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# SHIFTING PARADIGMS: FROM RELAPSE PREVENTION TO WELLNESS<sup>1</sup>

by ROBERT E. LONGO, LPC; NCC

*ABSTRACT: Today's youth present greater challenges than during any other time in recent history. The author proposes that "sex offending by youth is a symptom of a greater problem." Young people with sexual behavior problems and sexual aggression behaviors must be looked at from a holistic/ecological perspective as they may be subject to co-morbid diagnosis, traumatic histories that may have neuro-biological impact on the brain and brain development, and learning deficits and disabilities among other concerns.*

*This article will briefly outline the current thinking about assessing youth with sexual behavior problems and youth who are sexually aggressive from both a sexual risk perspective as well as risk in other life areas, and recommendations for treatment.*

## INTRODUCTION

In their recent text, Longo & Prescott, describe the history and development of the field of assessing and treating young people with sexual behavior problems and youth with sexual aggression problems.<sup>2</sup> They describe a field that during the course of the past three or more decades adapted adult-based assessment and treatment models in its beginning, to one that over the course of the past six to ten years has emerged as a field that is cognizant of taking into account developmental and contextual factors, current science that addresses brain development and the impact of trauma on the brain, as well as learning styles and labeling of young people in harmful and counter productive ways.<sup>3</sup>

Risk assessment is no longer a simple act of determining if a young person poses sexual risk, and if that risk can be lowered through the course of sex-offense specific treatment. Rather, risk assessment must take into account several factors that look at the young person from a developmental and contextual framework, and the youth's ability to thrive in the community. First, the findings from risk assessment of youth should be considered time-limited. Developmental issues result in young people constantly changing and evolving into young adults. Sexual development and general development is fluid until the young person reaches maturity both physically and mentally. Risk assessments, when written into reports, should clearly indicate that such assessments have value over a six to twelve month period before they should be considered obsolete and another assessment performed. In other words, such assessments are a snapshot in time and the factors and other points addressed in this article continuously influence a particular youth's risk to both sexually reoffend as well as their risk and ability to be productive and safe in a variety of arenas, i.e., family, school, community, within peer groups, and so forth.<sup>4</sup>

## A SHIFT IN PARADIGMS

Clinical observation and preliminary research suggest that juvenile sexual abusers (JSA) are a *heterogeneous population* representing a variety of developmental pathways leading to offending behavior and various patterns of sexually abusive behaviors.<sup>5</sup> Some youth appear to be at high risk for re-offending and in need of institutionalization, while many others appear to be at lower risk and highly amenable to community-based interventions. As such, it does not appear to be

clinically, legally, or fiscally prudent to formulate a “one size fits all” approach to their management.

These young people differ in a variety of dimensions, including the extent of their sexual offending behavior; ranging from sexual harassment, internet violation, and statutory rape, to rape of children and adults, and in some rare instances the rape and murder of a victim.<sup>6</sup> The dimensions include; 1) personality characteristics, 2) anti-social makeup, 3) criminal behavior and history, 4) sexual deviance, 5) mental health, and 6) their own sexual victimization.<sup>7</sup>

New therapies and interventions now provide us with the ability to assess and address a variety of co-morbid disorders with youth who are often diagnosed with a variety of disorders including but not limited to Attention Deficit Hyperactivity Disorder (ADHD), Post Traumatic Stress Syndrome (PTSD), Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), Depressive Disorders, Anxiety Disorders, Attachment Disorders, and more.<sup>8</sup>

This is not to excuse the abusive, and in some cases horrific sexual acts perpetrated by young people. The statistics regarding youth who commit sexual crimes vary, because uniform definitions are not applied across state or at international levels. The National Center on the Sexual Behavior of Youth (NCSBY) defines adolescent sex offenders (ASO) as “adolescents from 13 to 17 who commit illegal sexual behavior as defined by the sex crime statutes of the jurisdiction in which the offense occurred.”<sup>9</sup>

While reported statistics vary, in the United States (US) ASO commit a substantial number of sex crimes, including 17% of all arrests for sex crimes and approximately one third of all sex offenses against children.<sup>10</sup> Females under the age of 18 account for one percent of forcible rapes committed by juveniles and 7% of all juvenile arrests for sex offenses, excluding the category of prostitution.<sup>11</sup> This translates to approximately seventeen percent of all arrests for sex crimes and approximately one-third of all sex offenses against children are committed by young persons under the age of 18 (females under the age of 18 account for approximately one percent of forcible rapes committed by juveniles and seven percent of all juvenile arrests for sexual offenses excluding prostitution).<sup>12</sup>

The NCSBY goes on to note the following:

- Adolescents do not typically commit sex offenses against adults, although the risk of offending against adults increases slightly after an adolescent reaches age 16.<sup>13</sup>
- Approximately one-third of sexual offenses against children are committed by teenagers. Sexual offenses against young children, under 12 years of age, are typically committed by boys between the ages of 12 to 15 years old.<sup>14</sup>
- Adolescent sex offenders (ASO) are significantly different from adult sex offenders. (They have different developmental pathways, are heterogeneous, and we should therefore never assume a “one size fits all” approach to assessing, treating, and/or managing these clients):
  - Adolescent sex offenders are considered to be more responsive to treatment than adult sex offenders and do not appear to continue re-offending into adulthood, especially when provided with appropriate treatment.
  - Adolescent sex offenders have fewer numbers of victims than adult offenders and, on average, engage in less serious and aggressive behaviors.
  - Most adolescents do not have deviant sexual arousal and/or deviant sexual fantasies that many adult sex offenders have.
  - Most adolescents are not sexual predators nor do they meet the accepted criteria for pedophilia.
  - Few adolescents appear to have the same long-term tendencies to commit sexual offenses as do some adult offenders.
  - Across a number of treatment research studies, the overall sexual recidivism rate for adolescent sex offenders who receive treatment is low in most US settings as compared to adults.<sup>15</sup>
- ASO are different from adult sex offenders in that they have lower recidivism rates, engage in fewer abusive behaviors over shorter periods of time, and have less aggressive sexual behavior. Adolescent sex offenders rates for sexual re-offenses (5-14%) are substantially less than their rates of recidivism for other delinquent behavior (8-58%).<sup>16</sup>
- Adolescent sex offenders commit a wide range of illegal sexual behaviors, ranging from limited exploratory behaviors committed largely out of curiosity to repeated aggressive assaults.<sup>17</sup>

The concern, however, is that despite research and knowledge over the past decade, the trickle down assessment and treatment phenomenon from adult-

based treatment models to JSA treatment models means the majority of JSA treatment programs seldom focus on areas outside of the sexual offending behavior.<sup>18</sup> Many of these programs and assessment centers are often forensic models designed to work with normal functioning adult male sex offenders in prison settings.<sup>19</sup> Even our labeling of youth uses adult-based terminology, despite many authors/researchers suggesting against the use of these terms, i.e., predator, perp, mini perp, pedophile, etc.

#### WHO ARE JUVENILE SEXUAL ABUSERS?

Sexually abusive and aggressive youth have been described as very diverse, and 1) are otherwise well-functioning youth with limited behavioral or psychological problems, 2) are youth with multiple non-sexual behavior problems or prior non-sexual juvenile offenses, 3) come from both well-functioning families and highly chaotic or abusive backgrounds.<sup>20</sup>

#### TYPOLOGIES AND RISK

The first typologies for JSA were “clinical” typologies back in the early 1990s, and were not researched.<sup>21</sup> In recent years, however, John Hunter and his colleagues have been researching a typology of JSA.<sup>22</sup> As this typology develops, it is hoped that it will guide our field in several positive directions. First, these data will help guide the field in risk assessment, and second, these data will hopefully guide the field in addressing the extent and types of treatment models and modalities that would be most useful and effective in working with JSA.

The current research by Hunter and colleagues indicates that there are two major types of JSA; adolescents who sexually abuse children and, adolescents who rape peer and adult females.<sup>23</sup> Youth who perpetrate against prepubescent children differ from those who target pubescent females.<sup>24</sup> Within both major groups are three sub-categories. The first category is the *life style persistent* (anti-social and aggressive) type JSA who are typically poor responders to treatment and account for approximately 5-10% of all sexually abusive and aggressive youth.<sup>25</sup>

The second group which accounts for approximately 5-10% of all sexually abusive and aggressive youth are referred to as *adolescent onset paraphilic* (developing paraphilic interests) type and show an increased number of post treatment arrests for sexual offenses.<sup>26</sup>

The third group which accounts for the majority of adolescents with sexual behavior problems and sexually aggressive behaviors are referred to as the adolescent onset, non-paraphilic (transient interests in criminal sexual behaviors) type, and are considered to have the best response to treatment.<sup>27</sup>

#### TREATMENT ISSUES

##### *Continuum of care*

Recent trends have placed an increasing number of youth in detention and residential care.<sup>28</sup> Long-term residential care and exposure to delinquent youth may result in long-term harmful effects as young and less disturbed youth incorporate negative anti-social values.<sup>29</sup> When considering JSA for treatment one should always chose the least restrictive environment based upon risk and other factors addressed in this article.<sup>30</sup>

#### DEVELOPMENTAL FOCUS

Faniff & Becker note that JSA are still maturing in many areas and specifically two major areas, 1) biological factors (neuro-psych deficits) and 2) environmental factors – i.e., parents, family, community, etc.<sup>31</sup> From a biological perspective, the brain is still developing and can be impacted by; 1) trauma to the limbic system from which emotional regulation is impaired, 2) frontal lobe development which controls emotional, behavioral, reasoning, and problem solving and matures around age 23-25, and 3) trauma impacts frontal lobe which inhibits aggression.<sup>32</sup>

Social development and social skills are a critical part of the development in young children and adolescents. Social development issues include but are not limited to; 1) self-esteem, 2) pro-social behavior, 3) goal-directed behavior, and 4) self-reliance. These developmental items can be affected when there are problems with healthy attachment. Many JSA have anxious and/or resistant

attachment concerns that may result in; 1) increased frustration, 2) decreased coping abilities, 3) decreased social skills, and 4) increased aggression.<sup>33</sup>

Abuse leads to increased risk for attachment relationships with parents, caregivers, and others. Faniff and Becker note that 95% of maltreated children have insecure attachment with their abuser, and that one third of children in non-clinical settings have insecure attachment which falls into one of three styles; 1) avoidant attachment – the child keeps distant from others, 2) resistant attachment – the child is ambivalent towards others, and 3) disorganized attachment – the child demonstrates externalized behavioral problems and controlling of others.<sup>34</sup>

As is well known, the abuse of children can lead to a variety of behavioral and psychological problems. With male JSA, Faniff and Becker caution that maternal sexual abuse tends to be associated with psychological pathology.<sup>35</sup> They go on to note that moral development may be impacted by child maltreatment.<sup>36</sup>

#### *Co-morbid disorders*

Brad Johnson notes that clinicians and others need to become more familiar with commonly seen diagnosis with youth.<sup>37</sup> JSA are no exception. In residential care, it is not uncommon to see patients who are dual diagnosed/have co-morbid disorders that include but are not limited to: ADHD, ADD, PTSD, CD, ODD, Attachment Disorders (RAD), Bi-Polar Disorder, Dysthemia, Mood Disorders, and substance abuse.

Johnson suggests one pay attention to youth diagnosed with ADHD, because these adolescents often 1) engage in sexual intercourse at an earlier age, 2) are more promiscuous, 3) are more likely to have difficulty in peer relations, and 4) often have other socialization problems.<sup>38</sup> For example, Johnson notes that 73% of ADHD youth 1) have difficulty getting along with siblings and other family members, 2) may also have conduct disorder, 3) may develop opposition defiant disorder (and then go on to have conduct disorder), and suffer from impulsivity.<sup>39</sup> He also notes that ADHD may lead to increased risk for psychopathology and conduct disorder.<sup>40</sup>

## MOVING BEYOND RELAPSE PREVENTION

Current research shows that the sexual re-offense rate for JSA who receive treatment is low in most US settings. Studies suggest that the rates of sexual re-offense (5 – 14%) are substantially lower than the rates for other delinquent behavior (8 – 58%).<sup>41</sup> Additionally, the assumption that the majority of JSA will become adult sex offenders is not supported by the current literature.<sup>42</sup> Simply, the research is not at a point where we can categorize JSA and pick empirically supported treatment.

What we do know from clinical experience is that many JSA are successfully treated in shorter, less intensive treatment programs; this despite the surveys that suggest that the average length of treatment in both community-based and residential sex-offense specific programs ranges from 18-24 months.<sup>43</sup> Many JSA are seen in outpatient group treatment programs that meet once a week for 8 to 28 months.<sup>44</sup>

With advances in our knowledge and what we know about treatment, the most pressing concern is the recognition that traditional relapse prevention for sexual offenders is no longer considered a viable model.<sup>45</sup> It is a medical model designed for a single pathway to reoffend, and uses avoidance and escape strategies vs. positive goal setting and strength-based concepts. There are no studies that have been conducted that address the efficacy of sex-offense specific relapse prevention with youth.

Relapse prevention assumes that the client is: 1) under-regulated, 2) lacks adequate coping responses, 3) lacks self-esteem, 4) is not self-directed with recognition of strengths and positive goals (but rather sets up the self. . .based upon a negative emotional state), and 5) is an inflexible model.

As we begin to look at youth from a holistic/ecological perspective it is important to address multiple problems with a broad brush of interventions designed to work with multiple diagnosis, healthy sexuality, shame issues and fairness, and take into account trauma and its impact on the brain.

## PROMOTING HEALTHY SEXUALITY IN YOUTH

According to the Henry J. Kaiser Family Foundation, it is estimated that the average adolescent views 1400 sexual references, jokes, and sexual innuendo, each year on television, yet only one in eighty-five references abstinence, contraception, or marriage.<sup>46</sup> With the bombardment of society and specifically youth with incomplete, distorted, and even misinformation about human sexuality, teaching healthy sexually while confronting unhealthy and/or problematic sexual behaviors is an increasingly greater challenge to professionals and families.

Brown & Schwartz make note that our field tends to avoid the reality that JSA are or will be sexual people; instead we focus on containing their sexuality vs. helping them become sexually healthy.<sup>47</sup> The field of treating JSA does not traditionally promote sexuality, and some programs prohibit it with youth. The focus of treatment programming is often on addressing “deviant” and problematic sexual behaviors while seldom spending equal or greater amounts of treatment time addressing healthy sexuality and related issues. Brown & Schwartz note; we teach JSA what “*not to do*” with sexuality versus “*what to do*” in order to be sexually healthy.<sup>48</sup>

There is no recent professional literature, evidence or science to support the notion that “once a sex offender, always a sex offender”. When applied to adult sex offenders, and there is growing literature and evidence that many adult sex-offenders do heal and do not recidivate, the message implies sexual offending is and will always be a life-long problem; in other words there is no cure. As noted above, JSA generally do not grow up to become adult sex offenders. In fact, the recidivism rates for JSA are low and many JSA will not commit future sex offense one detected and caught. Latham & Kinscherff note that the majority of JSA do not have diagnosable paraphilias, and will not go on to commit sex-offending behaviors as adults.<sup>49</sup>

## DEALING WITH SHAME, FAIRNESS, AND ETHICS

Alan Jenkins’ timeless book, *Invitations to Responsibility*, (1990) uses an invitational model to engage clients which combines both Narrative and Motivational Interviewing therapies and techniques.<sup>50</sup> His entire approach is based on

a positive growth developmental model. Current research on attachment and the impact of trauma point to the use of positive adult and peer relationship development as an essential component of treatment.

Jenkins notes that we want clients to; 1) declare their ethics, 2) establish goals related to their personal ethics, 3) develop personal motivation, and 4) examine their personal ethics and action in relation to their personal goals. He suggests that the principles of intervention are, 1) safety, 2) responsibility, 3) accountability, 4) fairness, and 5) respect.<sup>51</sup>

In following Jenkins suggested principles, the therapist wants to make sure to; 1) address youth without reproducing dominant abusive practices – confrontation, the use of layouts, 2) address disadvantage of their own victimization, 3) address the client within a developmental context, and 4) avoid colonization (the psychological invasion, benevolent bullying, protest and insurrection [“being done to”] of the client).<sup>52</sup>

Many professionals acknowledge that shame is at the root of violence,<sup>53</sup> and as reported by Jenkins often results in; 1) a challenge to the client’s personal integrity, 2) avoidance of thinking about one’s behavior, 3) withdrawal, 4) negative peer relations, 5) alcohol & drug abuse, and 6) self-harm, and/or aggression and violence.<sup>54</sup>

Our field has historically shot itself in both feet with the double-barrel shotgun phrases, “*there is no cure for sex-offenders*”, and “*victims are damaged for life*”. Such statements may be both confusing and conflicting for JSA, and when made to patients give the message of there being no hope for getting well (from being a perpetrator or victim).

#### FORGIVENESS

All too often, JSA programs and therapists focus on the patient taking responsibility for their actions (sexual abusive and aggressive behaviors) while deemphasizing one’s personal victimization issues. As a result, therapists give the message to patients that they should not ask for forgiveness, and seldom address the idea of forgiveness as a therapeutic theme. Forgiveness is a vehicle for addressing one’s personal anger issues, especially as it pertains to forgiving

one's abuser.<sup>55</sup> Survivors of all forms of abuse and trauma often heal more completely when they come to forgive transgressions against them.

Forgiveness can be a significant healing process, and is a concept that must be addressed.<sup>56</sup> However, forgiveness should never be a forced or public act, but rather an act done at one's own pace and time, and most generally in a private fashion.<sup>57</sup> Caroline Myss notes, "*One of the main beliefs I want you to adopt in order to heal your life or illness is a belief in the importance of forgiveness. Forgiveness frees up the energy necessary for healing.*"<sup>58</sup>

#### TRAUMA AND NEURO-BIOLOGY

It is not uncommon, especially in residential treatment settings, to see a large percentage of patients with a PTSD diagnosis. The literature on trauma and trauma's impact on the brain is growing at a rapid rate and professionals should not ignore the possibility of patients having this diagnosis.

Given the impact of trauma on the brain, it is important to understand how we as professionals can work with trauma in productive and healing ways. When trauma occurs, brain development is impacted.<sup>59</sup> Helping the patient heal and work with trauma impact will often require the professional to go beyond "sit-down, talk therapy". Trauma often results in various parts of the brain not communicating and in particular the right and left hemispheres. This lack of communication between hemispheres occurs when trauma impact the corpus callosum.<sup>60</sup>

Trauma also impacts the limbic system, the part of the brain dedicated to survival.<sup>61</sup> The thalamus senses stimuli coming into the brain. The hypothalamus maintains a sense of balance and well-being and provides communication between the brain and the body. The amygdala codes memories from fear producing experiences (trauma) and monitors incoming stimuli that may be considered as threatening. The amygdala is what activates the flight-fight-freeze phenomena when we feel a threat to our personal safety and well-being. The hippocampus is like a memory chip in a computer. All memory goes through the hippocampus. The corpus callosum, which connects the two hemispheres of the brain, allows for conscious information to be exchanged between hemispheres. The anterior commissure carries unconscious, emotional information between the two hemispheres.

As we understand more about the workings of the brain, the impact of trauma to the brain, and brain development; new treatments and technologies have begun the shape the way we work with traumatized patients. Engaging patients in experiential work, exercises, fitness programs, yoga, and other therapeutic experiences helps the brain to communicate better and reestablish healing functioning.<sup>62</sup> Commercially available products by BrainGym® International, BrainMaster® The Wild Devine Project, The International Center for Reiki Training, among many others provide practitioners with the option to work with and teach patients a variety of self-regulation, calming, relaxation, and impulse control techniques.

The limitations to this article prohibit a more detailed explanation and analysis of new trends in working with high-risk youth, and specifically youth at risk for sexual offending. What is becoming increasingly clear, is that traditional methods and models, especially those that have trickled down from the world of adult sexual offender treatment, should be considered as inappropriate at least and potentially harmful at worst if applied to JSA.

Youth with sexual behavior problems and those who are sexually aggressive pose complex problems that can not be addressed, let alone treated, with simplistic, canned (one size fits all) programming, and/or sex-offender specific methods and /or models alone. Many youth come to specialized professionals with an array of problems that are directly related to their sexually abusive behaviors and problems. As professionals, we have the obligation to both understand and treat these patients with the appropriate treatment models and methods. To fully address the needs of these patients, and therefore the possible risks posed to the patient's self, others, and the greater community, we should be mindful that sexually abusive behavior is often a symptom of a much greater problem.

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## NOTES

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7 *Id.*

8 B.R. Johnson, Co-morbid Diagnosis of Sexually Abusive Youth, in CURRENT PERSPECTIVES: WORKING WITH SEXUALLY AGGRESSIVE YOUTH AND YOUTH WITH SEXUAL BEHAVIOR PROBLEMS, *supra* note 1, at 167-192.

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10 *Id.*

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12 *Id.*

13 <http://www.ncsby.org/pages/publications/What%20Research%20Shows%20About%20Adolescent%20Sex%20Offenders%20060404.pdf> (Retrieved September 1, 2006).

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15 *Id.*

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18 Robert E. Longo, *Emerging Issues, Policy Changes, and the Future of Treating Children with Sexual Behavior Problems*, in 989 SEXUALLY COERCIVE BEHAVIOR: UNDERSTANDING AND MANAGEMENT at 506 (R.A. Prentsky et al., eds., 2003)

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21 Longo, *supra* note 17.

22 See Hunter and Hunter & Longo, *supra* note 19.

23 Hunter, *supra* note 19.

24 *Id.*

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26 *Id.*

27 *Id.*

28 B. Holman & J. Ziedenberg, *The Dangers of Detention: The Impact of Incarcerating Youth in Detention and Other Secure Facilities*, JUSTICE POLICY INSTITUTE (2006).

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32 *Id.*

33 *Id.*

34 *Id.*

35 *Id.*

36 *Id.*

37 See Johnson, *supra* note 7.

38 *Id.*

39 *Id.*

40 *Id.*

41 <http://www.ncsby.org/pages/publications/What%20Research%20Shows%20About%20Adolescent%20Sex%20Offenders%20060404.pdf> (Retrieved September 1, 2006).

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48 *Id.*

49 C. Latham & R.T. Kinscherff (2006). Address at ATSA 25th Annual Research and Treatment Conference: Chasing the dead horse around the bush: Misdiagnosing children with sexual behavior problems. (September 27, 2006).

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52 *Id.*

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- 61 *Id.*
- 62 *Id.* and Interview with John Bergman, Director, Stonewall Arts Project, Melbourne, Australia (November 13, 2006).

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