

Clinical Practice Guideline for Intervention with Adolescents with Sexualized Behavior Problems

1. Overview

Problematic sexualized behaviors in adolescents (ages 12-17) can be defined as behaviors involving sexual actions that are developmentally inappropriate and may cause harm to others. These sexual behaviors may be based on coercive, intrusive, or abusive actions toward another person. Adolescents with problematic sexualized behaviors may violate the rights of others based on what appears to be sexually motivated desires or impulses. This behavior may or may not be motivated by sexual desires. Sexualized behaviors resulting in police involvement or criminal charges may include lewd conduct (e.g., public nudity or masturbation), incest, molestation, sexual assault, or rape.

Adolescents with sexual behavior problems are at times referred to as juvenile sex offenders in clinical settings; however, the term **“sex offender” is a legal term** and should only be used in reference to an adolescent who has been convicted of a sex crime. In instances where youth engage other children or adolescents in sexual activity, it is the responsibility of professionals working with the youth and their families to determine whether the behavior is normative, or whether intervention by social services, police, and/or clinicians is warranted. The purpose of the clinical practice guideline is to offer guiding principles informed by best practice when evaluating and treating adolescents with sexual behavior concerns.

Youth with Problematic Sexualized Behaviors

There are currently no population-based figures available on the incidence and prevalence of sexual behavior problems in youth (Association for the Treatment of Sexual Abusers - ATSA, 2008), but the literature assists clinicians with recognizing tendencies for the population. Young people who display problematic sexualized behaviors are a heterogeneous group who may otherwise engage in ways that are typical for their age. This group tends to have similar early experiences when compared with juvenile sex offenders which causes concern about a potential risk for engaging in behavior which may constitute an offense (Letourneau, Schoenwald, & Sheidow, 2004; Bauman, 2002). Youth with problematic sexualized behaviors tend to have:

- Histories of sexual victimization and/or exposure (e.g., witness to sexual behavior among family members); youth may be described as sexually reactive
- Comorbid internalizing and externalizing behavior problems

Not all youth who engage in sexualized behaviors require a sex offender evaluation. Some concerns can be addressed by a child and family therapist on an outpatient basis. Research supports the use of short-term therapeutic interventions emphasizing caregiver involvement such as Multisystemic Therapy (MST). A clinician familiar with child development and sexualized behavior problems in youth can assist a parent or guardian with knowing when to make a referral for a sex offender specific evaluation (SOSE) which requires a specialist. The SOSE

provides information about the juvenile's risk for re-offending and other specific recommendations for treatment and supervision.

Juvenile Sex Offenders

Youth who have engaged in sexual offending behavior are a less heterogeneous group than youth with sexual behavior problems, but there is currently no profile for the population (Letourneau et.al, 2004). While the information available on juvenile sex offenders is limited (in comparison to the adult population), research in the area has grown and we know more about rates and treatment than in previous years.

- Juvenile sex offenders tend to have similar family factors (e.g., histories of physical abuse, family disruptions, harsh/inconsistent discipline, low parental monitoring/supervision)
- Delinquent youth may have deviant peer associations and significant school problems; however, there are youth who commit sexual offenses who may not present with these issues
- Younger ages of offending are associated with higher risk of re-offending
- Adolescent males tend to be identified more than adolescent females with problematic sexual behaviors; however, females are being increasingly identified according to arrest records
- Approximately 8-9% youth report experiencing sexual victimization—a factor associated with higher risk of re-offending
- Based on reported crimes, sexual recidivism rates range from 7-13% of juvenile sexual offenders; recidivism rates are much lower for youth than for adult sexual offenders, emphasizing the importance of early intervention

Research on offender subtypes reveals multiple pathways and presentations for juvenile sex offenders (Letourneau et.al, 2004). Youthful offenders may have different motivations, needs, personalities, skill levels, and causes for their behavior (Bauman, 2002). Considering this, it is imperative for evaluators and clinicians working with the population to obtain information about the incident resulting in a sexual offense and characteristics of the juvenile when making clinical determinations and planning treatment.

Individual characteristics of the juvenile (ex. antisocial, isolated, impulsive, reserved, socially charming, aggressive, peer-influenced, or has experienced abuse or trauma) may provide insights regarding tendencies and potential risks. For example, one study of typologies found offenders identified as antisocial/impulsive tend to have experienced more physical abuse than other types and are more likely to have had criminal charges. Understanding the pathways leading to the sex offender's behavior, highlighted by the self-regulation model for treatment (ex. Avoidant-passive, avoidant-active, approach-automatic, and approach-explicit), is also advantageous as it allows practitioners to tailor their management approaches more effectively. Therapy and supervision needs may differ depending on the characteristics of the offender. While research on typologies is well-documented, it should be noted that the ATSA cautions use of distinct typologies due to potential overlap between sub-types (ATSA, 2008). For more

information on the theories related to specific types of juvenile sex offenders, refer to the article referenced by Sheri Bauman Ph.D. (2002) and the resources of the Center for Sex Offender Management (CSOM, U.S. Department of Justice).

Adolescents seen in clinical settings for sexual behavioral issues may demonstrate symptoms of attachment deficits which might present as disruptive behavioral problems during childhood. Attachment concerns may be evidenced by delinquency, aggression/violence, impaired empathy, and social/interpersonal skill development. As previously noted, these youth may have histories reflecting family dysfunction, harsh or inconsistent discipline, sexual abuse and/or exposure to sexual content, and/or abandonment. They may have cognitive limitations and/or academic difficulties. Many have co-occurring diagnoses such as Oppositional Defiant Disorder, Conduct Disorder, Victim of Physical/Sexual Abuse, ADHD PTSD, Substance Use Disorders, Borderline Intellectual Functioning and Learning Disorders. Treatment for juvenile sex offenders should reflect a balance between corrections and mental health intervention involving caregiver involvement and collaboration with related systems. Supervision and treatment completion are vital factors for reducing risk among youth with sexualized behavior problems.

It is critical that adolescents receive early diagnoses and complete treatment for sexualized behaviors to reduce the likelihood of a future offense. Factors including young age at first offense, personal experience of sexual victimization, impulsivity, access to and interaction with younger children, and short duration/incomplete treatment are associated with higher risk of re-offending. There is a high risk of non-sexual offense recidivism in this population. The ability to predict the risk of sexual re-offending is reduced in the adolescent population due to limitations of the available assessment tools. There is currently no actuarial (actuarial: statistical calculation of risk) risk assessment tool for adolescents; however, skilled clinicians can make informed determinations of risk using their clinical judgment and/or empirically-guided approaches informed by behaviors and characteristics of youth at risk for sexual re-offending.

2. Assessment

A multidisciplinary assessment is necessary when diagnosing youth. Youth are best understood in the context of their family, cultural, and social environments, family dynamics, and social settings such as school, community and peers (AACAP, 1999). A clinician familiar with child development and sexualized behavior problems in youth can assist a parent or guardian with knowing when to make a referral for a sex offender specific evaluation (SOSE) which requires a specialist. The SOSE provides information about the youth's risk for re-offending and other specific recommendations for treatment and supervision.

When to Refer: The National Child Traumatic Stress Network (NCTSN) and National Center on the Sexual Behavior of Youth (NCSBY) collaborated on parent/caregiver-friendly information regarding normative sexual development/behavior in children which can also be of benefit to clinicians. The NCTSN/NCSBY document, *Sexual Development and Behavior in Children*, outlines common sexual behavior in young children (age 4 and younger) through age 12. The NCTSN/NCSBY also produced a document on *Understanding and Coping with Sexual Behavior Problems in Children*, which highlights specific examples of behaviors posing a clinical concern. ***Please refer to the related resources list for links to both of these documents.***

Clinicians are cautioned to consider the guiding information while applying good clinical judgment in determining when a clinical concern may be present. In instances when a youth's behavior extends beyond normative sexual development and behavior (per guidance documentation such as the literature provided by the NCTSN and NCSBY, or per clinical judgment), a clinician should refer the youth to a clinician capable of completing psychosexual risk assessments. It should be noted that there are instances when a specialist may complete an

initial screening and determine that further assessment in their clinic is not indicated for the youth referred. In those instances, it would be recommended that the referring clinician maintain the specialist's feedback in their client's clinical record along with a copy of the consent to release information form (signed by the legal guardian).

Evaluators faces challenges when assessing juvenile sex offenders. There are no currently approved tools to statistically **predict** risk for adolescents; however, there are tools that assist evaluators in making an informed determination about the **presumed level of risk** based on the juvenile's history and characteristics. Professionals are encouraged to use clinical interviews, extensive record reviews, and empirically-guided approaches that include structured scales or checklists to rate the presence or absence of risk factors associated with recidivism. Parents and collateral contacts can supply information to the evaluator to assist with case conceptualization, diagnosis, and treatment planning. For more information on challenges with juvenile sex offender assessment, please refer to the references from the Center for Sex Offender Management (CSOM, U.S. Department of Justice).

Below are available **empirically-guided assessment tools** for adolescents:

- Adolescent Sexual Interest Card Sort
- Multiphasic Sex Inventory Adolescent Version
- Child Sexual Behavior Inventory
- Estimate of Risk of Adolescent Sexual Offense Recidivism Version 2.0 (ERASOR)
- Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II)
- Juvenile Sexual Offense Recidivism Risk Assessment Tool-II (JSORRAT-II)

The purpose of the assessment is to assess level of risk (for re-offending), amenability to treatment, assessing for appropriate level of care, and to establish treatment goals (AACAP, 1999). During the evaluation process the youth is informed about the limits of professional confidentiality. Clinicians involved with these evaluations are trained to explore concerns in a manner to obtain critical information which may be used support the clinical treatment juvenile with recognition that the documentation is subject to review by the courts.

3. Treatment

Adolescents with sexual behavior problems respond to short-term treatment that includes caregivers (Letourneau, Schoenwald, & Sheidow, 2004). While prevention efforts in reducing abuse/sexual victimization are widely endorsed, early treatment should be strongly promoted given the detrimental effects of untreated sexual abuse. Treatment programs should be selected based on the juvenile's individual need rather than a "one-size fits all" approach (Bauman, 2002). It should be reiterated that not all youth who engage in sexualized behaviors require sex offender evaluation or treatment. Some concerns can be addressed by a child and family therapist on an outpatient basis.

Nationally, juvenile sex offender programs have grown from approximately 350 (1986) to over 900 treatment programs according to the Safer Society Foundation (SSF). The SSF reviews current practice and trends in comparison with best practice in the field using data obtained through a survey of treatment programs for individuals who have sexually abused others. As of 2009, there have been a total of 9 surveys. According to the 2009 Survey (Safer Society Foundation; McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010), juvenile sex offender treatment programs following best practice for the population:

- Use evidence-based models of change

- Use trained staff
- Collaborate with related stakeholders (ex. probation and parole officers, social services) to coordinate services
- Adhere to risk, need, and responsivity principles
 - Risk principle – programs match the intensity of services to the youth’s risk level
 - Need principle – programs focus on problems directly linked to offending behavior for the youth in treatment
 - Responsivity principle – programs use effective methods such as cognitive-behavioral and skills-based interventions matched to the learning style of the youth in treatment
- Provide aftercare services
- Monitor and evaluate their effectiveness and are committed to quality improvement on a continual basis

Evidence-based treatment for juveniles includes: Wraparound Services, Cognitive-Behavioral Therapy, Multisystemic Therapy (Problem Sexual Behavior) and Functional Family Therapy. Regarding the specific models actively used with the juvenile populations in treatment, approximately 86% or more of programs (for adults and adolescents) identify **cognitive-behavioral therapy** as one of the top three choices used in their facilities. Approximately one-third of adult and adolescent programs identify **the good lives model** as a top-three choice, and about one-quarter of those programs use **the self-regulation model**. Nearly all of the reporting juvenile programs indicated that they provided family therapy (Safer Society Foundation; McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010).

Juvenile sex offender treatment programs can be community-based, residential or in institutional settings. Within those locations, the modalities may include individual, group and or family, although there is more evidence for multimodal interventions involving caregivers with this population.

As previously noted, factors that increase the risk of re-offending include the age at first offense, (the younger the age, the higher the risk), personal experience with sexual victimization, impulsivity, access to and interaction with younger children, and incomplete treatment or treatment with a short duration. When adolescents are given the correct treatment, they tend to respond better than adults. They do not tend to continue to re-offend into adulthood, especially when provided with appropriate treatment (Letourneau et. al., 2004; ATSA, 2000).

For youth who have sexual offenses, the guiding principle is that treatment should be multidisciplinary and comprehensive with the goal of reducing sexual victimization. The goal of treatment for this population is to help the youth take responsibility for their behavior, develop empathy for the victim, identify patterns, make an impact on the pathways to behavior, and improve the juvenile’s coping and pro-social skills. If the youth identified as a juvenile sex offender has been victimized, their trauma must be addressed by a specialist.

There are challenges for patients engaging in treatment and recovery. Professionals need to take into account that cognitive development is not fixed or stable, and some evidence-based treatment utilized for adult populations may not be appropriate or effective for adolescents. Examples of interventions that are considered controversial or those not accepted as standard of practice with juveniles (AACAP, 1999) include:

- Arousal assessment (e.g., plethysmograph/phallometric assessment)
- Aversive conditioning
- Relapse prevention

- Shame techniques
- Interventions lacking the involvement of parents
- Polygraph
- Hormone Replacement: Anti-androgen

Other Special Considerations

It should be noted that sex offender evaluations are conducted more frequently for adolescents than adults given the developmental differences with this population. Challenges exist regarding access to competent professionals and specialized treatment providers can be limited. When a child enters treatment there may be loss of access to family or loved ones thus creating feelings of separation and isolation. There are also potential social implications for youth leaving their educational setting, peer network, and possibly leaving home, which may require special consideration when planning treatment and transitions.

The literature is clear that youth with problematic sexual behavior problems and juvenile sex offenders require early identification and treatment by skilled clinicians. It is imperative that all clinicians who encounter these cases support efforts to reduce safety concerns, connect youth to services based on their needs as early as possible, encourage caregiver involvement in treatment, support youth and their families with completing treatment, and involve multiple stakeholders to assist in developing plans to ensure that the youth are sufficiently supervised to reduce the development of more severe behavioral concerns and/or reduce the risk of re-offending behavior for juveniles who have committed a sexual offense. Please review the list of related resources for more information on intervention reflecting best practice for adolescents with sexualized behavior problems.

Related Resources

American Academy of Child and Adolescent Psychiatry (1999). Practice parameters for the assessment and treatment of children and adolescents who are sexually abusive of others. *Journal of the American Academy of Child and Adolescent Psychiatry*, Volume 38(12 Supplement):55S-76S. **[Historical Parameter]**

[http://www.jaacap.com/article/S0890-8567\(99\)80004-5/pdf](http://www.jaacap.com/article/S0890-8567(99)80004-5/pdf)

Association for the Treatment of Sexual Abusers (ATSA). <http://www.atsa.com/>

Association for the Treatment of Sexual Abusers (2008). Report of the task force on children with sexual behavior problems. <http://www.atsa.com/sites/default/files/Report-TFCSBP.pdf>

Association for the Treatment of Sexual Abusers (2000). The effective legal management of juvenile sex offender. www.atsa.com/ppjuvenile.html

Bauman, S. (November 2002). Types of juvenile sex offenders. *The Prevention Researcher*, Volume 9(4), pp. 11-13.

Chaffin, M., Letourneau, E., and Silovsky, J.F. (2002). Adults, adolescents, and children who sexually abuse children. *The APSAC Handbook on Child Maltreatment, Second Edition*, [by] Myers, J. E. B. et al. Sage Publications, Thousand Oaks, CA, pp. 205-232

Hanson, R.K. & Yates, P. (February 2013). Psychological treatment of sex offenders. *Current Psychiatry Reports*, 15:348.

Kersting, K. (July/August 2003). New Hope for Sex Offender Treatment. *Monitor*. American Psychological Association. <http://www.apa.org/monitor/julaug03/newhope.aspx>

Letourneau, E.J., Schoenwald, S.K., and Sheidow, A.J. (February 2004). Children and adolescents with sexual behavior problems. *Child Maltreatment*, Vol. 9(1), 49-61.

McGrath, R.J., Cumming, G.F., Burchard, B.L., Zeoli, S., and Ellerby, L. (2010). Current practices and emerging trends in sexual abuser management. *The Safer Society 2009 North American Survey*. The Safer Society Press, Brandon, Vermont. A Program of The Safer Society Foundation, Inc.

MST –Target Populations: Problem Sexual Behavior

<http://mstservices.com/target-populations/problem-sexual-behavior>

National Child Traumatic Stress Network (NCTSN). (April 2009). *Caring for Kids: Sexual Development and Behavior in Children - Information for Parents and Caregivers*.

http://nctsn.org/nctsn_assets/pdfs/caring/sexualdevelopmentandbehavior.pdf

National Child Traumatic Stress Network (NCTSN). (April 2009). *Caring for Kids: Understanding and Coping with Sexual Behavior Problems in Children - Information for Parents and Caregivers*.

http://nctsn.org/nctsn_assets/pdfs/caring/sexualbehaviorproblems.pdf

NC Association for the Management and Treatment of Sex Offenders (NCAMTSO)

<http://www.ncamtso.org/home>

NC Division of Social Services and the Family and Children's Resource Program (2002). Children's Services Practice Notes: Working with Juvenile Sex Offenders. Vol. 7, No. 2.

http://www.practicenotes.org/vol7_no2/special%20practice%20issues.htm

Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART); Office of Justice Programs, U.S. Department of Justice. (October 2004). Sex Offender Management and Planning Initiative

<http://www.smart.gov/SOMAPI/printerFriendlyPDF/complete-doc.pdf>

Powers-Sawyer, A. B., & Miner, M. H. (2009). Actuarial prediction of juvenile recidivism: The static variables of the Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II). *Sexual Offender Treatment*.

Safer Society Foundation <http://www.safersociety.org/>

Smith, B. L. & Kercher, G. A. (2011). Adolescent sexual behavior and the law. Crime Victims' Institute, Criminal Justice Center, Sam Houston State University.

http://www.crimevictimsinstitute.org/documents/Adolescent_Behavior_3.1.11.pdf

Schladale, J., Barnett, P., Fredericks, K., Brown, D.E., Langan, T., Nunez, J., and Moylan-Trigiano, J. (2007). Community-based standards for addressing sexual harm by youth.

<http://resourcesforresolvingviolence.com/standards.pdf>

U.S. Department of Justice, Office of Justice Programs. Center for Sex Offender Management. The effective management of juvenile sex offenders in the community. A training curriculum.

<http://csom.org/train/juvenile/index.html>

U.S. Department of Justice, Office of Justice Programs. *The Comprehensive Assessment Protocol: A Systematic Review of Adult and Juvenile Sex Offender Management Strategies*

http://csom.org/pubs/cap/2/2_4.htm

Yates, P. M. (2013). Treatment of sexual offenders: Research, best practices, and emerging models. *International Journal of Behavioral Consultation and Therapy*, 8:89-95.