided here refer only to those services provided in DCF or other residential facilities per the contract for consulting, training and treatment services discussed.

The ages and gender of the juveniles receiving services from the JOTLAB Program are heavily dominated by 13 to 18 year old males. This group accounts for 70 percent of the total juveniles served. Pre-adolescent males comprise 20 percent of the youth receiving services and 5 percent of the youth involved in the JOTLAB Program are adolescent males with cognitive impairments. The additional 5 percent encompass the services provided to females, with 4 percent being pre-adolescents and 1 percent being adolescents.

The majority of youth that have been involved in the JOTLAB Program have been juveniles of color with lower socio-economic status. In fact, eighty-three percent of the juveniles and families obtaining treatment in the JOTLAB Program receive state medicaid; while juveniles of minority ethnic groups (60 percent), collectively represent the largest proportion of juveniles and families referred to the Program. Only 13 and 4 percent of the juveniles' and families involved with the Program have been in the moderate to high income range, respectively; and youth of European
descent comprise the remaining 40 percent of juveniles and families receiving treatment in the Program.

The high percentage of medicaid recipients and youth of minority ethnicity referred to a publicly-funded program, such as the JOTLAB Program, is consistent with the higher percentage of the ethnic minority referrals received from the state's child protective services agency, DCF and the Juvenile Court, respectively, the largest referral sources to the Program. The reality of this correlation, is that protective service agencies and the juvenile courts are more frequently involved in the lives of people of ethnic minorities and people with lower socio-economic status. Often, these biases are associated with the institutional and cultural racism and classism inherent in our society. The stereotypes that persist regarding poor people and ethnic minority peoples, are even more pernicious for an indigent person of color, who has engaged in sexually abusive behavior.

The biases and stereotypes are further reinforced by the reality of the ability of higher income families' ability to procure treatment services for their sexually abusive youth from private providers. This permits youth and families of a higher economic status, a larger proportion of whom are of European descent in Connecticut, to avoid both greater awareness of their problems by others, as well as, the associated stigmatization. As an aside, all
of the higher income families that came to the JOTLAB Program, first received services from private providers. When their children re-offended, they then decided to try the Program that had initially been recommended to them.

The JOTLAB Program Treatment Model & Modalities

The primary treatment model used in the JOTLAB Program is that of relapse prevention, with integration of psycho educational and cognitive-behavioral techniques to reduce arousal to inappropriate thoughts and fantasies. Also integrated and emphasized in the treatment is the concept of the abuse cycle. This combination provides a framework within which various behavioral, cognitive, educational and skills training approaches are utilized to teach sexually abusive youth how to recognize and interrupt the chain of events leading to relapse (See Relapse Prevention, p. 33).

From the commencement of specialized treatment for sexually abusive behavior, the juvenile is learning about his or her own sexual abuse cycle or patterns, ways to interrupt that cycle, high risk factors and high risk situations, and methods for coping with lapses in order to avoid relapses. Specifically used cognitive-behavioral techniques are Thought-Stopping, Covert Sensitization and Cognitive Restructuring. There is also on-going attention and thoughtfulness to the victimization of the youth,
integrated into the concentration given to the sexually abusive behaviors and their cessation. Relapse prevention also plans for an external supervisory component in order to reduce the risks of reoffense and the presence of supports for the juvenile. Case management and interagency collaboration are essential to the JOTLAB Program, and include the exchange of information with other providers, DCF and the Juvenile Justice systems.

The use of the modalities of group, family and individual therapy are also integral to the treatment, with particular emphasis placed on the former. Psychopharmacological interventions are also implemented as necessary for the treatment of coexisting conditions, such as depression, anxiety, hyperactivity or attention deficit disorders.

The primary topics of focus of the program serve to educate in the areas in which most sexually abusive youth have deficits, as these areas are seen as integral to the sexually abusive behavior of these juveniles. These topics include victim empathy, sex education, social skills, management of anger and aggression, communication, cognitive distortions, assertiveness training, personal trauma and victimization, the abuse cycle, clarification and apology for the abuse of the victim, pro-social sexuality, frustration tolerance/impulse control, thinking errors, relaxation techniques/stress reduction, and relationship skills.
The JOTLAB Program and Its Function in the Continuum of Care

The continuum of care, which was discussed in detail in Chapter 4, is considered optimal in that it provides both, treatment to its sexually abusive juveniles in progressively more and less restrictive settings as appropriate, while concurrently providing the highest level of safety to the community. The State of Connecticut is in relatively poor shape regarding its establishment of the necessary components for a well functioning continuum of care. The concerns regarding Connecticut's ability to meet the needs of this population relative to the continuum, speak to both a lack of available services along the continuum, as well as access to those services that do exist. The JOTLAB Program has sought to expand its initial programmatic vision in an attempt to provide some of the unavailable services necessary to responsibly treat the population of sexually abusive youth, in the context of the continuum of services.

Currently, there is a locked, secure, 15-bed facility providing specialized treatment services to adolescent males with normative cognitive functioning. Unfortunately, this facility is available only to those males that have been adjudicated as delinquents to Long Lane School, as the community in which the institution is located wanted an assurances of accountability from the state should any of the juveniles escape from the facility. This restriction prohibits accessibility of this program as a treatment
resource for youth who are not adjudicated and their families. These youth end up being referred to out of state treatment facilities, which causes even greater resistance than usual on the part of the juveniles' families. For those families amenable to having their child treated out of state for an extended period, the long distance logistics of such a placement typically prohibit consistent family involvement in the treatment.

There is one unlocked residential facility available in the state. This facility provides specialized treatment to adolescent males with borderline and mildly impaired intellectual functioning. This residential program for male youth with cognitive impairments is not a viable resource for youth or males functioning in the normal cognitive range, and it is unable to meet the demands of the large numbers of juveniles appropriate for the subpopulation it serves. So again, sexually abusive males of this group are placed out of state, in facilities that are even farther away than those of the males in the normal cognitive range, with similar limitations being placed on family involvement.

The JOTLAB Program sought to collaborate with three local residential facilities, one of which is a part of DCF, in order to increase access to this combination of services. The JOTLAB Program proposed to blend its expertise in the area of treatment of sexually abusive youth, with the
residential expertise of these established facilities. Beyond increasing the amount of services available in the state for this population, the rationale for such a suggestion was based on the importance of both familial participation in treatment, and the immediacy of a therapeutic intervention. Obtaining consistent familial participation is an arduous task in itself, without the added logistical rigors of interstate travel to facilities as far as a thousand miles away. Without the availability of local residential treatment, the reality for many of these youth would be months of languishing in interim DCF-related residential facilities, while awaiting out-of-state placement in order to receive the appropriate treatment. Of further concern is the impact of extended periods of time between the committed acts of sexually abusive behavior and the actual evaluation and/or treatment. Prolonged intervals between the abuse and the expectations for accountability do little more than enhance the denial, recalcitrance and resentment of these youth and their families.

Despite the seeming sensibility of the proposal, none of the three residential facilities were interested in formally collaborating with the JOTLAB Program in this way. The private facilities expressed opposition, due to the concerns of their boards of directors and the anticipated opposition of the local communities regarding overt service provision to this population. In spite their resistance,
however, these two residential facilities were willing to provide placement to youth in need of such treatment, as such placements could be arranged with little attention or awareness of local the community. Ultimately, the DCF facility also realized the wisdom of this opportunity and began formal, though unpublicized collaboration in this regard once the DCF-JOTLAB Program contract began in April 1998.

For the past four years with the private facilities and the past two years with the DCF facility, youth in need of residential placement and assessed to be at low to moderate risk of reoffending sexually, have been placed at these three institutions for residential treatment with concurrent treatment received in the JOTLAB Program at the Clinic. In addition to the collaboration that occurs with the staff of these institutions around the individual treatment needs of each youth, it is the concurrent responsibility of the JOTLAB Program staff to educate the residential staff and clinicians of these institutions, to the specialized treatment and supervisory needs of the youth relative to the maintenance of safety for the general population.

Currently, there are no group homes in the state that specifically provide residence and/or treatment to sexually abusive youth. There are however, generic group homes, working with mixed populations of youth, that are willing to offer residence to these youth with the condition that they receive concurrent specialized treatment for their sexually
abusive behaviors. Fortunately, there are two group homes in New Haven that have been willing to collaborate with the JOTLAB Program in the provision of these services. Similar responsibilities exist for the JOTLAB Program staff with regard to educating the residential staff of these facilities about the specialized treatment needs of the youth, as well as their supervisory needs relative to the maintenance of safety for the general population of the residence and the community.

For youth with histories of sexual abusiveness, there are a relative few opportunities for supervised apartments prior to their 18th birthdays. There are also very few foster homes available to adolescents with histories of sexually abusive behaviors. The few foster homes that are willing to take these youth into their homes have variable degrees of involvement in their foster child's specialized treatment and therefore would not be considered optimal, even if they were available. In spite of the potential risks to the community and these youth, the housing resources are so limited that DCF often places them in these foster homes until something better becomes available. To the extent possible, JOTLAB Program staff work with foster parents and seek to engage them as if they were part of the youth's biological family. In the absence of their natural families, foster families sometimes become the family resource for these youth.
Working within the continuum of care and the components outlined above, it is recommended (Bengis 1997), that each youth acquiring services along the continuum consistently receive specialized treatment for sexually abusive juveniles, regardless of the level of restrictiveness or treatment intensity at any particular point. Consistent with the continuum philosophy of providing services to these youth at each transition to a less restrictive setting, the JOTLAB Program also provides treatment services to youth when they return from residential treatment facilities. Some of these youth, having received a period of specialized residential treatment, are now appropriate for community-based treatment in the JOTLAB Program. Many of these youth are placed in either of the two group homes that exist in New Haven.

Currently, the JOTLAB Program is the only specialized treatment program for sexually abusive youth in the state that provides group, family and individual treatment, utilizing a relapse prevention model and providing inter-agency collaboration in the service of providing treatment and maintenance of community safety. The Program provides psychosexual evaluations and treatment to males and females youth of all ages and varying levels of cognitive ability. The Program treats both the juveniles who have engaged in sexually abusive behavior, as well as, their families.
The Referral Process

The JOTLAB Program attempts to reinforce the idea of the juvenile and his or her family being responsible for their role in the treatment at each step. This is critical due to many youth and families being mandated to attend the JOTLAB Program by either Juvenile Court or DCF. With this mandate, many juveniles and families come to believe that it is the JOTLAB Program that is "making them come," rather than the problems with their child and in their families. As such, from the time that a referral for a psychosexual evaluation is made, the parent/caretaker and juvenile are encouraged to take responsibility for their behavior regarding both, their appointments for the evaluation and the behaviors that made the evaluation necessary.

Most often, the person calling to make the referral is either a regional office social worker (ROSW), from the Department of Children and Families (DCF), a probation officer from the Department of Juvenile Probation, a parole officer from Parole Service of Long Lane School or personnel from the Superior Court for Juvenile Matters (SCJM). If a parent is involved with the juvenile regardless of which of these offices makes the referral, JOTLAB Program staff request that the person calling have the parent call to make the referral, as this serves to reinforce for both the parent and the juvenile, that the evaluation and any
subsequent treatment is in large part the parents' /
caretakers' and the juvenile's responsibility.

Program staff are also requested to evaluate juveniles
in detention or while they are incarcerated. In these
instances, JOTLAB Program staff still encourage the
involvement of parents/caretakers or the adult to whom the
juvenile is most attached, to be present. If a juvenile is
legally committed to DCF, Long Lane School or is on
probation, the ROSW, the parole officer or the probation
officer's attendance is needed at least for the first
session of the evaluation. In the case of a juvenile who is
committed to DCF, the presence of the ROSW is necessary even
if the parent is present, due to DCF's legal guardianship.
However, the presence of the ROSW, and/or the parole or
probation officer, also serves to present a united front to
the juvenile and the parent(s). This is significant in
reducing the amount of inconsistent information between the
parties involved and enjoining the participation of
the parents.

The JOTLAB Program staff collaborate with other
agencies and treatment providers in order to afford the
necessary supports to the juvenile and family, while
maintaining the safety of the community. Common
collaboration and planning regularly occur with DCF, parole
and probation officers, school personnel, public defenders
and various community service providers.
The JOTLAB Program psychosexual evaluation typically takes six and eight face to face clinical hours to complete and usually occurs over the course of as many weeks, with one session occurring per week. Depending on the urgency of the particular situation with regard to residence, supervision and estimated risk to the community, multiple sessions may be scheduled in a week in order to reduce the expanse of time necessary to complete the assessment. Emergency risk assessments may also be provided in order to facilitate immediate placement if necessary.

Prior to attending the intake session, parents/caretakers or the legal guardian have completed a Developmental History Questionnaire and a Parent Report - Child Behavior Checklist (PCBC) (Auchenbach, 1983) regarding the juvenile; a Teacher Report - Child Behavior Checklist (TCBC) (Auchenbach, 1993) is also sent to the juvenile's teachers as a part of the clinic's pre-treatment child information packet. The information from these questionnaires is also used in the evaluation.

The first session of the evaluation begins with an explanation of the JOTLAB Program, the evaluation process, confidentiality and its limits, and the fact that the evaluator is a mandated reporter. This first session is quite significant in that it informs the juvenile and his or her legal guardians of the limited parameters of
confidentiality and of the concept of the community's safety, as being the primary client and responsibility of the evaluator.

The guardian(s) and the juvenile are informed that an evaluative report, including recommendations regarding the juvenile's treatment, level of supervision and risk of reoffense, will be written upon completion of the assessment and provided to those who made the original referral (e.g., DCF, Juvenile Court, Juvenile Probation, Parole Services). The guardians and the juvenile then sign a form indicating that the limits of confidentiality and releases of information have been explained to them. Releases of information are then obtained from the legal guardian, which allow the evaluator both to acquire information from other sources that will assist in the assessment, as well as, to share it with necessary parties.

The evaluation process then consists of the completion of two assessment tools by the juvenile and three assessment tools by the parent or guardian. The first tool used with juveniles, the JOTLAB Program Juvenile Intake Form, is employed in the context of face to face interviews over a series of three to five contacts. It consists of inquiries that seek to gather information about various subjects regarding the juvenile's life experience, perceptions and sexually abusive behavior. The specific content areas of the JOTLAB Comprehensive Intake Form and the order in which
they are asked, was designed with the intention of requesting the least threatening information first, in an effort to establish rapport, as well as a record of honest disclosure by the juvenile to the evaluator. The use of these various tools seeks to obtain the relevant information outlined in Chapter 3, regarding the assessment of sexually abusive juveniles.

Following this final evaluative session, recommendations and/or a comprehensive report are written and sent to the referring agent, either the DCF regional office social worker, the probation or parole officer, or the referring clinician. Often only recommendations are initially written and sent out, due to the time that it takes to complete a written report. Access to the recommendations permit DCF or the Juvenile Court to move forward with the process of either placing the youth in an appropriate treatment interim facility.

Commencement of Treatment

Once a juvenile has been determined to be appropriate for community-based treatment, she or he begins the treatment process as soon as possible. During these initial treatment sessions, the juvenile and parents/caretakers are introduced to the JOTLAB Program Treatment Goals, which are consistent with the goals outlined in Chapter 4, the format of the group treatment and the primary psycho-educational
tools that will be used in treatment. The treatment goals are reviewed with the juveniles and their parents or caretakers. It is explained that accomplishment of the goals is necessary in order for the juvenile to complete at least the group portion of treatment. Juveniles are also given a treatment workbook, the sections of which are reviewed with both the youth and their parents. Parents and juveniles are also informed of the time schedule for family, individual and group appointments. Parents or caretakers are also informed of the format in which juvenile treatment groups proceed and the expectation for juveniles to make their treatment a priority. The treatment contract is reviewed and signed by the juvenile, the parents or caretakers and the clinician.

**Learning Resources**

The JOTLAB Program utilizes various resources to work with the diverse needs of the sub-populations served within the program. For adolescents, both male and female, the Pathways Workbook for Youth in Treatment (Kahn, 1993), serves as the primary resource in the treatment of adolescent males and females. This resource provides exercises that assist youth in meeting and The Relapse Prevention Workbook (Steen, 1999), serves as a secondary resource. Certain exercises in the Pathways Workbook are modified for use with the pre-adolescent clients, as well as
those with cognitive deficits. However, the primary resources for the pre-adolescent youth are the workbook, STOP! Just For Kids: For Kids with Sexual Touching Problems (Allred & Burns, 1997), Steps to Healthy Touching (MacFarlane & Cunningham, 1996) and When Children Abuse: Group Treatment Strategies (Cunningham & McFarland, 1998).

The workbook, Streetwise to Sex-wise: Sexuality Education for High-Risk Youth (Brown, 1993), is used as the primary resource for exercises regarding sex education for both the adolescents and pre-adolescent clients. Specific resources for clients with cognitive deficits include the use of the STOP Workbook, which is modified for use with this population regarding sexually abusive behaviors. The Circles Program is used for teaching these clients about appropriate boundaries and touch; and the Life Horizons Series slide series and modified exercises from Streetwise to Sex-wise are used for teaching sex education.

Videos are also used in treatment occasionally. Videos regarding sexual abuse, and the perspectives of victims are used for the purpose of enhancing juveniles' empathy, as well as fostering discussion. The use of videos of adults in treatment for sexually abusive behavior are also used as tools for discussion and empathy, as well as the role-modeling of disclosure and other treatment objectives.
JOTLAB Program Group Treatment

The JOTLAB Program groups are on-going and have open-membership, meaning that new group members enter a group at differing points in a group's progress and development; as well, those who have participated in a group for a period of time, may leave at various points in the group's progress and development. Group members are apprized in advance of the anticipated entry and planned departure of group members. The groups are led by two clinicians and there is constant striving to maintain diversity among the clinicians in any one group. As such, the co-therapist pairings are always considered in terms of the diversity they will offer the members. Male and female co-therapists are typically recommended for these groups in order to allow juveniles the experience of constructive and non-abusive interactions between women and men.

Similar to the limited experience of healthy interactions between males and females for the juveniles, are the oftentimes limited experiences of healthy interactions between different ethnic groups and the stereotyped ideas they have regarding people of different ethnicities. In order to offer more opportunity for youth to broaden their perspectives, as well as to address concerns directly within the group, pairings are also chosen to provide ethnic and cultural diversity. The Program is equally committed to
having staff be ethnically representative of the clients it serves.

**Family Treatment**

Family Therapy is a significant aspect of the JOTLAB Program treatment for those parents who choose to participate. Treatment initially focuses on parents' feelings of being failures and the sense of shame that they feel about themselves and their child. Issues of an absence of empathy for the victim are also typically present. Typically parents or caretakers have no idea as to what may have caused the youth to be sexually abusive. If the family is willing to engage, increased sharing of information regarding the family's dynamics leads to some understanding of what led up to the youth's abusive behavior.

Sometimes youth are acting out parental discord and dysfunction, and trying to get their attention. Sometimes the youth is functioning more as a provider to the younger siblings than the parents, and feels entitled to engage in the sexual behaviors, given all he or she was doing for the younger child. In other instances, the older child felt resentful for having to babysit the younger siblings and expressed his anger by abusing the them. In a similar situation, a teenage girl molested the neighborhood children she babysat for due to that same anger and resentment. In all of these situations, the dynamics are not as simplistic
as they are presented here, but involve an uncovering of the

dynamics that have built up over time.

Over the course of treatment, family sessions are also
used to provide support and encouragement to the youth
regarding their treatment and taking responsibility for
their behavior. This is especially true with regard to
relapse prevention and the parents’ roles as external
monitors of the juvenile after treatment. It is in the
final phases of treatment and following formal treatment
that relapse prevention is most important. The abusive
youth’s family or caretakers are an important part of the
youth’s support and prevention team. Based on this premise
that the potential for a youth to reoffend exists even upon
successful completion of treatment, relapse prevention must
be applied by both the individual and his or her family if
it is to be successful.

Unfortunately for many of the youth in treatment,
parents avoid confronting the issues and are unwilling to
consistently be involved in the treatment process. This is
most often due to the denial, shame and guilt the parents
feel regarding their child’s behavior. Parents often feel
they are failures and anticipate the negative judgement of
professionals and rather than engaging, either take a reca-
lcitrant stance that their child could not have committed a
sexual offense, or abandon the child due to their abusive
behaviors. Parents may also feel divided loyalty regarding
the support of the abusing child versus the victimized child. In many instances of such situations, parents do choose an extreme position either blaming the victim for the abuse or completely rejecting the abuser. A situation that is not uncommon, is that of a blended family, in which an older biological child of one parent, molests the younger child of the parent and the new spouse. In such situations the parent most often chooses to support the new spouse and victimized child, virtually or literally abandoning the perpetrating biological child. Frequently, here is little or no willingness on the part of the parent to explore the dynamics that led to the older child's abusiveness.

**Individual Treatment**

Individual treatment typically occurs once every two weeks for all youth in the Program. These sessions may be used to clarify the youth's progress in group or to clarify the treatment issues the youth is currently addressing. Individual sessions may also be used to explore new concerns of the youth or clinician regarding the youth's behavior. This time may also be used to discuss issues that have been revealed in family therapy.
SUMMARY

In light of the many service and treatment gaps in Connecticut, the JOTLAB Program has had to direct the Program to reduction of the gaps in the state's continuum of care and the reality of the limited tertiary prevention services for sexually abusive juveniles in Connecticut. The Program is engaged in the provision of evaluation and treatment services on almost every level of the continuum on a daily basis. The state's under funding of services at every level of care, has and will continue to put undue pressure on the Program to respond effectively and creatively, in attempting to meet the treatment needs of this population and the safety needs of those around them.

As the only publicly-funded, community-based treatment program in Connecticut, the JOTLAB Program can barely keep up with the weekly number of referrals it receives in contrast to its staffing resources. The more comprehensive the Program becomes the more overextended it is. Referring these youth to qualified private providers was not a viable option, as few private providers accept state Medicaid. There is great opposition received from Medicaid managed health care in response to requests for intensive treatment that requires two to four sessions per week for more than a year's time. The placement of juveniles with histories of sexually abusive behaviors in community settings without adequately trained staff raises issues regarding safety.
Yet without other in-state residential options, these youth cannot be denied access to treatment.

**Policy Recommendations**

The JOTLAB Program exists amid the political and social incongruence consistent with the disparity of wealth and poverty present in Connecticut. The perception that sexual abusiveness by juveniles is predominantly a problem of the poor and ethnic minorities, reduces the investment in resources that would make society safer. Yet, while the needs and the resources to deal with this problem exist, society's discomfort with the topic of sexuality and the reality of developing services for a marginalized population, combine to deny the issue political recognition. The following policy recommendations are offered in order to address the problem of sexually abusive behavior at the tertiary, secondary and primary levels of prevention.

Having reviewed the various deficits of tertiary prevention in the state of Connecticut's continuum of care, the recommendations are multiple. Successful change will include increased availability of services, greater collaboration by and support by the judicial system of clinical recommendations by qualified professionals, as well as by health care management systems. The recommendations include:
Establishment of specialized residential treatment units exclusively for sexually abusive juveniles, to be located at DCF's existing residential facilities, as well as at an existing private residential facility in both the eastern and western areas of the state. The receipt of any amount of public money by private facilities should be contingent on their willingness to provide these specialized treatment services. There will need to be separate units for juveniles with normative and impaired cognitive capacities. The clinical and residential staff working in these units would be specially trained to work with sexually abusive juveniles and would have the capacity to safely supervise and treat adolescents and pre-adolescents.

Establishment of specialized community-based treatment programs exclusively for sexually abusive juveniles, to be located at already existing public and private clinics in various areas in the state. These programs should be established at both publically- and privately-funded facilities in all of the various regions in the state. The receipt of any amount of public money by private facilities should be contingent on their willingness to provide these specialized treatment services. All clinical staff involved in the
provision of treatment services to sexually abusive juveniles will be specially trained.

Establishment of specialized group homes, exclusively for the residential placement of sexually abusive youth who are either moving to less restrictive treatment environments (i.e., specialized residential facilities); or who are appropriate for community-based treatment, but who cannot live with their biological families or caretakers while participating in treatment. All residential staff of these group homes will be specially trained. All group home residents will be required to concurrently participate in a specialized community-based treatment program for their sexually abusive behavior.

Homes consisting of at least two adults, both of whom are willing to receive specialized training regarding the needs of sexually abusive juveniles and regularly participate in the treatment of these youth, should be enlisted to provide Intensive Foster Parenting services to these youth as they move toward less restrictive services. After the initial training, these adults will need to participate in intermittent on-going training, as well as the family treatment of the juveniles residing with them. The state could pay
these Intensive Foster Parents a higher rate than normal for the extra time and energy investments they would need to make to the youth.

- Health Management Organizations (HMO) that contract with the state to provide services to recipients of Medicaid should be required to provide a minimum of 18 consecutive months of outpatient treatment services, at the rate of at least two sessions per week, to juveniles receiving specialized treatment for sexually abusive behaviors by qualified providers. Once HMOs contract to provide services they should then receive training regarding the issues and difficulties inherent with treating this population and the need for long term and intensive services. If the HMO is not willing to provide such services, they should not be allowed to contract with the state. HMOs should also be required to provide additional remuneration for the case management services provided to this population.

- The parents/caretakers of sexually abusive juveniles should receive the same mandate as their children with regard to participation in treatment. If the parents and or juveniles do not comply with the conditions of their adjudication, both should be held accountable and expected to answer to the court.
• All juveniles adjudicated for sexually abusive behavior(s) should be mandated to receive psychosexual assessments by qualified clinical specialists prior to court disposition of their cases. Dispositions should then mandate the recommendations of the evaluation regarding participation in specialized treatment, length of treatment periods and removal of juveniles from their homes during and after and treatment.

• All juveniles and their parents/caretakers should be required to receive their treatment through a specialized programs that utilize the modalities of group, family, individual and parent groups. Program providers must work collaboratively with probation/parole officers and other service providers. The programs may be publicly or privately funded, but must consist of all of the modalities.

Secondary prevention, that is the provision of services to juveniles who are at high risk of engagement in sexually abusive behavior(s), must also be addressed in order to eradicate sexual abuse. Recommendations at this level include:

• Training for all human service professionals from social workers to law enforcement to health care to
those in the legal system, regarding the dynamics of sexually abusive behavior and normative childhood sexuality. This training should include information regarding the experience of victims of sexual abuse as well as the dynamics that are inherent in and prohibitive of disclosure by victims. Trainings should include information about the steps to follow upon identification. These trainings should be required at the time of initial hire for all employees in the above fields and intermittently reviewed. This information could be included in the sexual harassment trainings now offered in many workplaces.

• Groups should be offered to all youth currently in the custody of protective services and/or juvenile justice. Presumably, juveniles involved with these agencies have been exposed to situations of abuse, neglect or vicarious victimization (e.g., witnesses of domestic and/or community violence), thereby putting them at greater risk for engagement in abusive behaviors with others. Juveniles either in residential facilities, detention centers or detainment facilities (e.g., Long Lane School) should participate in same sex groups that involve education and discussion of sexually abusive behaviors and the dynamics of such abuse. These groups should also provide information about normative
sexuality in childhood and adolescence; and would be excellent forums for discussions of safe sex and alternatives to penetrative sex. In addition to sexual behavior, these groups should promote discussion of relationships and their healthy and abusive elements. Having successfully participated in such groups, youth should then participate in co-ed groups which will enable them to hear the perspectives of the other gender and gender roles. Optimally this will not only enhance their understanding, and communication regarding these issues, but their empathy for the issues of each gender, as well. Given the representation of ethnic minorities in the protective service and juvenile justice systems, awareness and discussion of cultural norms and differences in gender roles should also be discussed in the groups.

Establishment of a Sex Information Hotline to be staffed by persons educated in the areas of normative childhood and adult sexuality, the dynamics of sexually abusive behavior and sexual abuse, safe sex and alternatives to penetrative sex, and sexual reproduction and birth control. The Hotline could provide information on these areas, as well as referrals to qualified professionals for assessment and/or treatment of identified areas of concern. The
Hotline would be for use by both public and professional callers interested in information about sex.

Primary prevention seeks to increase knowledge regarding the risk factors and risks associated with sexually abusive behavior by providing information regarding the issues. Implementation of a primary prevention approach uses the broadest methods in order to reach the greatest number of people. Recommendations for primary prevention include:

- Dissemination of knowledge and information regarding normative childhood sexuality and the dynamics of abusive sexual behavior are the key to widespread reduction of sexual victimization. Classes and discussion of such issues could be most easily accomplished by integrating them into already existing forums that presuppose child reproduction, such as Premarriage or Lamasse classes. Such classes should provide for same sex and then inter-gender discussion of normative and abusive sexuality, as well as sexual attitudes and the emotional and relational aspects of sexuality. Use of public service announcements (PSA's) on television, such as the current "FYI" PSAs about drugs and smoking, could also be an effective way to
provide important sound bites of information and numbers to call for further information.

- Special efforts need to be made to ensure dissemination of information to all groups that may not be reached by mainstream media, such as ethnic minorities and lower socioeconomic groups. Outreach to churches and community centers may be effective means of providing information to these populations. Churches are likely to be relatively conservative regarding discussion of normative sexuality, and such topics will likely need to be broached via the concerns that exist about sexually abusive behaviors. Of equal concern is reaching populations that do not believe that these issues are of concern to them; for instance, those that can afford to bury them in private psychotherapy.

- The "Sexual Education" classes taught in high schools need to expand beyond the scope of the physiological aspects of reproduction. These classes need to include information about normative childhood sexuality, both homosexual and heterosexual and the various reasons why people engage in sexual behavior(s), including the emotional and relational aspects of sexuality. Juveniles also need to be taught the dynamics of sexually abusive behaviors, as well as the dynamics of
healthy and abusive relationships. These classes should inform adolescents about birth control, safe sex and alternatives to penetrative sex. A part of sex education should include same sex groups for discussion of relationships and their healthy and abusive elements, including sexual relationships and the pressures experienced by members, based on gender. Having successfully participated in such groups, youth should then participate in co-ed groups which will enable them to hear the perspectives of the other gender and the pressures of their gender roles. Optimally this will not only enhance their understanding, and communication regarding these issues, but their empathy for the issues of each gender. Awareness and discussion of cultural norms and differences in gender roles should also be discussed in these groups.

- In Middle School, “Sex Education” classes should teach juveniles about reproductive physiology and the normative changes of puberty, as well as normative sexuality for their ages, both homosexual and heterosexual. The dynamics of sexually abusive behaviors and the healthy and abusive elements of relationships should also be taught. Same sex and then co-ed groups should be a part of this teaching in order
to facilitate greater understanding and communication between genders.

- In Elementary School children should learn about the dynamics of sexually abusive behavior and the healthy and abusive elements of relationships.

- Given that teachers are affected by society’s reluctance to discuss the sexual issues outlined in the above recommendations, it is likely that specialists in the area of sexual behavior and abuse dynamics will need to work with teachers in teaching about these areas and facilitating the groups. Parallel groups for parents should also be facilitated in order to inform them of the material being taught to their children, as well as to increase their awareness of the information. Subsequent to the parallel groups, parent-child groups should be implemented to review material and increase sharing of perspectives.

This society deals relatively poorly with sexuality, as compared with other industrialized nations. The explicitness of media portrayals of sex vies with the cultural conservatism with regard to sex education and information and access to methods for sexual risk reduction.
This ambivalence toward public discussion of sexuality has become more prominent as the risks associated with sexuality have increased. We are now aware that sex can kill and contribute to significant morbidity. Yet there continues to be reluctance to convey clear information to our most vulnerable population; our youth. The need for discussion regarding sexuality is essential to successfully addressing the concerns that sexuality presents for each of society’s members. From the topics of sexual abusiveness to the threat of AIDS and other sexually transmitted diseases, prevention will not be most efficaciously practiced until there is discussion of normative sexuality in the context of these issues. Adults, particularly parents and professionals, must take responsibility for normalizing the discussion and learning about sexuality among themselves. Once begun, it will be easier to focus no the ways in which information regarding the hazards related to sexuality can be made available to the general public and particularly to juveniles. The risks are too great to wait.
References


