

Treating Juveniles with Problematic Sexual Behaviors

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Snap Shot Agenda

- **Snap shot: Juvenile sexual offender typologies**
- **Snap shot: DJJ Sex Offender Treatment Programs**
- **Snap Shot: Balancing treatment planning and reentry**

Sex Offender Treatment Resources

- **Virginia Sex Offender Treatment Association (VSOTA) Conference March 13-16, 2018**
- **Nov 3rd, 2017: Digital Deviance - Assessment, management and treatment of sex offenders on-line (David Delmonico & Elizabeth Griffin)**
- **WWW.VSOTA.COM**
- **Center for Sex Offender Management (CSOM)**
- **Association for the Treatment of Sexual Abusers (ATSA)**
- **NEARI Press and Safer Society Press**

Snapshot of Juvenile Sexual Offenders

Myth or Fact

- Youth who have perpetrated a sexual offense are on a life-course persistent path of sexual offending...

Myth –

Most adult sexual offenders were not sexually offending youth. Longitudinal studies of criminal career patterns distinguish juvenile and adult sexual offenders as two separate phenomena (Lussier & Blokland, 2014)

[adult swim]



ESPN



CARTOON NETWORK



NBC SPIKE

GET MORE ACTION



MUSIC TELEVISION



SHOWTIME

THE CW



Sci Fi

CNN



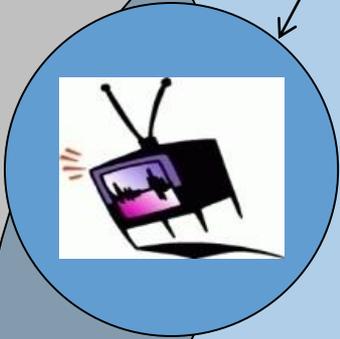
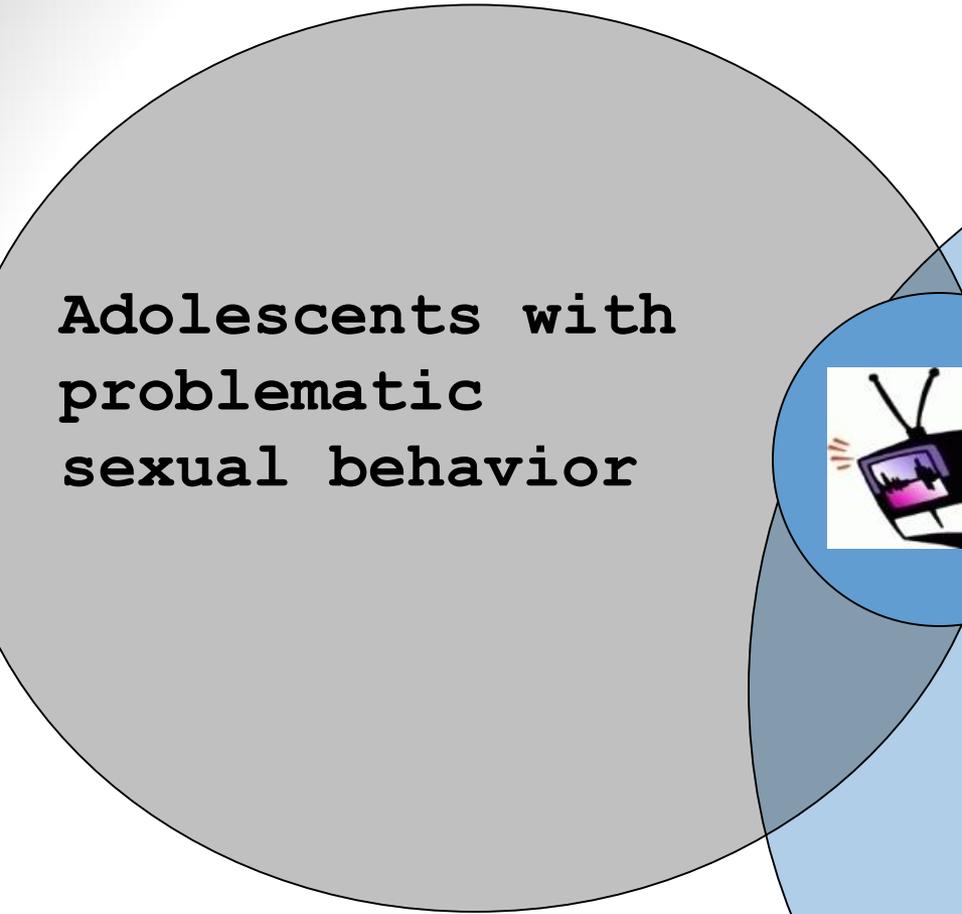
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FOX



Media



Typology Purpose

- Most classification systems for sexual offenders were developed for mental health professionals for assessment and treatment purposes.
- And... law enforcement needed a typology that would help officers and prosecutors:
 - Investigate cases
 - Find evidence
 - Arrest, and convict sexual offenders.



Old School Child Molester

1950's & 1960's, primary focus in limited literature is on “stranger danger.”

- Dirty Old Man
- Raincoat
- Candy
- Approaches children at play
- “Say no, yell and tell.”



FBI

“A Law Enforcement Typology”

Developed by Dr. Park Elliot Dietz & Kenneth Lanning
1992, 2001

A Child Molester is...

- **“A Significantly older individual who engages in any type of sexual activity with individuals legally defined as children.”**

Lanning 2001

Three kinds of Child Molesters

- Intrafamilial
- Acquaintance
- Stranger

Intrafamilial

- Intrafamilial (incest) offenses between an adult and a child is the most common form of child sexual victimization.

Child Molester Subtypes (Lanning)

- **Situational or** (*Regressed*, Groth model 1978)
 - Regressed
 - Morally Indiscriminate
 - Inadequate
- **Preferential or** (*Fixated*, Groth model 1978)
 - Seduction
 - Introverted
 - Sadistic
 - Diverse*

Demystifying the Pedophile

- The word “pedophile” is a clinical term defined in the DSM 5... not a legal term.
- The term is used loosely among professionals & non professionals, the media & the general public - often incorrectly.
- Not all child molesters are pedophiles.

Pedophilic Disorder

Diagnostic Criteria for 302.2 Pedophilic Disorder

- Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity w/ a prepubescent child (generally age 13 or less).
 - The Person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.
 - The Person is at least age 16 and at least 5 years older than the child or children in Criterion A.

Juvenile Sex Offender Typology

(O'Brian & Bera, 1986)

Type 1 : Naïve Experimenter

An attempt to explore and experiment with newly developing sexual feelings

- Younger offender
- Adequate social skills
- ***Sexually naïve***
- Victims are 2-6 years old
- No force or threats

Type 2 : Under Socialized Child Exploiter

An attempt to achieve intimacy and self importance, and raise self esteem

- Few same age friends
- *Feels inadequate / insecure*
- Gravitates to younger children
- Uses manipulation & rewards

Type 3 : Pseudo Socialized Child Exploiter

A guiltless and narcissistic exploitation of vulnerable children to gain sexual pleasure

- Older juvenile
- ***Good social skills***
- Confident
- A “parentified child”
- Shows little remorse
- Will rationalize and use DM

Type 4 : Sexual Aggressive

An attempt to use sex to experience personal power through domination, expression of anger or humiliation of the victim

- ***Antisocial behavior***
- **Disorganized / abusive family**
- **Uses force, threats & violence**
- **Victims are peers, adults or children**

Type 5 : Sexual Compulsive

*Engaged in repetitive, sexually arousing behavior of a **compulsive** or addictive quality*

- Offenses are usually hands off
- Followed by masturbation
- Offenses alleviate anxiety
- Potential fetish

Type 6 : Disturbed Impulsive

Motivation is complex and individually determined but the result of an acute disturbance in reality testing from a thought disorder or substance abuse

- *Serious psychological problems*
- Severe family problems
- Learning disabled
- Offends against children, peers & adults

Type 7 : Group Influenced

The offender gives in to peer pressure or attempts to gain attention, approval, or leadership from others.

- Younger juvenile
- Little history of acting out
- *Sexual abuse occurs with a peer group*
- Projects blame onto victim or peers

CSOM TYPOLOGY

Offend on a Peer / Adult

- Predominantly assault female / stranger / acquaintance.
- With other criminal activity / public place.
- Hx of non-sexual offenses.
- Higher levels of aggression, violence, use weapons, cause injury to victim.

Offense against Children

- Nearly half assault at least one male, approx. 40% of victims are siblings / relatives.
- Use Opportunity, tricks.
- Deficits in self-esteem / social competency.
- Display signs of depression & other mental health issues.

Sex-only and Sex-plus Typology

Butler and Seto (2002)

- **Dead-end offenders (One and done)**
 - **No other history of sexual or non-sexual offending behaviors**
- **Generalists**
 - **Delinquent Sexual Offenders**
 - **Sex offenses are only part of criminal actions**
- **Specialists**
 - **Conduct is based on sexual deviation**
 - **Numerous sexual offenses**

Sex Offender Treatment in Virginia

- **First DJJ Sex Offender Treatment program opened in 1990 at Hanover Juvenile Correctional Center.**
 - **Ellen Allen Program - 14 bed unit**
 - **Staffed with one psychologist - Ed Wieckowski**
- **Residents were handpicked to fill beds**



DJJ Sex Offender Treatment Program

- **1992 – Oak Ridge (DD) and Beaumont opened Sex Offender Treatment Units**
- **1994 – Sex Offender population dramatically increased**
 - **Hanover opened a second unit**
 - **Beaumont increased to three units**

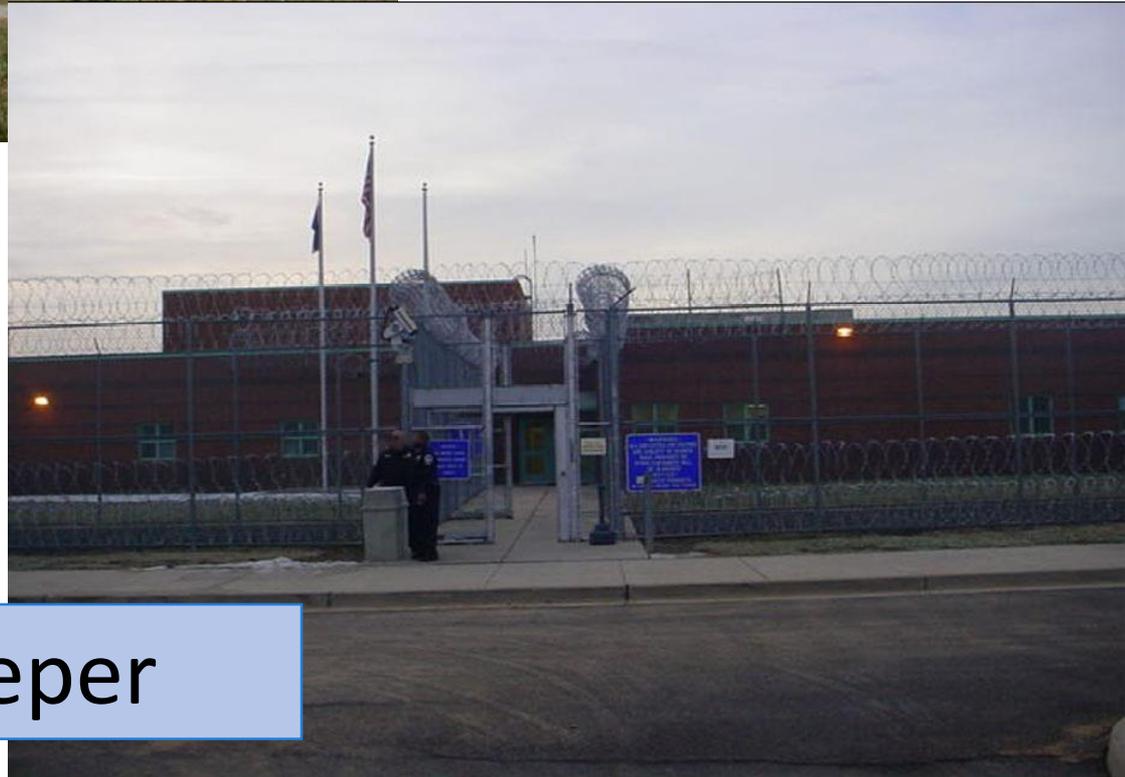
The Coming of the Super-Predators

- Nov 27, 1995 / John J. Dilulio Jr. penned an article in *The Weekly Standard*
- Coined a phrase “superpredator.”
- “Superpredator” caught the attention of reporters and politicians, some of whom used it to push for the continued overhaul of juvenile justice systems they considered too lenient.
- By the end of the 1990s, nearly every state had passed laws to make it easier to try juveniles in adult courts or to increase penalties for violent juvenile crimes.

Bon Air Expansion



Beaumont Expansion



Culpeper

Jacob Wetterling Crimes Against Children Registration Act (US Law)

- Named after Jacob Wetterling, a Minnesota eleven-year old boy who was abducted by a stranger in 1989.
- Effective November 20th 1993
- Amended by Congress in 1996 with Megan's Law, requiring law enforcement agencies to release information about registered sex offenders to the public

By the late 90s We had...

- **Approximately 200 residents with mandatory and recommended sex offender treatment needs across the system**
- **Long waiting lists for sex offender treatment**
 - **(as long as nine months at its peak)**
- **Program length of stay that averaged 18 months**

Sign Of the Treatment Times

- *Early 90s*

- Nationally speaking - Juvenile Sex Offender Treatment was a relatively new concept in public sector programming
- Sex Offender Treatment programs ***borrowed concepts*** from substance abuse treatment
 - Steeped in combating defense mechanisms
 - Used modified therapeutic communities
 - Highly confrontational
 - Weren't that much different from adult programs
 - High treatment dosage / one size fits all

DJJs Original Clinical Approach

- Grounded in Cognitive Behavioral Therapy
 - CBT – the examination of thoughts and emotions as they related to behavior
- Relapse Prevention Oriented
 - Applied CBT techniques / skills as they relate to high risk factors.
- Origin of the “15 Treatment Objectives”

The 15 Treatment Objectives

- **Autobiography**
- **Disclosure**
- **Cycle of Offending**
- **Cognitive Distortions**
- **Defense Mechanisms**
- **Log Book**
- **Anger**
- **Power & Control**
- **Role Model**
- **Personal Obj. 1**
- **Personal Obj. 2**
- **Fantasy and Arousal**
- **Family Issues**
- **Victim Empathy**
- **Relapse Prevention**

In 2000 (first major twist to program)

- **Treatment became more individualized and holistic**
- **10 treatment goals replaced 15 treatment objectives**
 - **8 core treatment objectives/activities remained to safeguard minimal dosage**
 - **Auto, disclosure, cycle, cog dist, family issues, fantasy and arousal, empathy and relapse prevention**

Treatment Goals

(Circa 2000-2015)

1. Take responsibility for actions, and decrease excuses, rationalizations, and projection of blame.
2. Reduce thinking that supports general or sexual criminal attitudes.
3. Understand factors that contributed to offense(s).
4. Manage anger and other emotions that contributed to offense(s).
5. Interact with others in socially acceptable ways.

Treatment Goals

(Circa 2000-2015)

6. Understand impact of offense on victim, and reduce exploitation of others in sexual and non-sexual ways.
7. Understand role of own victimization in sex offense.
8. Understand family dynamics that contributed to offense, and work toward improving family relations if appropriate.
9. Control own sexually deviant interests.
10. Interrupt cycle of offending by applying information learned in treatment.

In 2006 (another twist to programming)

- **MI / ME techniques began creeping into mental health, SA, AM and SO programming.**
- **SO TX programming placed more emphasis on motivation enhancement / less on traditional confrontation**
- **MI / ME & Stages of Change was infused into assessment and treatment**

Stages of Change (Prochaska & DiClemente)

- Pre-Contemplative
- Contemplative
- Preparation / Planning
- Action
- Maintenance
- Relapse



2015 (current program)

- **Adopted R-N-R model**
- **New LOS Guidelines Oct 15 2015**
 - (no man or rec)
- **Added ERASOR to sex offender risk assessment**
- **Revamped treatment tracks**
 - **Added mid-level program**
- **Individualized goals and objectives**
 - **No minimums / All based on R-N-R**

Risk-Needs-Responsivity

- **Intervention following RNR adheres to three overarching principles:**
 - 1. The highest intensity intervention should be offered to the highest risk offenders – the risk principle (the WHO)**
 - 2. Intervention should target the factors that lead the individual to commit crimes – the need principle (i.e. targeting intervention at individuals' specific problematic-criminogenic needs) (The WHAT)**
 - 3. It is offered in a manner that maximizes the likelihood that the individual benefits from it – the responsivity principle (i.e., matching intervention to the individual's abilities and motivation) (The HOW)**

Track	Program LOS*	Dosage*	Placement
III. Prescriptive (Low Risk)	1-3 Months	Individual Therapy <ul style="list-style-type: none"> • Focus on psycho-education • Non-SO specific • Once weekly 	Anywhere
II. Mid-Level (Mod Risk)	6-10 Months	Individual / Group / Family Therapy** <ul style="list-style-type: none"> • Flexible range of services • Psycho-education, healthy relationships, skills, etc. • Once weekly 	SCU / ISU
I. Inpatient (High risk) Tier V (Special Decision Case)	10-18 Months	Individual / Group / Family Therapy** <ul style="list-style-type: none"> • Full range of services • Target cognitive distortions, deviant arousal, skills, etc. 	SCU / ISU

*Approximations

**By Appointment

Active Treatment Grid

Facility	Inpatient (High Risk)	Mid-level (Mod Risk)	Prescriptive (Low Risk)	Total
Bon Air JCC	30	9	2	41
Residential	3	1	0	4
DetRe / CPP	2	0	0	2
Total	35	10	2	47

Inactive

Completed = 10

Intake = 3

Waiting = 1

9/11/17

Sex Offender Treatment Assignment

Post Oct 15th 2015

- LOS is based on YASI and most serious committing offense*
- *Except serious offender / Tier V (level I)
- Treatment is based on need
 - You get a “yes or no”
- Track level determined by Sex Offender Assessment Review Committee (SOARC)
 - Sex Offender Treatment Program Sup / BSU CAP Treatment Director / CAP Supervisor

SOARC Process

- CAP Psychosexual Assessment
- ERASOR items present / partially or possibly present (inpatient criteria)
 - Deviant sexual interests
 - Obsessive sexual interests / preoccupation with sexual thoughts
 - Attitudes supportive of sexual offending
 - Unwillingness to alter deviant sexual interests
 - Threats / use of violence, weapons during sexual offense
 - Sexually assaulted a stranger
 - Indiscriminate choice of victims

SOARC Process (cont.)

- **Other ERASOR items that are considered but not automatic for Track 1 Inpatient Program**
 - **Sexually assaulted 2 or more victims**
 - **Sexually assaulted the same victim 2 or more times**
 - **Sexually assaulted a child**
 - **Sexually assaulted a male victim**
 - **Diverse sexual assault behaviors**

SOARC Recommendations

- Level I: Inpatient = Tier V (no LOS)*
- Level II: Mid-level = LOS*
- Level III: prescriptive = LOS*



*Excludes serious offenders

Bon Air Juvenile Correctional Center

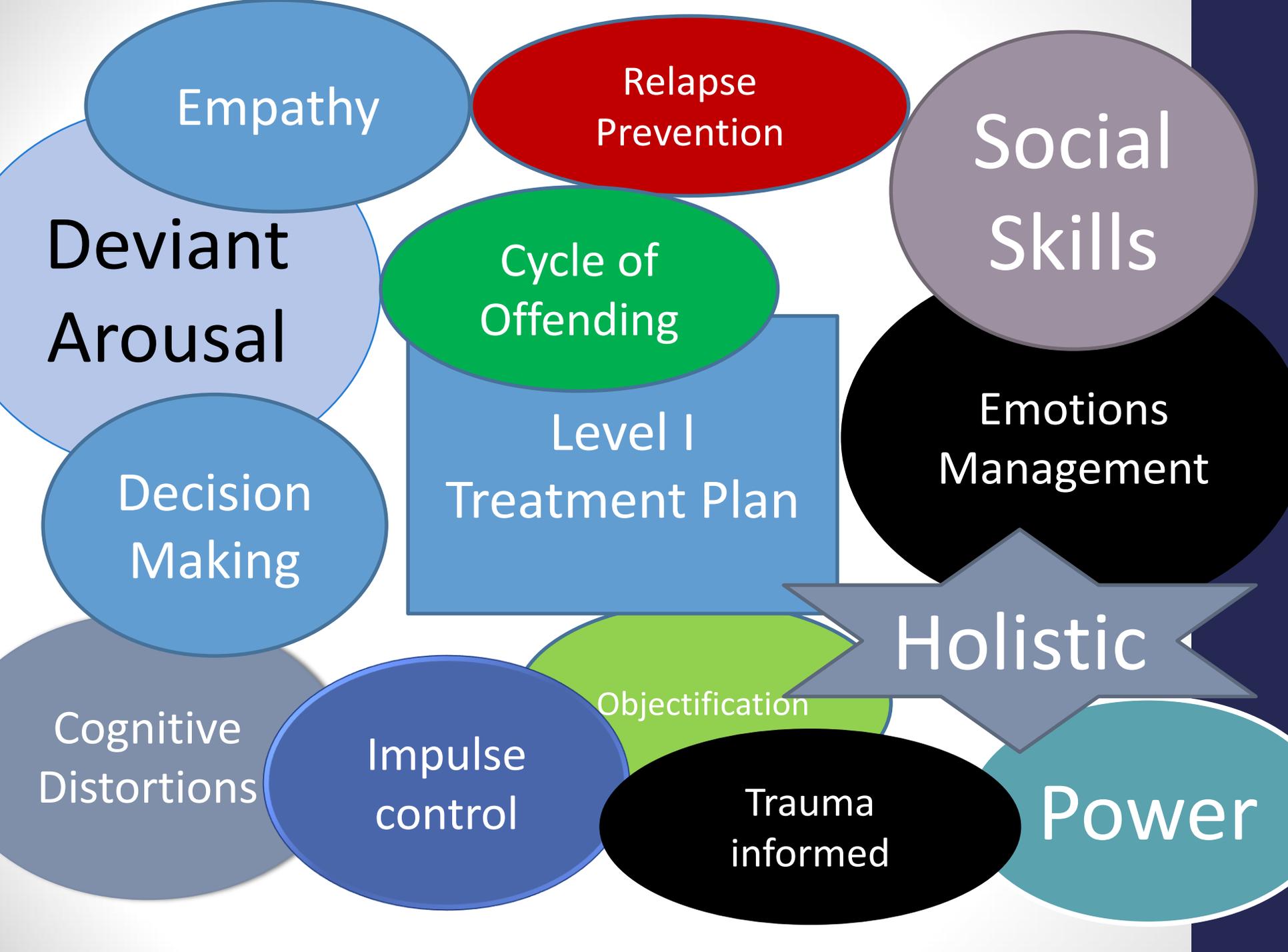
- **Opened 2000**
- **Currently 3 Units (66, 67, 68)**
- **12-14 beds**
- **Two levels of programming**
 - **Level I – Inpatient**
 - **Level II - midlevel**



Community Treatment Model Staffing

Combination of:

- BSU Psychologists and/or Therapists
- Community Coordinator
- Counselor
- Resident Specialists
- Clinical program overseen by BSU Supervisors, Program Supervisor of sex offender Treatment services (that's Me).



Skills
Development

Relapse
Prevention

Emotions
Management

Criminal
Thinking

Level II
Treatment Plan

Holistic

Cognitive
Distortions

Trauma
informed

Building Healthy
Relationships

Objectification

Skills
Development

Emotions
Management

Trauma
informed

Level III
Treatment Plan

Holistic

Decision
Making

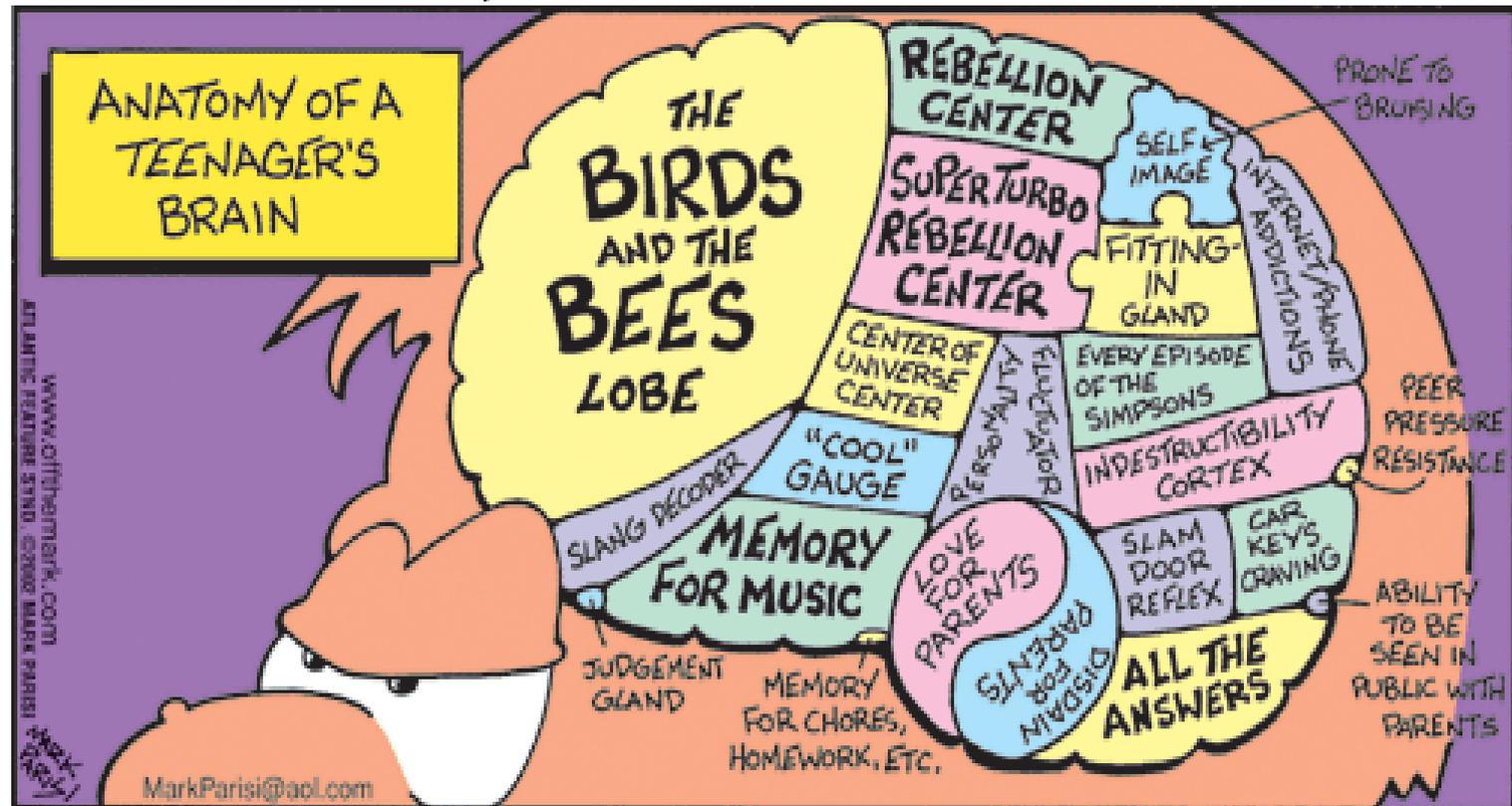
Building Healthy
Relationships

Developmental Considerations

off the mark

by Mark Parisi

www.offthemark.com



Clinical Review Process

- **Track I and II residents have a clinical review process**
 - **Chaired by SO Program Sup / BSU Supervisor**
 - **Usually three panel members**
 - **CC, PO, CO, etc., are invited**
- **Panel presentation / Assessment of:**
 - **Progress in treatment / goals**
 - **Relapse prevention plan**
 - **Re-entry plan**

To Complete Or Not Complete

- **Treatment Completion:**
 - Addressed treatment goals and activities with respect to risk level
 - Refer to the continuum of care for release or step down
 - Await LOS
 - Serious Offender Review / Blended Sentences
 - Special Decision Cases

To Complete Or Not Complete

Consider treatment goals / activities left to be accomplished and balance with:

- Overall risk (high / mod / low)
- Progress in treatment / applying techniques
 - Or exhausted programming
- Facility behavior / compliant vs. non-compliant
- Re-entry options / re-entry plan

Then... Consider continuum versus Facility

Should He Stay Or Should He Go

Consider continued treatment at facility:

- Larger gap of treatment goals yet to be accomplished with:
 - Poor behavioral progress
 - Prior residential treatment failures / flight
 - Prior community treatment failures
 - Lack of/or poorly matched resources to step down

Should He Stay Or Should He Go

Consider transition to a continuum of care placement when:

- It's timely for treatment continuation
- It supports family involvement (proximity)
- It matches security needs
- Clinical resources match individual needs
 - Level I-III / Individual / group / family therapy

Questions....

Hanover BSU Circa 1994



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