Best Practices in Treatment Planning for Adolescents Who Have Sexually Abused

Katie Gotch, Seth Wescott, and David Prescott

Flow

- Key themes
  1. Katie: Background (RNR Principles; policy; guidelines; evolution of risk assessment)
  2. David: Selecting and framing treatment goals; therapeutic alliance; roles of ambivalence and adversity in defining goals)
  3. Seth: Putting it all together; strategies; expectations; what really matters

Note About Person-First Language

- Labels do not serve our shared goals of rehabilitation and change
- Research has shown negative biases and responses to labels such as "addict," "sex offender," etc.
  - Don't label or call people the exact thing we don't want them to do or be!
- Any use of the term SO/SA in the slides during the training is for brevity purposes or due to statutory language

Foundational Principles: Risk, Need, Responsivity

- Risk Principle: matching level of services to offender's risk level (e.g., higher risk receive more intensive services than lower risk)
- Need Principle: identifying individual criminogenic needs (dynamic risk factors) and target with interventions
- Responsivity Principle: tailoring and delivering services in a way to maximize offender's ability to learn (e.g., mental illness, cognitive limitations, culture, gender)

Assessment-Guided Treatment Planning

- It is important to recognize that individuals accused and/or convicted of sexual crimes are **not all the same**
- Youth are also **not** mini-adults. They require specialized approaches for assessment, treatment & management that are:
  - Developmentally appropriate
  - Individualized
  - Client-focused
  - Goal-driven
  - Risk and needs are continually being assessed
  - Interventions are proportional to identified risk/needs
  - Includes family and other support persons

A little bit of history…

- 1990s = "juvenile superpredators"
  - Policies enacted that treated adolescents like adult offenders, number of juvenile correctional facilities grew significantly
- Broadly targeted youth without consideration of developmental status
- Continues despite research attesting to policy failure and/or strong theoretical arguments that policy impedes rather than promotes youth prosocial development

Current Policies in Practice

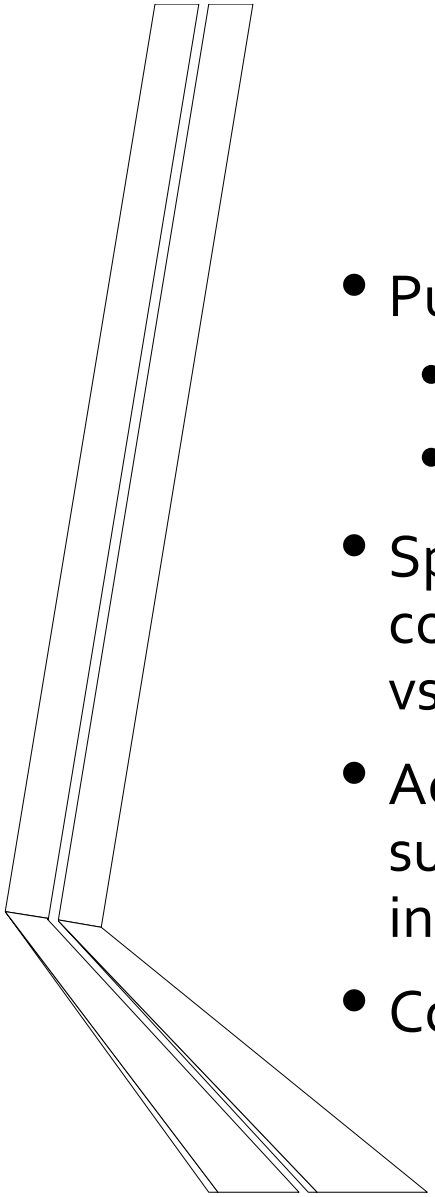
- Tiers/Level Systems
  - Conviction based systems fail to accurately distinguish lower risk from higher risk youth (also for adults)
- Civil Commitment
  - Fails to accurately identify adolescents at high risk of recidivism
- Residence Restrictions
  - Limited studies specific to youth, numerous adult studies show failure to support community protection and prevention
  - Numerous unintended consequences which actually undermine versus promote community safety/prevention

Current Policies in Practice (cont.)

- Registration/Community Notification (SORN laws)
  - Registered youth have low sexual offense recidivism rates indistinguishable from nonregistered youth
    - 2.5% stranger victim (Finkelhor et al., 2009)
    - Continuation of sexual offending into adulthood is unlikely (Lussier et al., 2012)
    - Sexual recidivism in juveniles adjudicated for a sexual crimes falls approximately between 3% and 10%, ***with a global average of approximately 5%*** (Caldwell, 2016)
  - Does not deter first time juvenile sexual offenses or reduce juvenile sexual, violent or nonviolent recidivism
  - Numerous unintended consequences which actually undermine versus promote community safety/prevention

Unintended Consequences of SORN Laws

- More shame, isolation, hopelessness, loss of friendships, stress (Mercado et al., 2008)
- Ostracized due to the "sex offender" label, with registration of youth essentially registration of parents/family (Comartin et al., 2010)
- Registered Youth were also: (Letourneau et al., 2018)
  - Four times more likely to attempt suicide in past 30 days
  - Five times more likely to report being approached by an adult for sex in past year
  - Twice as likely to report having been sexually victimized in past year



Four Fundamental Aspects of Effective Policy …and Effective Treatment Planning!

- Purposefully designed to:
  - Promote prosocial development of youth
  - Effectively mitigate risk posed by youth
- Specifically designed for adolescents versus adults & consistent with aims of juvenile justice (e.g., rehabilitation vs punishment)
- Acknowledge importance of parents, other caregivers to successful development of youth and importance of involvement in interventions
- Consistent with RNR principles

What about recidivism?

Juvenile Males

- Caldwell (2016): large meta-analytic study revealed between 3% and 10% sexual recidivism, with a global average of approximately 5%
  - This study also demonstrated a 73% decline in adolescent sexual recidivism over the past 30 years
- Even across a 20-year prospective follow-up study with a clinical sample, sexual recidivism rates remained low, with the lowest recidivism rates identified for youth who participated in specialized treatment (9% in treated compared to 21% untreated; Worling et al., 2010)

Juvenile Females

- Unknown due to small sample sizes and limited to no research

Desistance

Desistance is the process of discontinuing and demonstrating long-term abstinence from criminal behavior.

Juveniles (Lussier et al, 2012)

- Retrospective study on ~500 juvenile males adjudicated for a sexual crime
- Approximately 10% of the sample continued to commit new sexual offenses in adolescence and adulthood, whereas 90% desisted
  - "Adolescent-limited" (89.6%) versus "High-Rate Slow Desisters" (10.4%)

Evaluation & Assessment: How

ATSA Guidelines – Assessment (Adult Males)

- An evaluation should include:
  - Level of risk for sexual and non-sexual recidivism;
  - Recommended types and intensity of interventions that will be most beneficial, including level of care (e.g., community versus more secure placement);
  - The specific dynamic risk factors or criminogenic (i.e., causing or likely to cause criminal behavior) needs to be targeted through interventions;
  - Amenability to interventions;
  - Responsivity factors that may impact engagement in and response to interventions; and
  - Strengths and protective factors relative to the individual, as well as those that exist within family, peer, and other community support systems.

ATSA (2017) Guidelines - Assessment (cont.)

- The evaluation process includes:
  - Client interviews;
  - Interviews with collateral informants, as applicable (e.g., family members, intimate partner/spouse);
  - Thorough review of official documents (e.g., police reports, victim impact statements, criminal justice records, previous assessment and treatment records, pre-sentence or social services investigations);
  - Empirically grounded general psychometric testing (e.g., intellectual, diagnostic);
  - Empirically grounded instruments designed to measure broad sexual, as well as offense-related, attitudes and interests;
  - Empirically grounded, objective psychophysiological measures of sexual arousal, interests, and/or preferences; and
  - Empirically grounded strategies to estimate the risk of sexual and/or non-sexual-recidivism.

ATSA Guidelines: Juveniles

- Provides evidence-informed guidance for assessment, treatment and management of youth
- Similar in scope to adult guidelines, with emphasis on developmental and similar differences specific to youth, which include:
  - Practitioners have expertise in normative adolescent development and conduct developmentally sensitive assessments recognizing that adolescence is a time of rapid change and growth;
  - Practitioners conduct reassessments at regular intervals – at least semi-annually – to monitor progress, guide treatment planning, and inform administrative or legal decisions;
  - Added focus on Family/Home/Educational Domains within youth risk/need assessments
  - Not recommended to use physiological measurements designed for adults (e.g., polygraph or plethysmographs) on youth

Good Risk Assessment Tools

- Empirically developed and validated through research.
- Assess empirically informed static and dynamic risk factors.
- Are tested on different groups, different offences and at different times to ensure the tools are applicable to a wide range of situations and individuals.
- Get similar results when used with different populations.
- Are able to assess if there has been a change.
- Have at least moderate levels of predictive ability.
- Used by trained individuals who are consistent and conscientious about applying the tools in the appropriate manner (e.g., following the coding rules, etc.).

Risk Assessment Tools: Adult Males

<u>Static Actuarial</u>

- Static-99R/STATIC-2002-R (Helmus et al., 2012)
- MnSOST-R (Epperson et al., 1998)
- SORAG (Quinsey et al., 2006)

<u>Dynamic</u>

- STABLE & ACUTE-2007 (Hanson et al., 2007)
- VRS-SO (Olver et al., 2007)
- SOTIPS (McGrath et al., 2013)
- SRA-FV (Thornton & Knight, 2013)
- RSVP (Hart et al., 2003)

SO Specific Risk Assessment Tools: Juvenile Males

- ERASOR V-2 (Worling & Curwen, 2001)
- JSORRAT-II (Epperson et al., 2005)
- J-SOAP-II (Prentky & Righthand, 2003)
- MEGA (Miccio-Fonseca, 2009)

Issues with Juvenile Risk Prediction Tools

1. Research regarding risk prediction accuracy levels
   - Existing research has ***not*** identified any risk assessment instruments that reliably predict sexual recidivism in adolescents convicted of a sexual crime (Caldwell, 2016)
2. 33%-100% of the risk factors are static: adolescents are not
3. Research regarding established risk prediction factors
4. Narrow age range (typically 12-18)
5. Dated language does not reflect changes in the field
6. Most tools not applicable for subgroups (e.g., females, noncontact offenses, bestiality, child abuse images…)
7. Arbitrary risk ratings with some tools (e.g., what does "High Risk" mean? "Moderate Risk?")
8. Only looks at risk factors: ***no*** protective factors

Protective + Risk Observations for Eliminating Sexual Offense Recidivism (PROFESOR, Worling 2017)

- Structured checklist to assist professionals to identify and summarize protective and risk factors for adolescents and emerging adults (ages 12-25)
- Intended to assist with planning interventions that can help individuals to enhance their capacity for sexual and relationship health and, thus, eliminate sexual recidivism.
- 20 bipolar factors (i.e., both protective and risk characteristics) that were chosen based on a review of the available literature and on clinical experience with adolescents and emerging adults who have offended sexually

https://www.profesor.ca/

PROTECTIVE + RISK OBSERVATIONS FOR ELIMINATING SEXUAL OFFENSE RECIDIVISM

Total=20

PROFESOR

Enter 1 'X' per factor

Name of Individual JOHN SMITH Age 16 ID

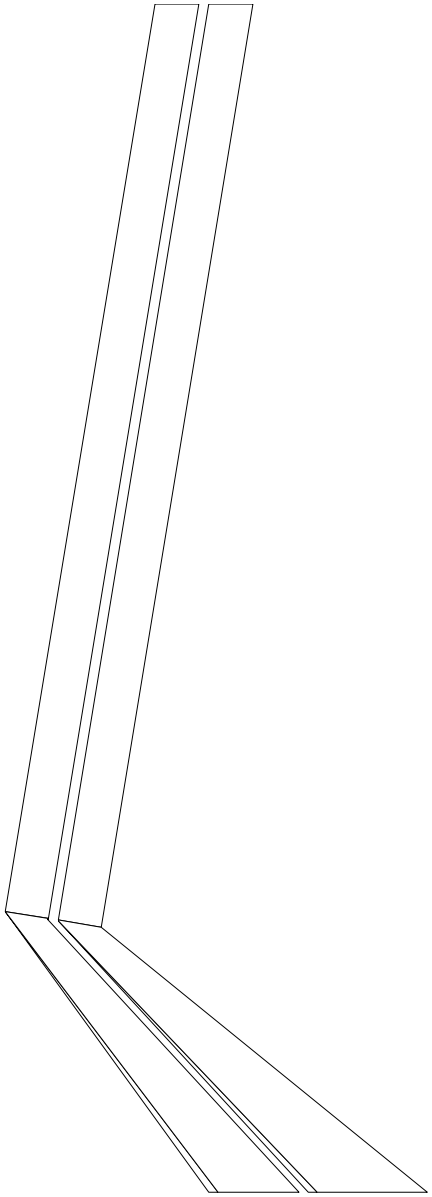
Name of Evaluator Jane Doe Date (mm/dd/yyyy) 03/10/2025

	Protective	Protective	Neutral	Risk	Risk
1	Hopefulness regarding healthy sexual future	x			Hopelessness regarding healthy sexual future
2	Respectful sexual environment		x		Abuse-supportive sexual environment
3	Respectful and age-appropriate sexual beliefs/attitudes		x		Abuse-supportive sexual beliefs and attitudes
4	Respectful sexual interests in age-appropriate partner(s)		x		Abuse-supportive sexual interests
5	Balanced sexual interests		x		Preoccupied/obsessive sexual interests
6	Good awareness of laws and procedures to facilitate respectful sexual relationships		x		Poor awareness of laws and/or procedures to facilitate respectful sexual relationships
7	Good awareness of consequences of sexual offending		x		Poor awareness of consequences of sexual offending
8	Appropriate use of reasonable strategies to prevent sexual offending			x	Lack of use of reasonable strategies to prevent sexual offending
9	Compassionate and caring towards others	x			Callous and/or uncaring towards others
10	Prosocial values and attitudes	x			Antisocial values and attitudes
11	Good self-regulation		x		Poor self-regulation
12	Good problem-solving	x			Poor problem-solving
13	Responsive to reasonable guidance and support	x			Rejecting of reasonable guidance and support
14	Healthy self-esteem		x		Unhealthy self-esteem
15	Emotional intimacy and close friendship with prosocial peer(s)			x	Lack of emotional intimacy and/or close friendship with prosocial peer
16	Feels close to and supported by a parent/caregiver		x		Feels distant from and/or rejected by parents/caregivers
17	Parents/primary caregivers provide warmth and appropriate structure		x		Parents/primary caregivers fail to provide warmth and/or appropriate structure
18	Strong commitment to and engagement in school and/or work	x			Weak commitment to and/or engagement in school and work
19	Strong commitment to and engagement in organized leisure activity	x			Weak commitment to and/or engagement in organized leisure activity
20	Feels stable and secure in current living arrangement				Feels unstable and/or insecure in current living arrangement
Total		**7**	**10**	**2**	**CATEGORY** **3**

Category 1	Category 2	Category 3	Category 4	Category 5
Predominantly Protective Fewer than 10 neutral **AND** 80% or more of non-neutral are protective.	**More Protective Than Risk** Fewer than 10 neutral **AND** more protective than risk by at least 3, **AND** less than 80% of non-neutral are protective.	**Predominantly Balanced** 10 or more neutral **OR** Fewer than 10 neutral **AND** difference between protective and risk of less than 3.	**More Risk Than Protective** Fewer than 10 neutral **AND** more risk than protective by at least 3, **AND** less than 80% of non-neutral are risk.	**Predominantly Risk** Fewer than 10 neutral **AND** 80% or more of non-neutral are risk.

Evolution of Juvenile Risk Assessment

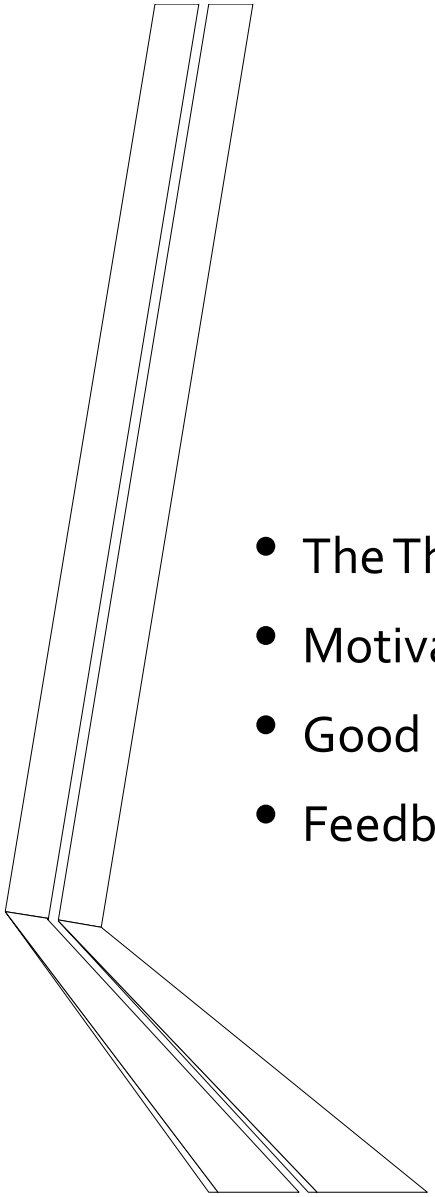
Clinical Decision Making	Actuarial	Structured Professional Judgment
• Earliest attempt at risk assessment. • Involves use of "intuition." • Often performed, worst than chance. • Difficult to replicate and lacks transparency.	• Second generation • Empirically based risk factors. • Computes a probability estimate (i.e. 5% recidivated over 10 years). • Does not account for change.	• Most recent advancement. • Examines both static & dynamic variables. • Does not yield a probability estimate. • Best for assessing risk in the short-term (6 months.)



The Good Lives Model (GLM)

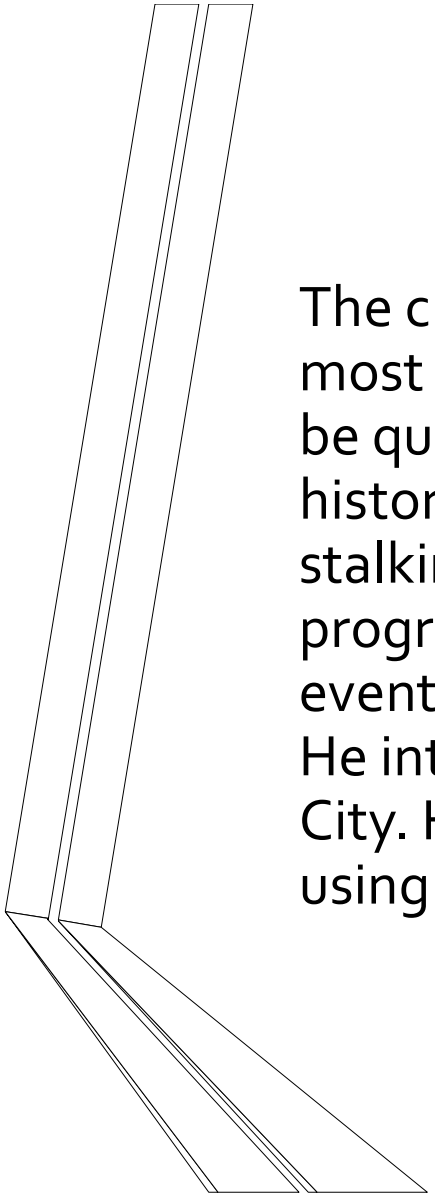
"…[our clients] want better lives, not simply the promise of less harmful ones"
(Ward et al., 2007)

Questions?

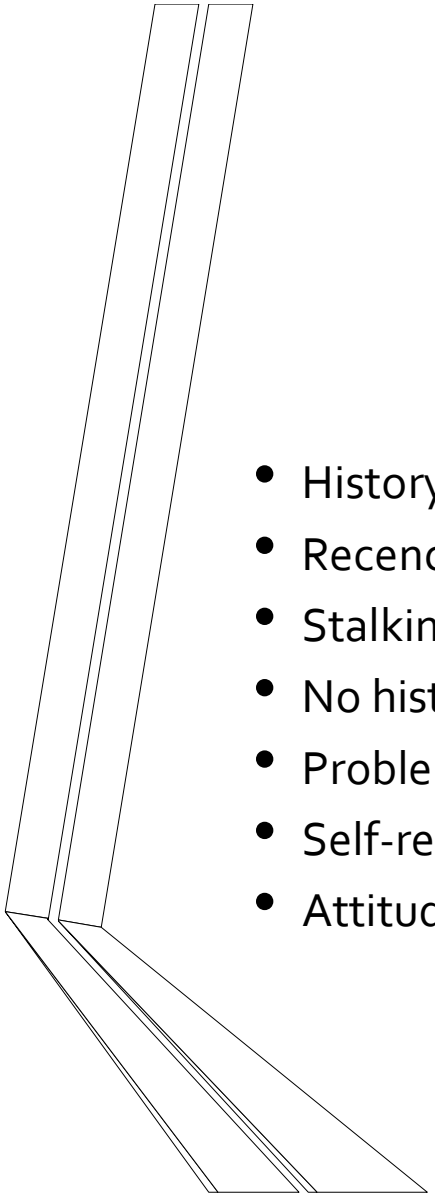


Four Frameworks

- The Therapeutic Alliance
- Motivational Interviewing
- Good Lives Model
- Feedback-Informed Treatment



The client just turned 17. He has high-functioning Autism, which is most apparent in his social interactions and rigid thinking. He can also be quite paranoid and suspicious of others' intentions. He has a long history of being violent towards his family and he was more recently stalking a young woman in school. He spent some time in a treatment program in another country. He wants to meet a young woman and eventually have a family. However, his planning is very rigid indeed. He intends to meet her, then move to London, and then to New York City. He intends to accomplish this in five years. Where do you start in using the Good Lives Model?

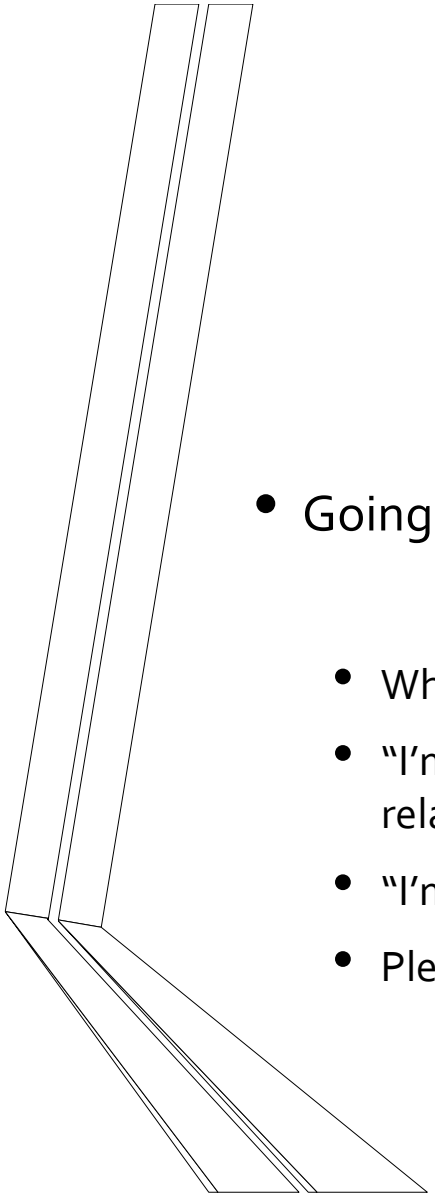


Risks

- History of violence
- Recency of violence (?)
- Stalking persisting despite concerns expressed by others
- No history of positive relationships
- Problem-solving skills?
- Self-regulation skills?
- Attitudes and beliefs?

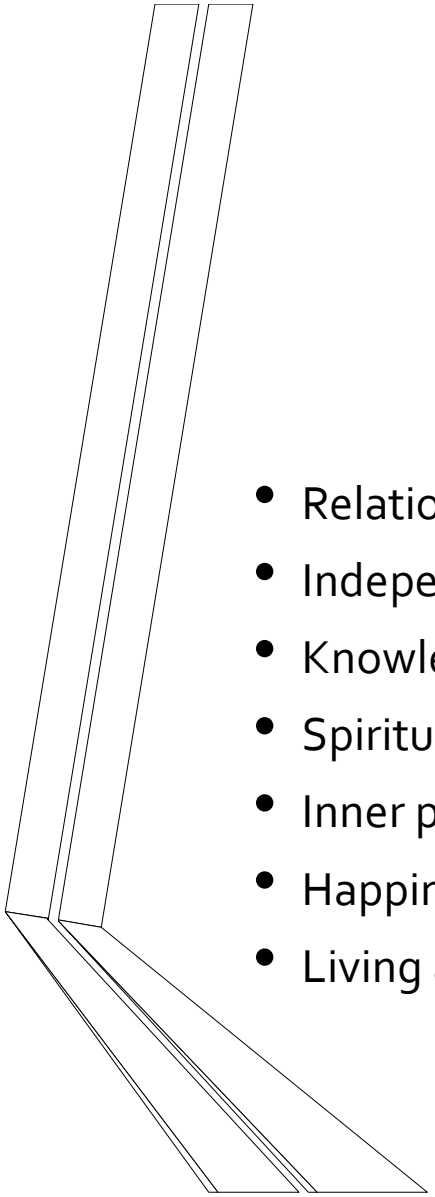
Preliminary Strengths/Protective Factors

- Desires relationships
- Wants to know how he fits into the world around him/seeks knowledge
- Apparently stable in other areas of his life
- No expressed concerns about medications
- Involved with services



Important Skill

- Going Upstream:
  - What's the larger goal behind the immediate goal or clinical presentation?
  - "I'm not gonna" and "you can't make me" reflect deeper goals around autonomy and relationships.
  - "I'm not the same person as I was then" reflects avenues for inquiry regarding identify.
  - Please note that one statement or action can reflect multiple goals!



Good Lives Model Goods/Goals

- Relationships and friendships
- Independence and autonomy
- Knowledge
- Spirituality: Meaning and purpose
- Inner peace
- Happiness and pleasure
- Living and surviving

Goods/Goals Implicated in Violence and Stalking

- Relationships and friendships
- Living and surviving
- Independence/autonomy (inc. personal choice)
- Knowledge
- Happiness and pleasure

Obstacles to Good Life Plan

- Internal capacity: lacking relationship skills, problem-solving skills, coping skills, independent living skills

➔

- Use of inappropriate means to attain goods/goals

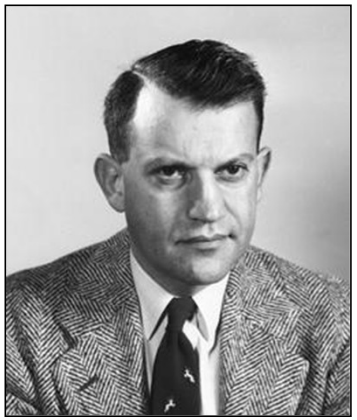
➔

- Narrow scope of good life

➔

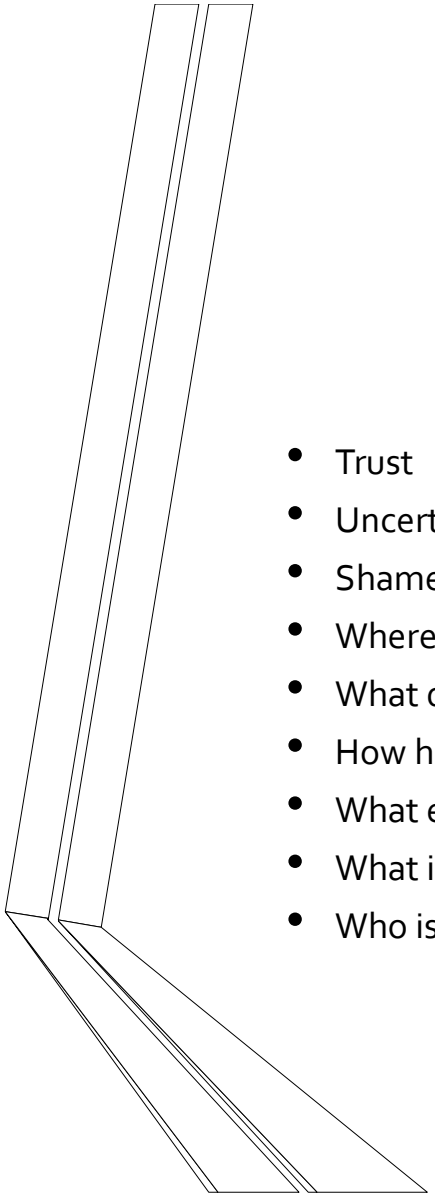
- Conflict between goals and goods

1979: Edward S. Bordin



- Therapeutic alliance:
  - Agreement on goals
  - Agreement on relationship
  - Agreement on tasks
  - (Norcross, 2002, would add client preferences)

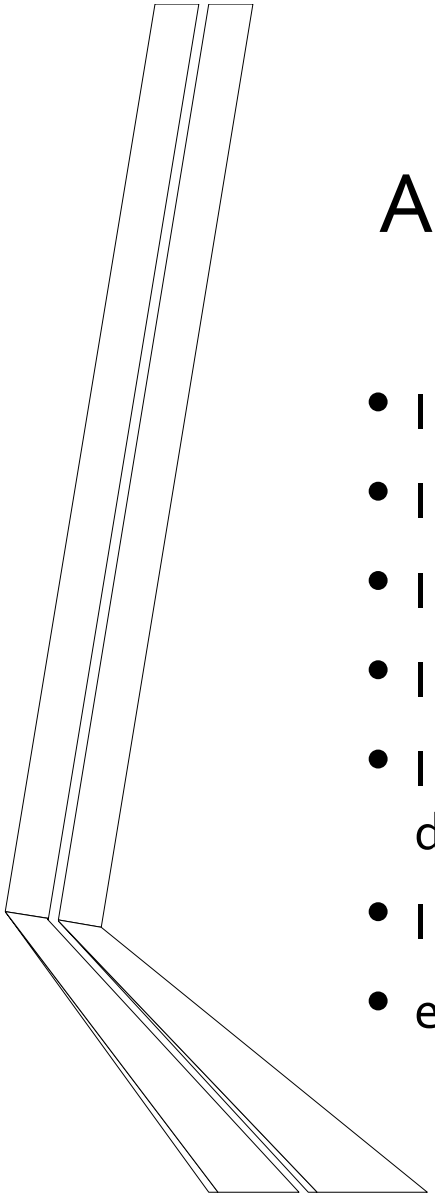
- Over 1,100 studies have emphasized the importance of the alliance in psychotherapy since (Orlinsky & Rønnestad, 1994)



Upstream

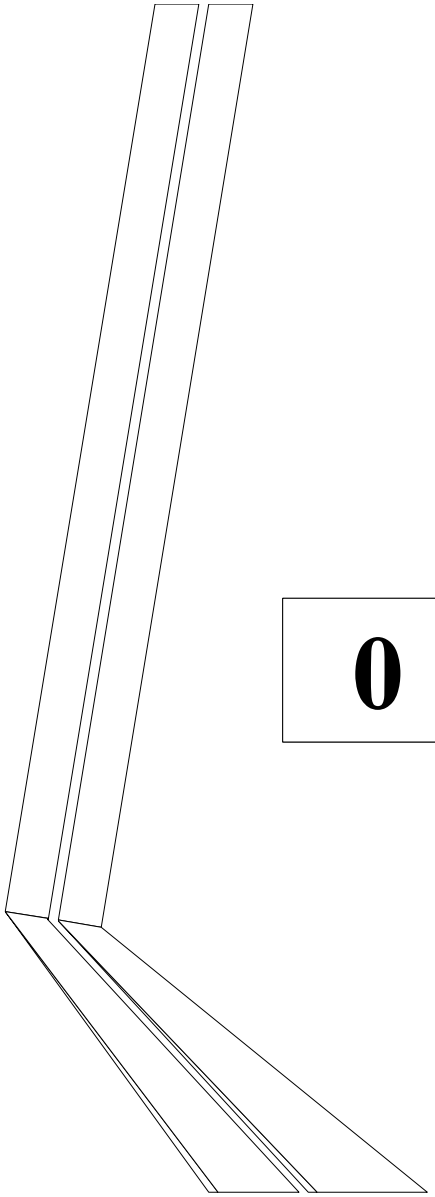
- Trust
- Uncertainty
- Shame
- Where does safety lie?
- What does he do with pain?
- How has he been hurt in the past and what how did he make sense of it all?
- What else would he do if he could just cut loose and be free?
- What is he longing for?
- Who is he longing for?

Ambivalence



Ambivalence

- I want to talk with you and I don't want any more trouble
- I want to work with you, and I don't want to look like a fool
- I want to tell the truth and I want my family to still love me
- I want to change, and I want to be respected
- I want to be in treatment, and I don't want to be in a one-down position
- I want to look at myself, and I don't want to feel less manly
- etc. etc. etc. etc. etc.



Are We Ready?

0 1 2 3 4 5 6 7 8 9 10

Motivation = importance + Confidence

Good Life Goals

(Yates & Prescott, 2011)

Good Lives Model Goals

Life: Living and Surviving

Knowledge: Learning and Knowing

Being Good at Work & Play

Personal Choice and Independence

Inner Peace/Peace of Mind

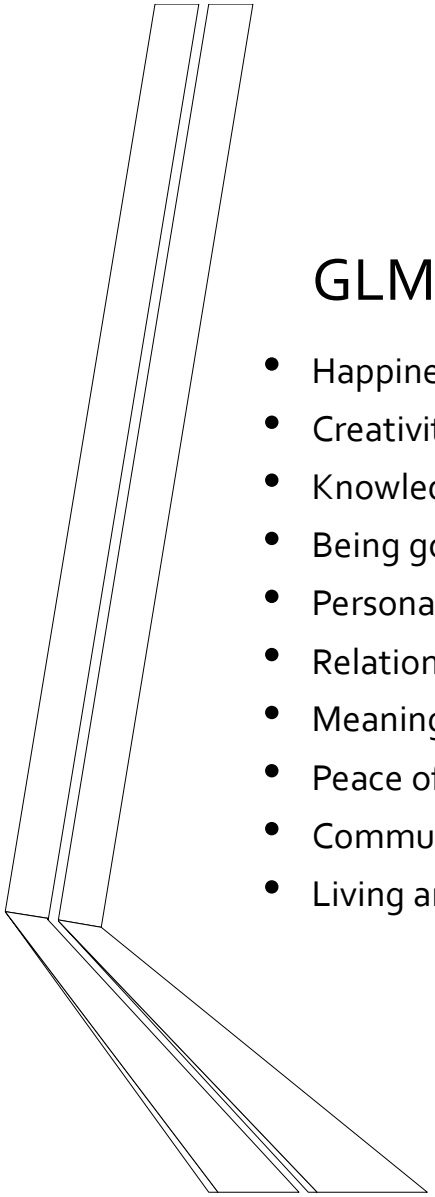
Relationships and Friendships

Community: Being Part of a Group

Spirituality: Having Meaning in Life

Happiness

Creativity



GLM vs. Andrews & Bonta Big 8

(Possible comparison)

GLM

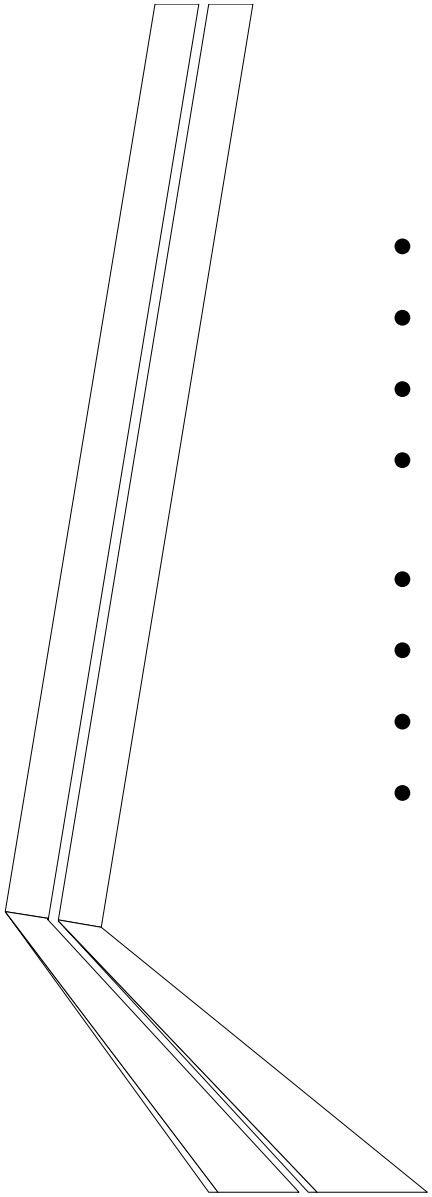
- Happiness/Pleasure
- Creativity
- Knowledge
- Being good at work and play
- Personal choice/independence
- Relationships and friendships
- Meaning and purpose in life
- Peace of mind
- Community
- Living and surviving

Big 8

- Substance abuse and other pleasure seeking
- Poor performance in school or work
- Impulsivity/self-regulation deficits
- Antisocial peer group/social isolation/family problems
- Antisocial history
- Aggression/irritability
- Attitudes and beliefs supportive of sexual violence
- Alcohol/drugs, reckless, dangerous behavior

Good Life Goals
(Prescott, 2018; Also Print, 2013)

- Having fun
- Being an achiever
- Being my own person
- Being connected to other people
- Having a purpose in life
- Meeting my emotional needs
- Meeting my sexual needs
- Being physically healthy



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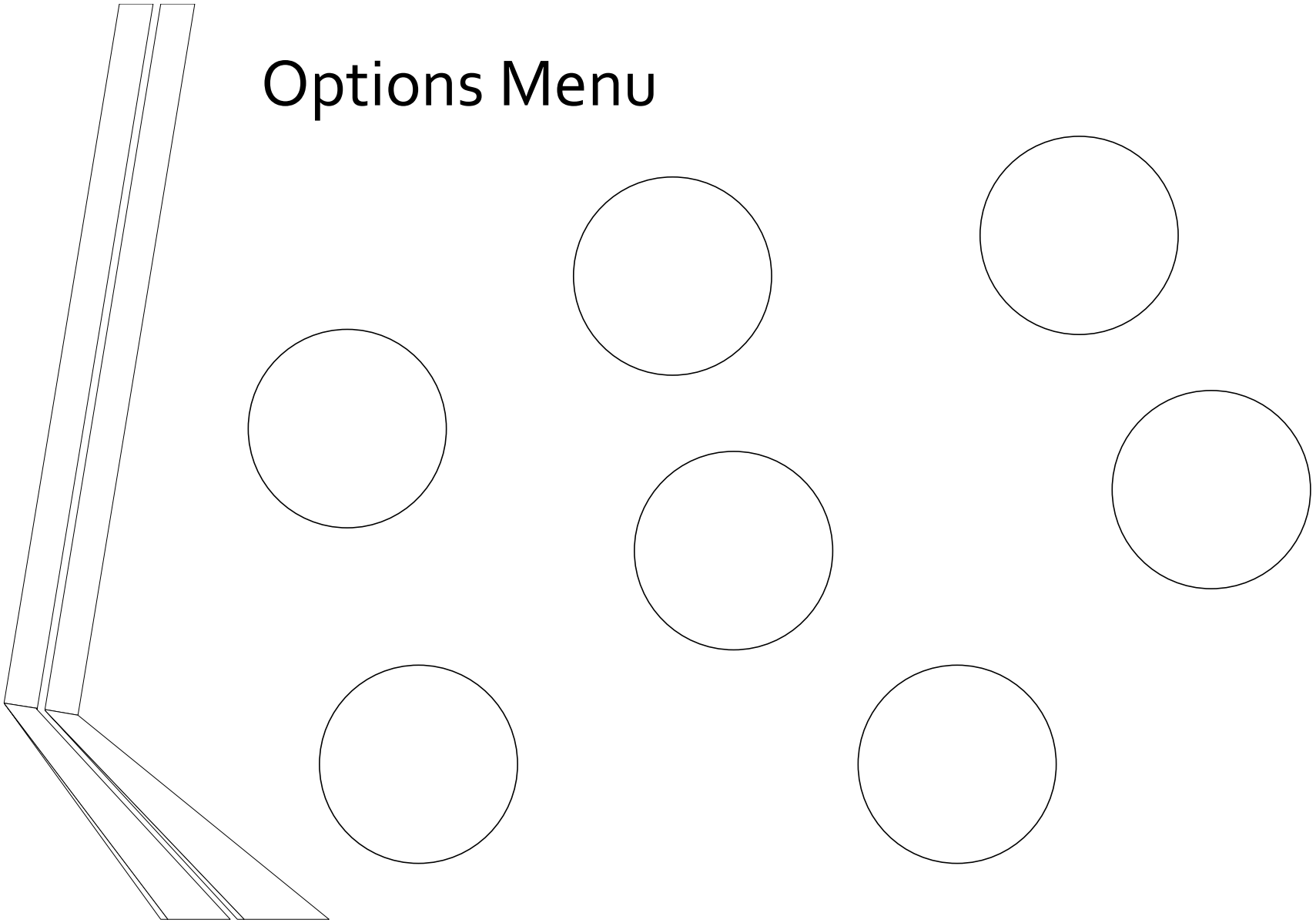
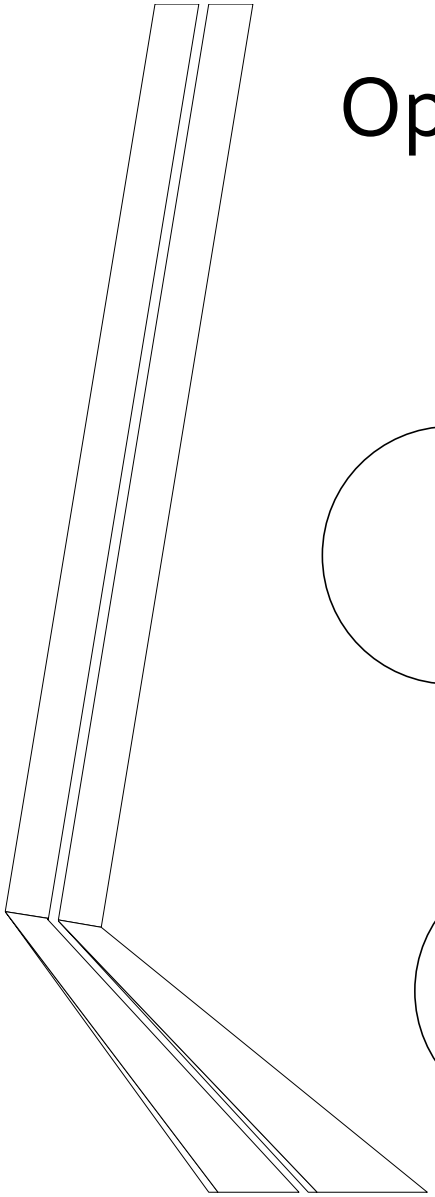
GLM vs. Andrews & Bonta Big 8

(possible comparison)

Options Menu



Options Menu



How have you been?

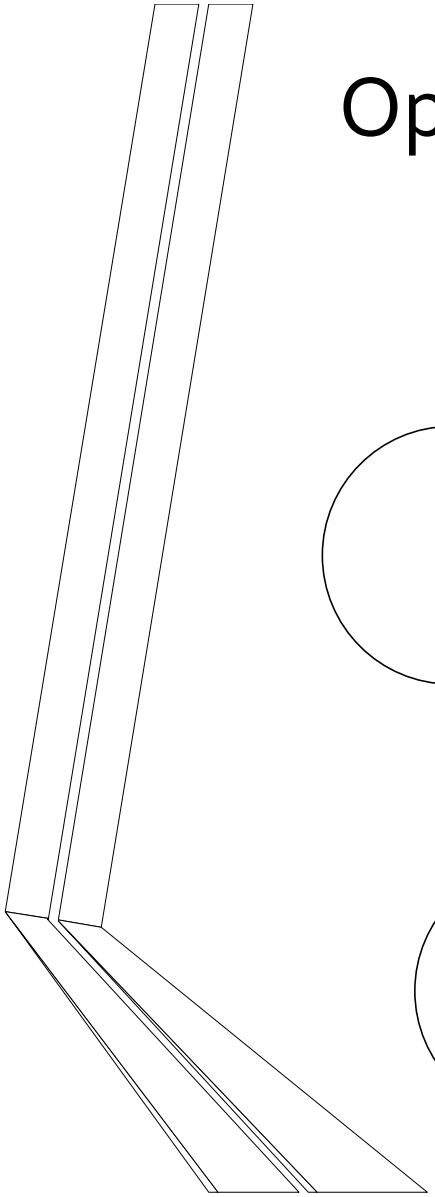
School

Relationships

Family

Home-work

Options Menu

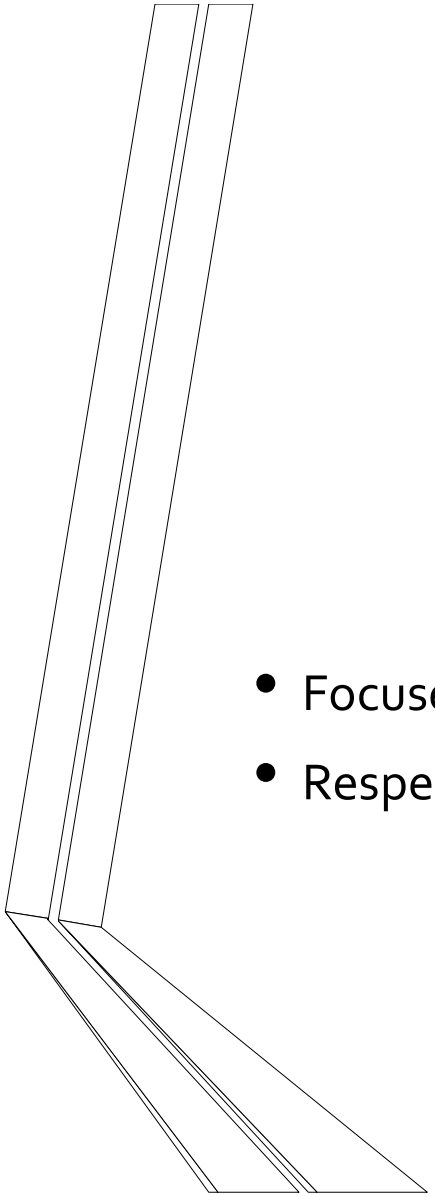


How are you?

Recent Incident

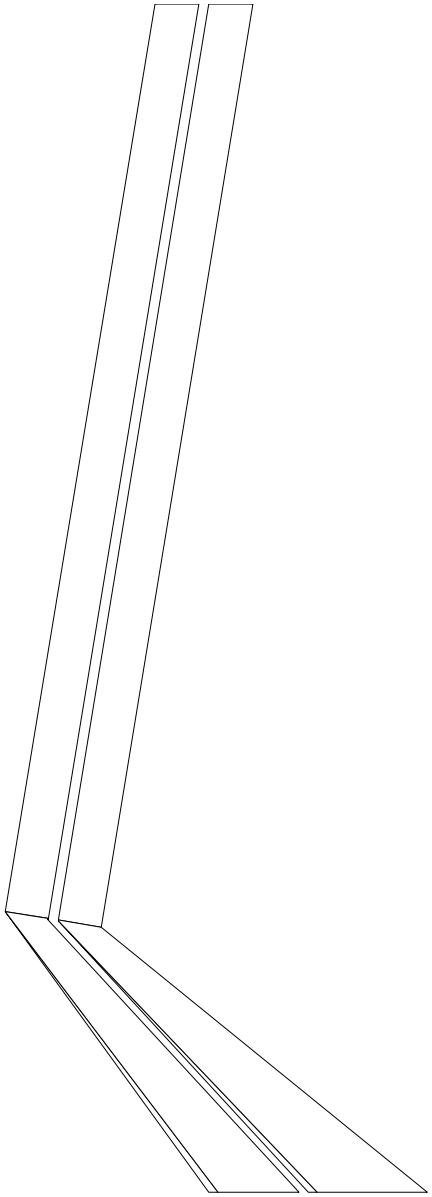
Peers

Plans

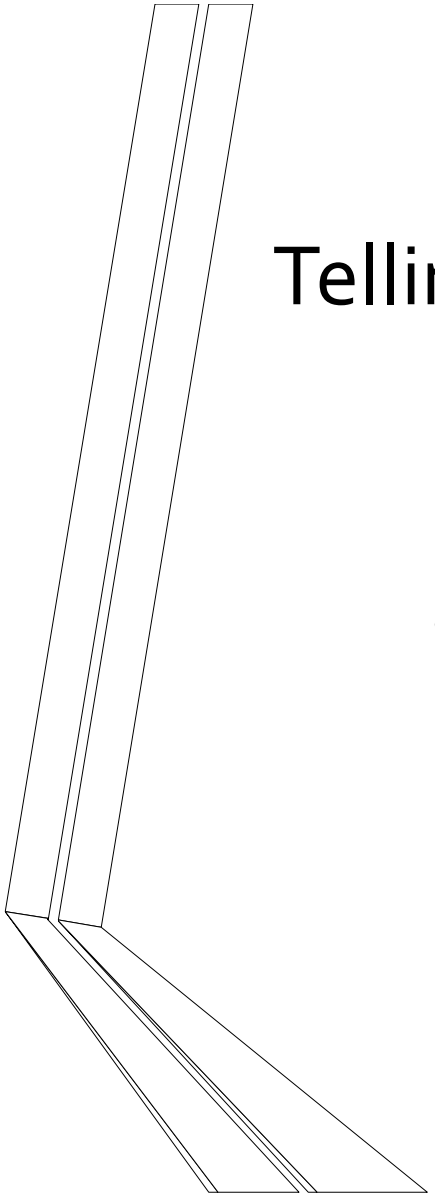


A Good Options Menu

- Focuses the direction
- Respects client autonomy

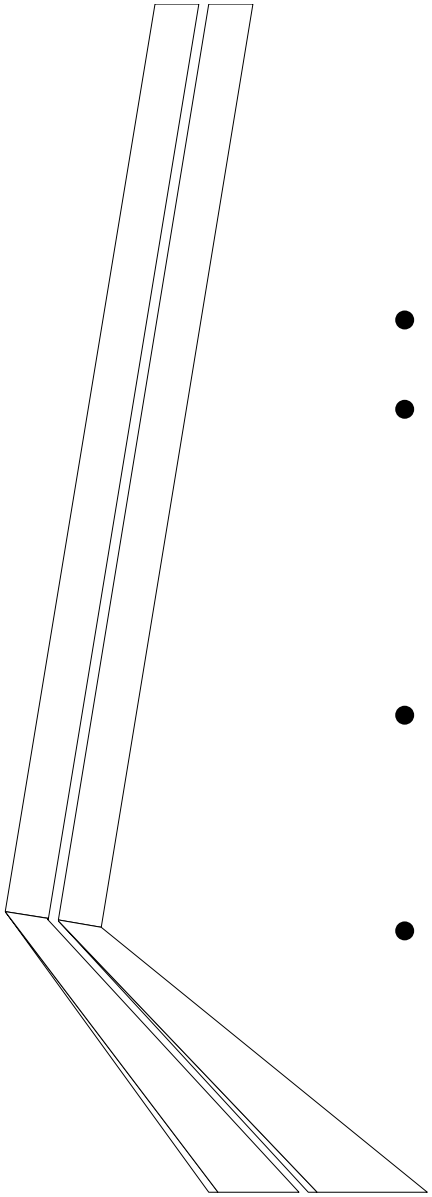


Ideally



Telling "The Hard Truth"

- Elicit => Provide => Elicit
  - Ask permission to give feedback, give the feedback, then elicit the client's thoughts about your feedback



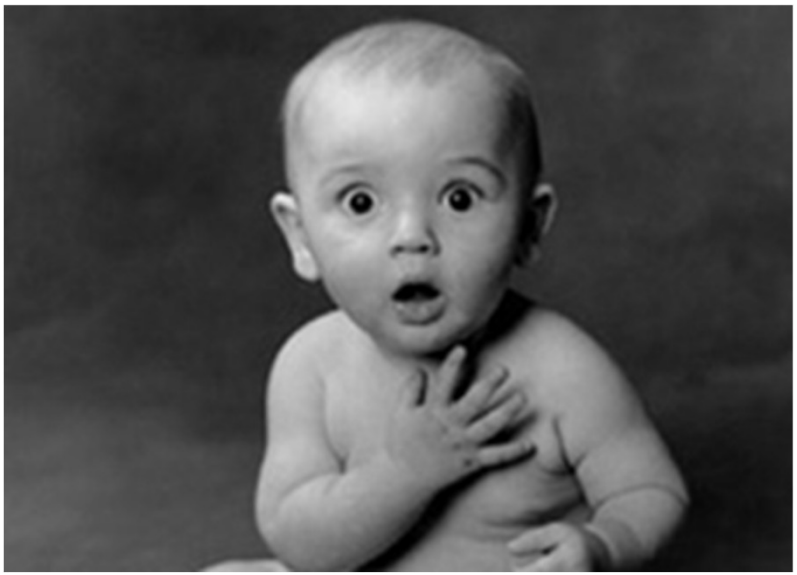
Culture of Feedback

- Superior therapists elicit more negative feedback
- Atmosphere in which clients are free to rate their experiences
  - Without retribution
  - With a hope of having an impact
- Beyond displaying openness, this involves introducing available outcome measures thoughtfully and thoroughly
- Not just more forms to fill out!

Central Point

- "Love yourself as a person and doubt yourself as a therapist."
  - Helene Nissen-Lie

Openness and Surprise



ROUTINE OUTCOME MONITORING

- Tracking global outcomes
- Tracking the working alliance
- Session-by-session feedback
- Examples include Youth Outcome Questionnaire, Outcome Rating Scale, Session Rating Scale, etc.

OUTCOME RATING SCALE (Miller et al., 2003)

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing*

Individually

(Personal well-being)

I----------I

Interpersonally

(Family, close relationships)

I----------I

Socially

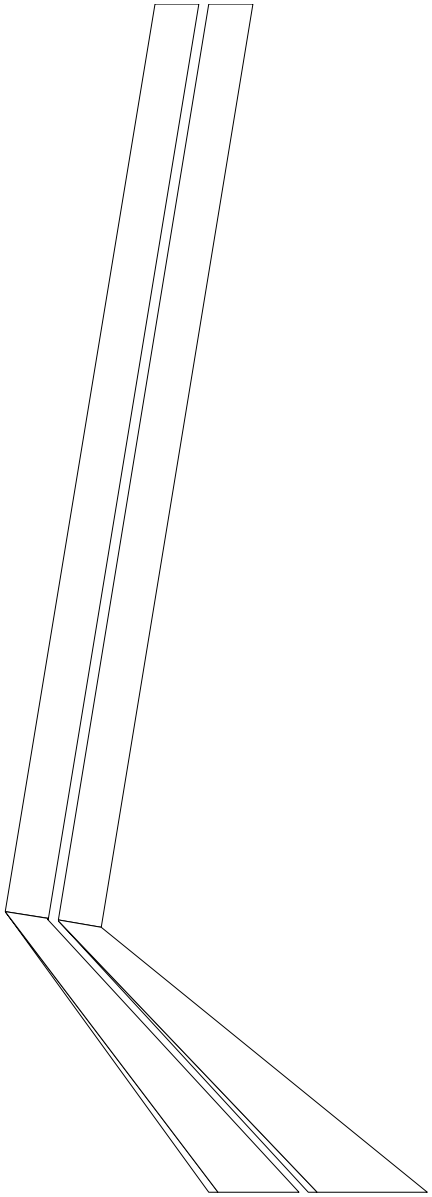
(Work, school, friendships)

I----------I

Overall

(General sense of well-being)

I----------I



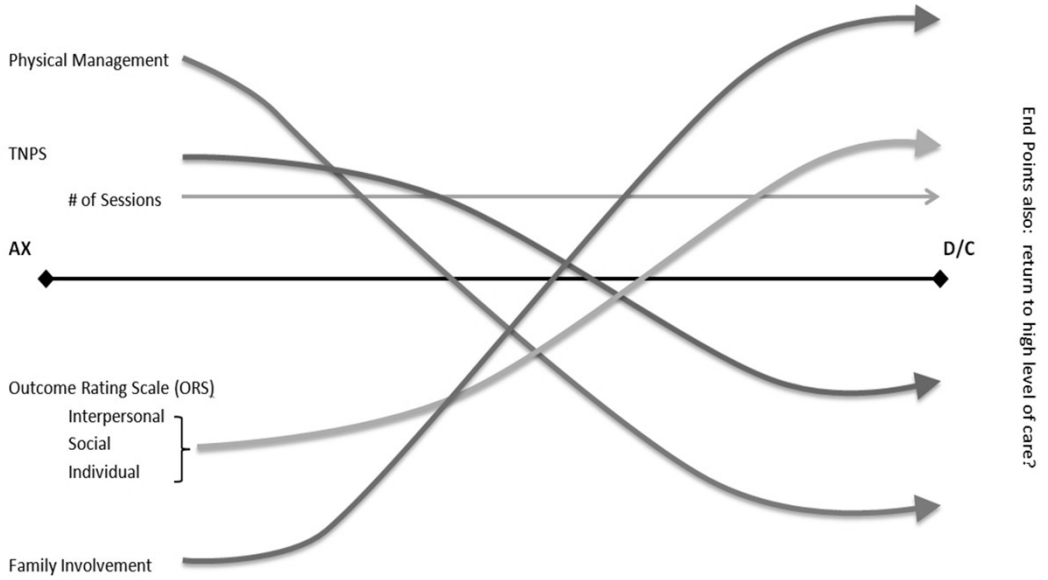
Session Rating Scale
(Miller et al., 2002)

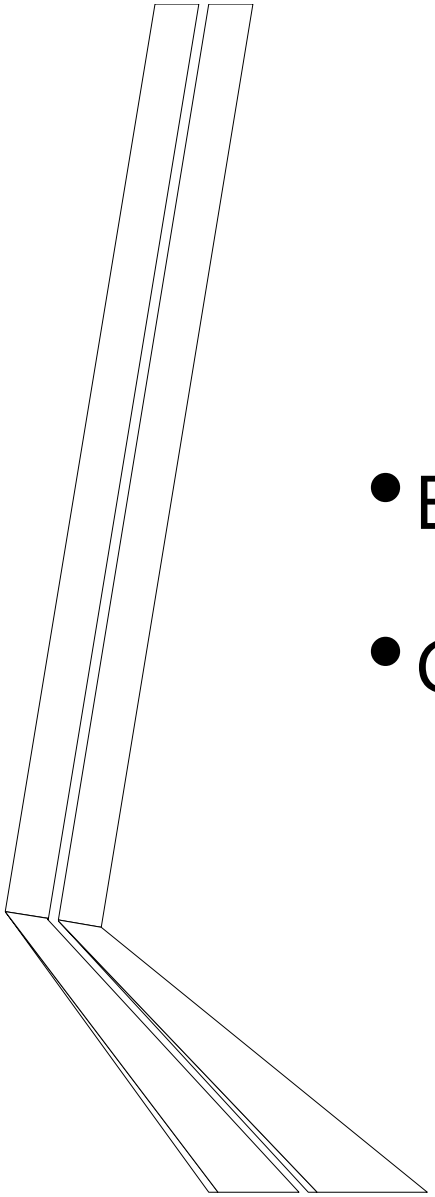
Please rate today's session by placing a mark on the line nearest to the description that best fits your experience:

I did not feel heard, understood, and respected	Relationship I----------I	I felt heard, understood, and respected
We did not work on or talk about what I wanted to work on or talk about	Goals and Topics I----------I	We worked on and talked about what I wanted to work on and talk about
The therapist's approach is not a good fit for me	Approach or Method I----------I	The therapist's approach is a good fit for me
There was something missing in the session today	Overall I----------I	Overall, today's session was right for me

(Miller, Duncan, & Johnson, 2002)

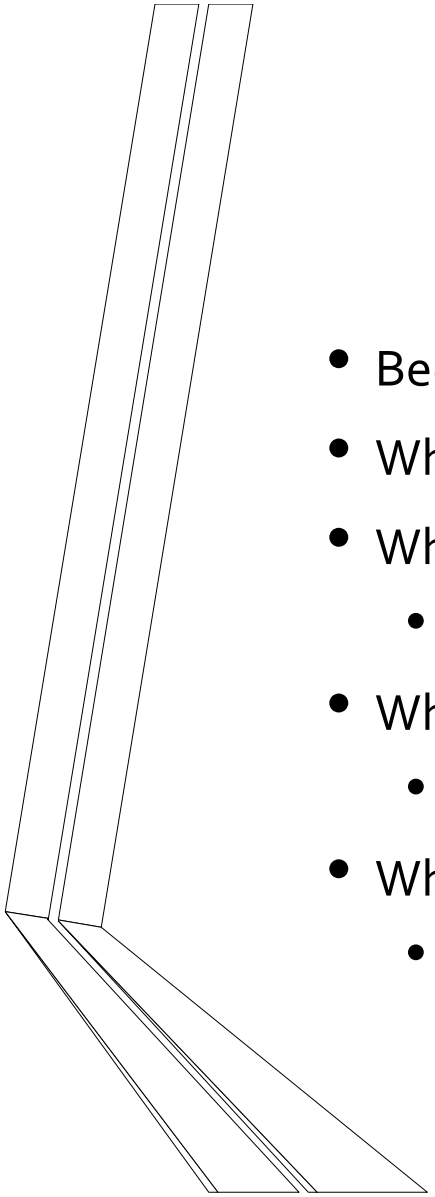
WELCOME TO MY WORLD





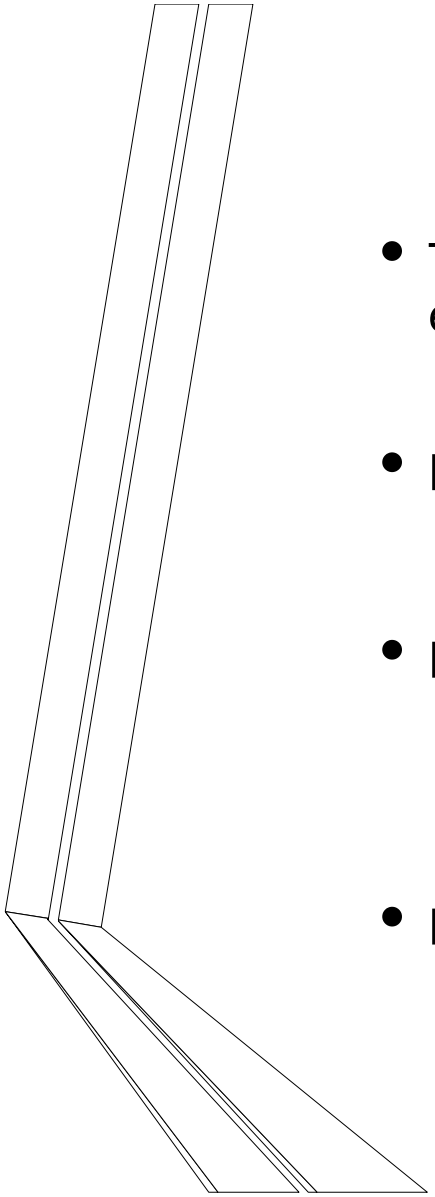
More Take-Home Skills

- Establish a culture of feedback
- Get actionable feedback:
  - Clients
  - Colleagues



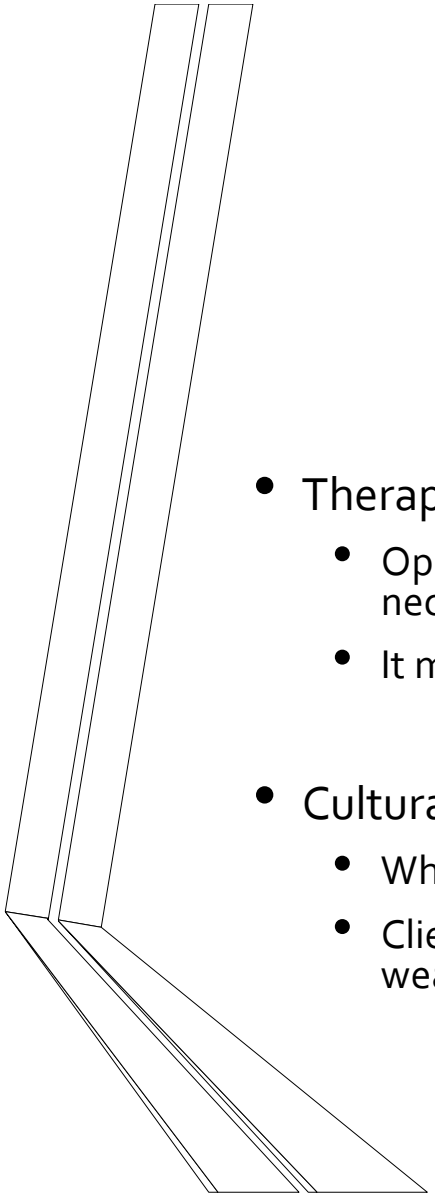
When Supervising

- Begin with a case and consider:
- What are this client's goals?
- Who are you in this client's life, from his/her perspective?
  - (clarifying relationship)
- What things do and don't work for him/her in treatment
  - (clarifying tasks and approach of therapist)
- What cultural considerations exist?
  - Is the therapist taking these into account in constructing services?



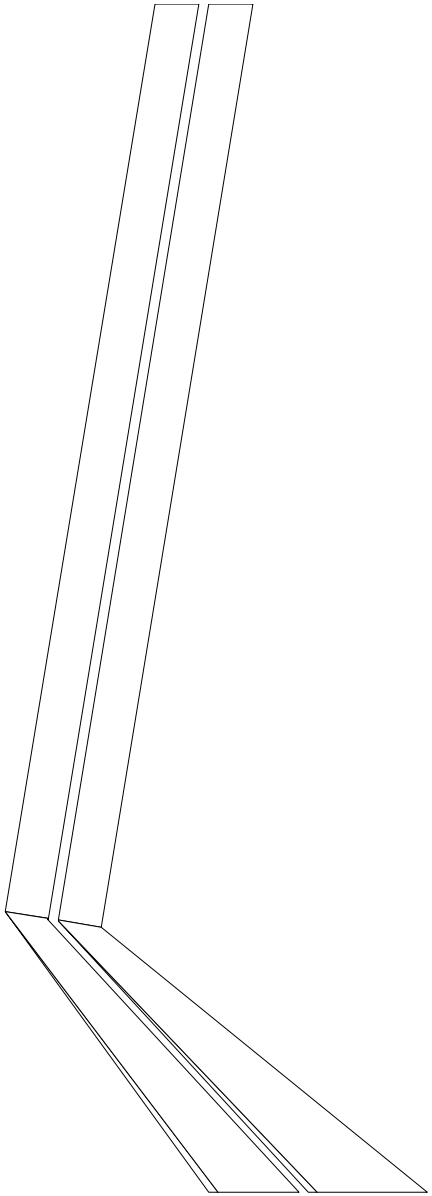
Example

- The seemingly impossible case: Unmotivated, uninterested, has had enough of therapists
- First, consider possible trauma history
  - Attempts to avoid painful topics and appearing numb can be PTSD symptoms
- Explore client goals
  - His desire for freedom and living in the community indicates a strong priority on personal choice and independence.
  - Set therapist goal of exploring other goals with interest and no agenda as part of a regular conversation; not overtly clinical
- Explore client relationship
  - Who is this therapist in the client's life? Just an innately annoying person? Define what the therapist can and can't do



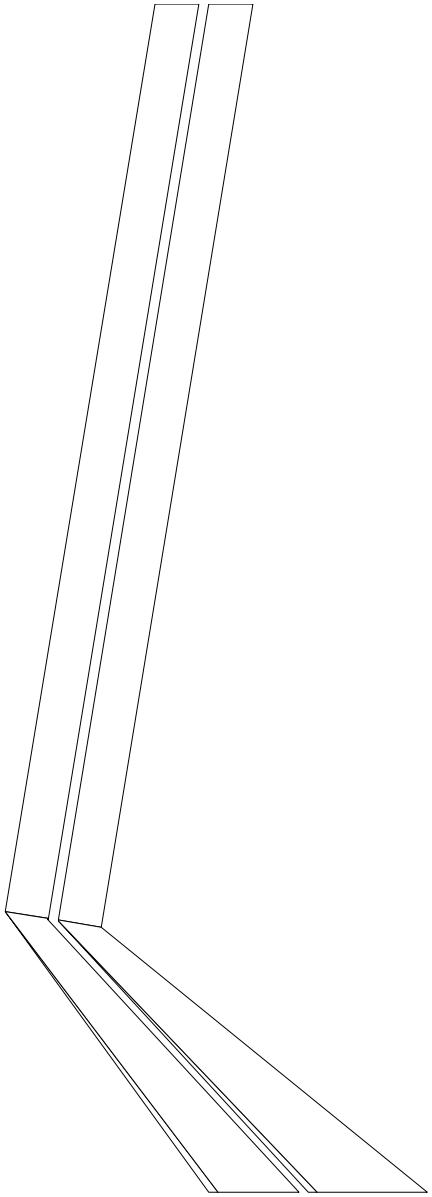
Example

- Therapist approach
  - Open discussions about what is working for the client, what kind of approaches may be necessary, and why.
  - It may be as simple as "what's in it for you".
- Cultural considerations
  - What strongly held values assist or impede this case?
  - Client comes from a family in which receiving assistance of any kind is considered a sign of weakness.



Additional Treatment Process Ideas

and Process Challenges

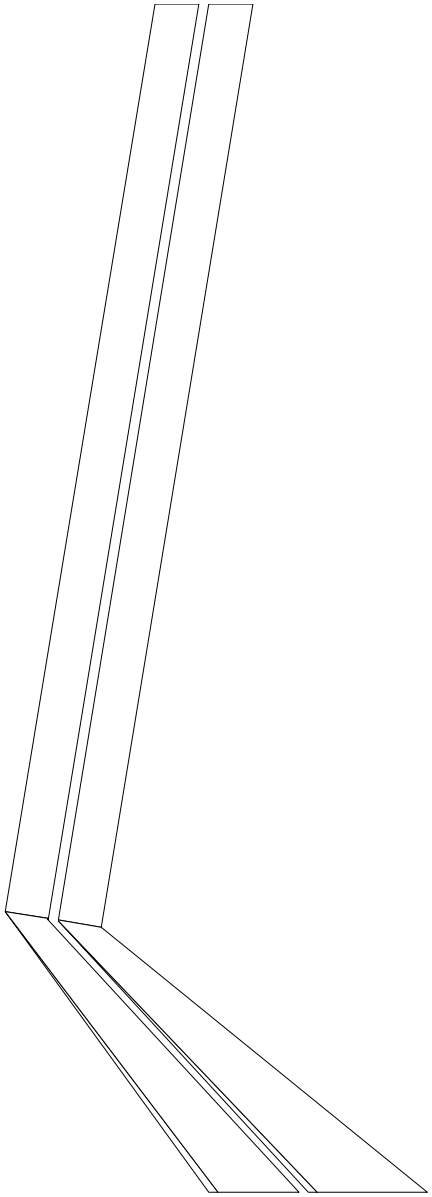


Thinking On These Goals

- What will progress in this look like to me and others?
- What can I do to make positive changes in this?
- What problems might happen as I try to improve?
- How would I know when things aren't working?
- How would others know when things aren't working?
- What can I and others do when things start to go wrong?
- How can I and others acknowledge progress when it happens?

Thinking Further On These Goals

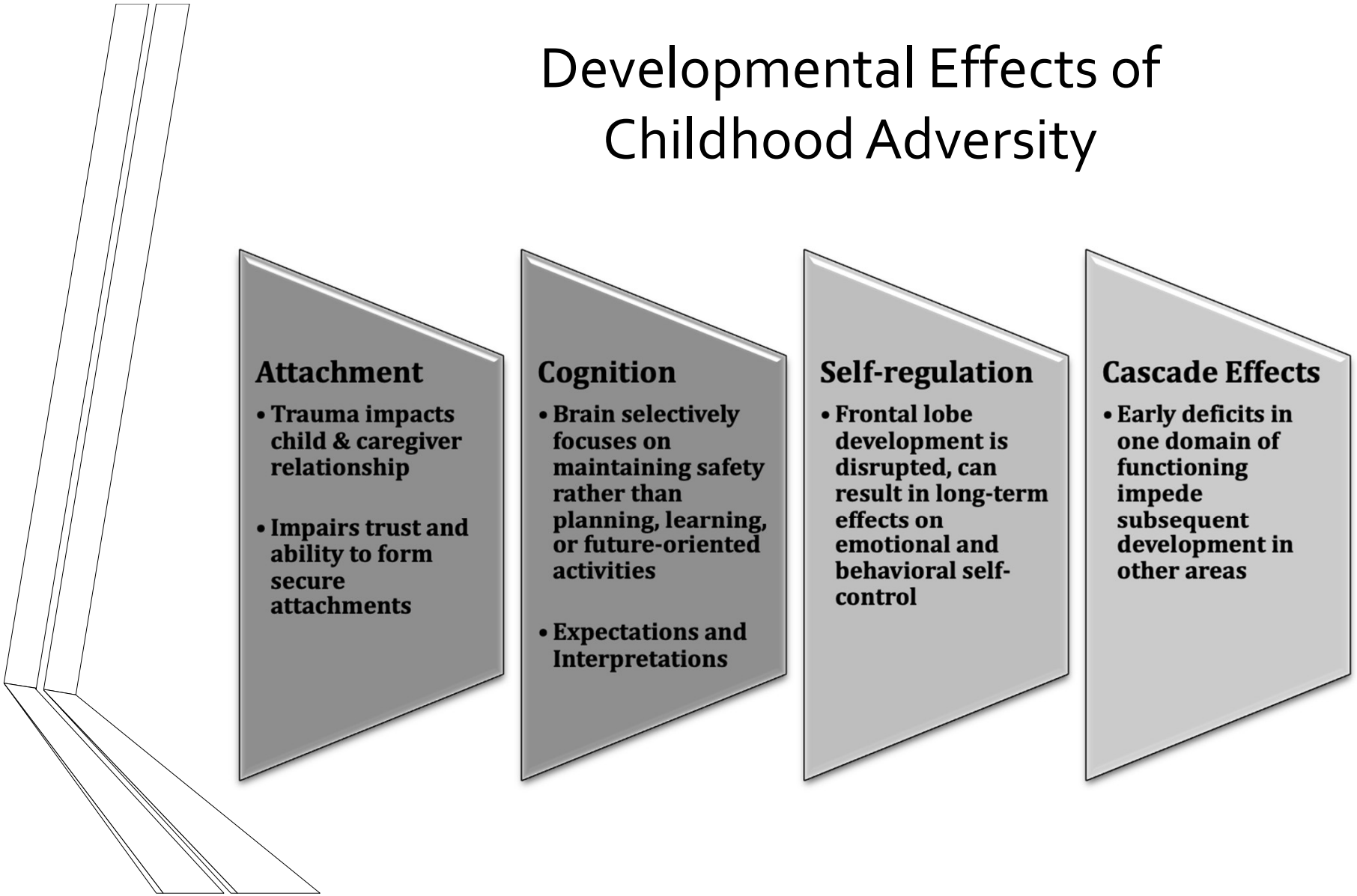
- How have traumatic and otherwise adverse experiences affected this person's ability to get this goal?
- How have the same experiences affected how he looks at the world?
- Where are all the places that this person may experience ambivalence about this goal?
- How can we elicit the client's internal motivation(s) regarding attaining this goal without harming others?



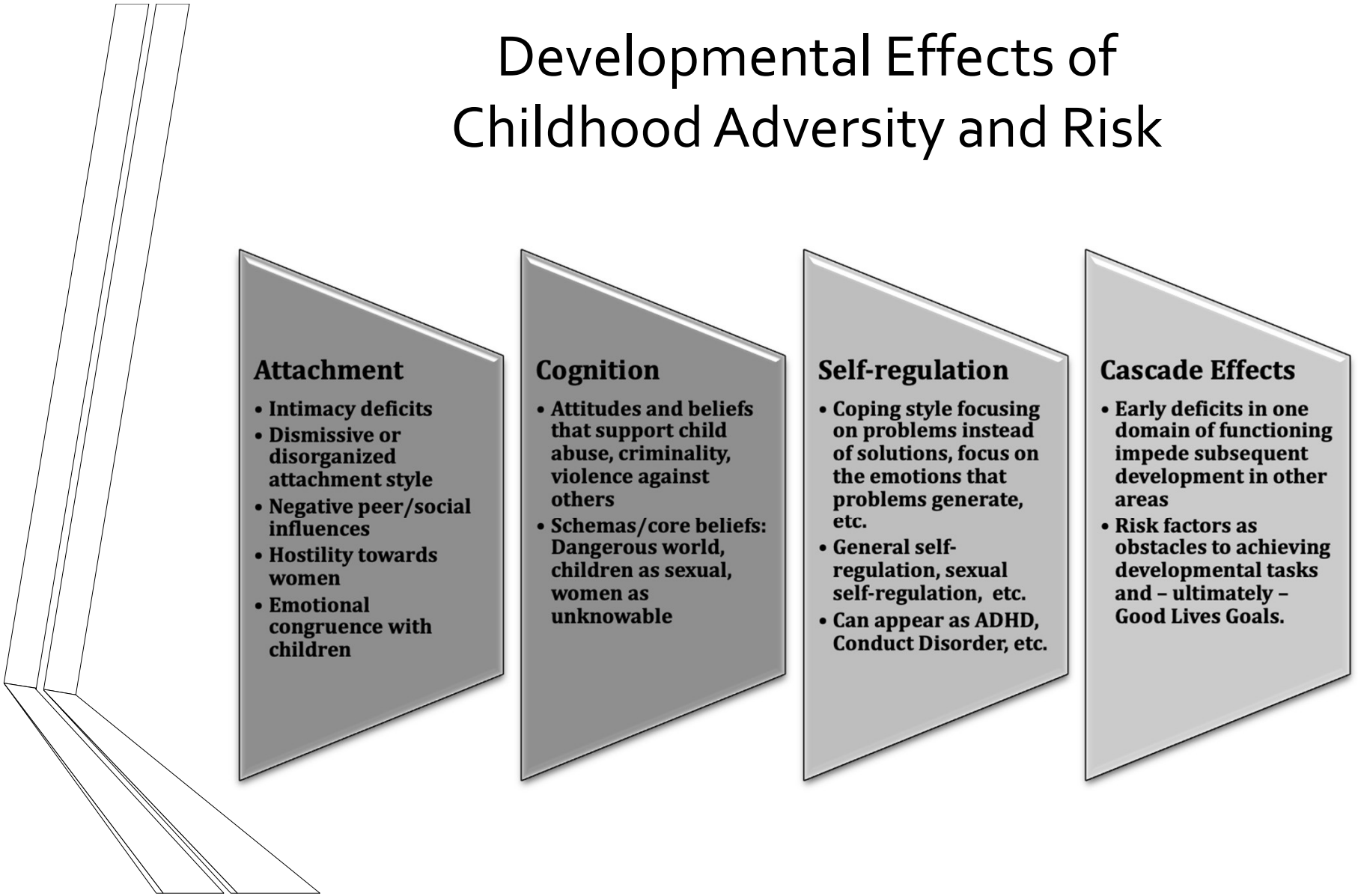
How Does Trauma and Adversity Affect Development?

And Risk Factors?
And Good Lives Goals?

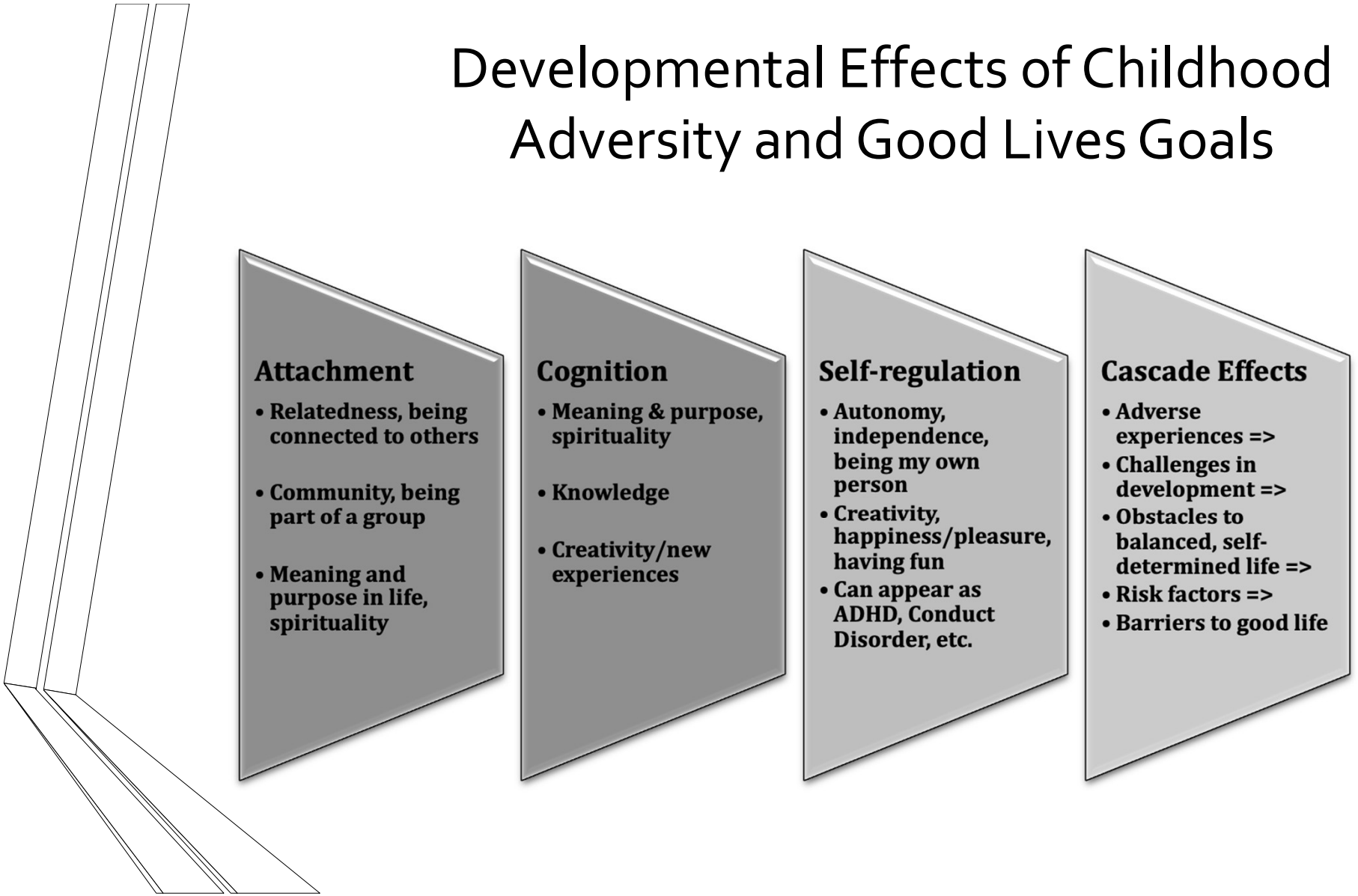
Developmental Effects of Childhood Adversity



Developmental Effects of Childhood Adversity and Risk



Developmental Effects of Childhood Adversity and Good Lives Goals



Finally…

Chunking Logic

- Taking big ideas and finding the components that make them up

"*When it doubt, chunk it out!*"

Empathy

(Adapted from Andrew, 2022)

- Listen with a goal of understanding
- Sit with what they say
- Consider what it's like to be them or what they must be thinking
- Seek the meaning beneath the words
- Respond with a gentle guess that starts by naming the meaning
- Watch how that response lands
- Tune in to their reactions and listen with a goal of understanding
- Repeat, going ever closer to accurate empathy

Staying Safe Sexually

(Adapted from Willis et al., 2024)

- Managing stimuli/situations that may trigger offense-related impulses or provide opportunities for abuse
  - Awareness, attitudes, and behavioral choices that go beyond what the client may be compelled to do by external constraints
  - Can the client bring these to the attention of others appropriately and regularly
- Developing and implementing strategies to manage inadvertently encountered situations
- Interrupting offense-related sexual thoughts or impulses
  - For example, look-away skills, cognitive interruption of thoughts or impulses
- Healthy expression of sexual drive
  - Client not using sex to cope with negative affect

Active Participation

- Client brings topics for discussion, completed homework assignments, etc. into session without being prompted
- Behaviors indicate that client is working with professionals and not against them
- Client actively describes thoughts, feelings, situations, and behaviors that present challenges

Example

(gratitude to Brittany Decker & Dave McAllister, Laraway Programs of Vermont)

Historical and Current Presentation (not “presenting problem”)

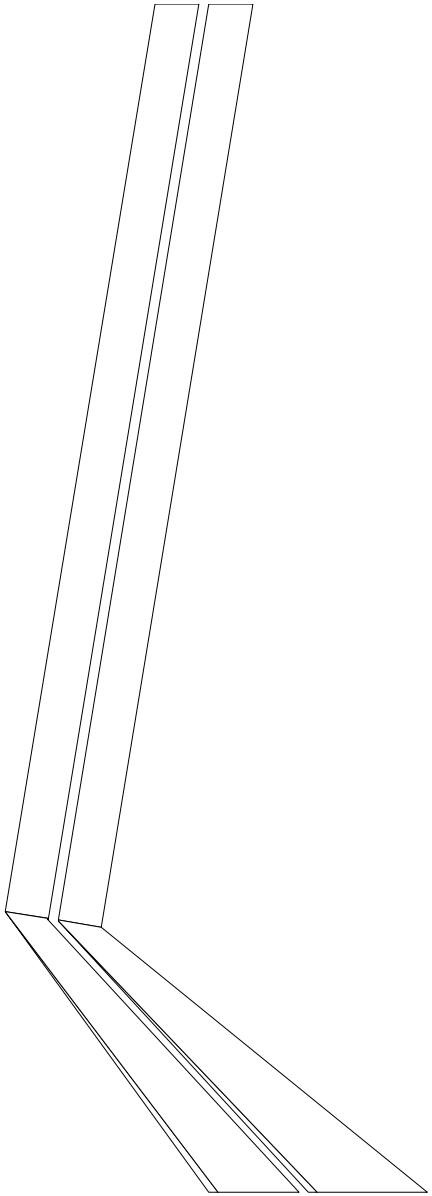
Goals (with each followed by objectives/action steps and who is responsible)

- Physical Health & Wellness
- Mental Health & Wellness
- Interpersonal/Relationship Development
- Emotional Regulation/Expression
- Spiritual Development
- Family Relationships

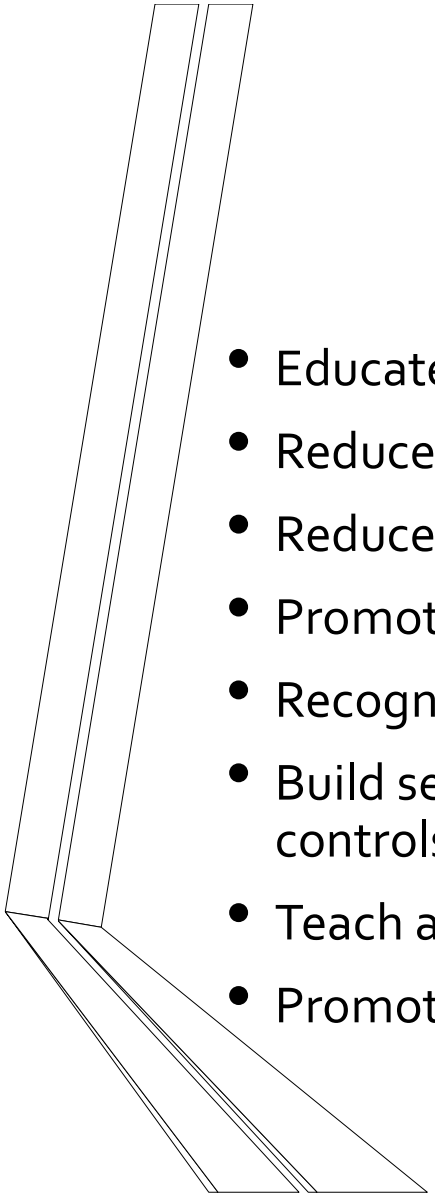
Transition plans

Putting it all together

Connecting the puzzle pieces

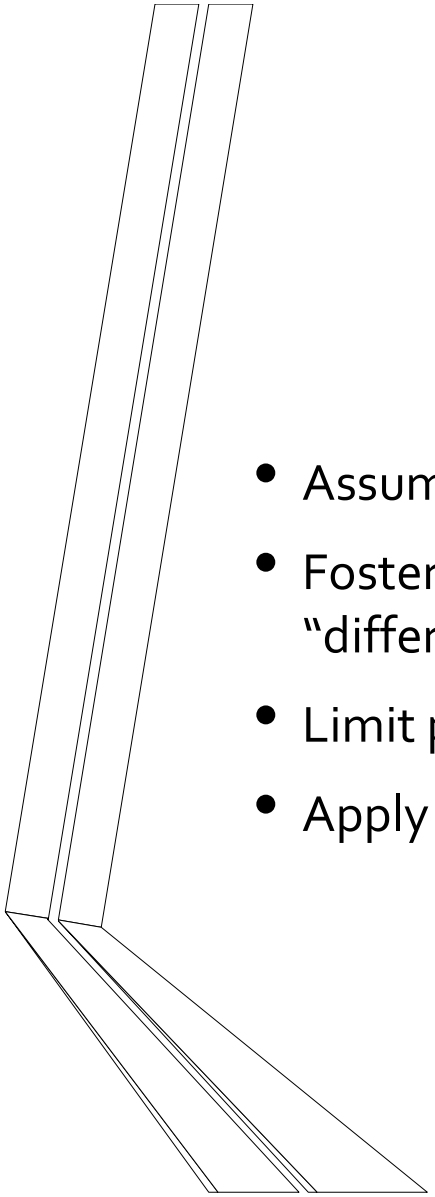


What are our goals as a treatment team?



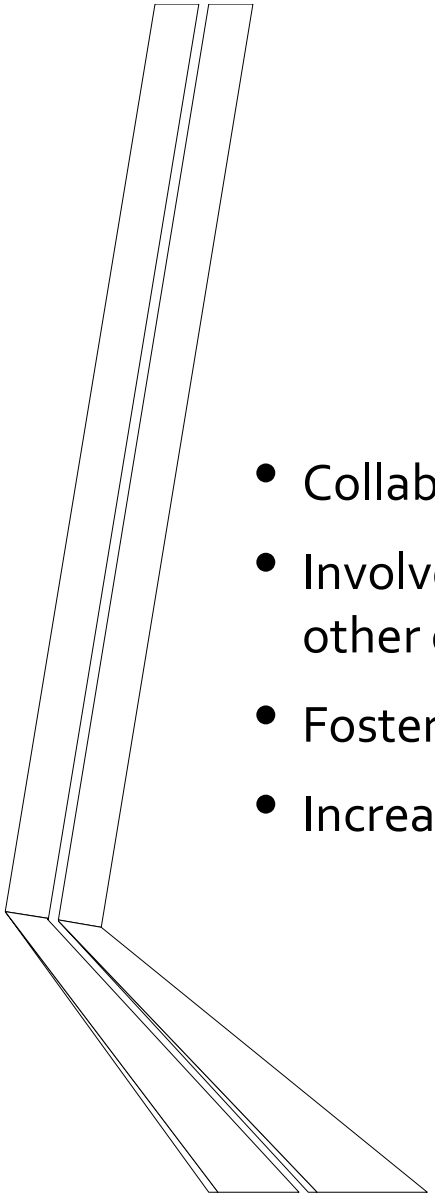
We get it right when we

- Educate – listen, teach, support
- Reduce shame and guilt
- Reduce feelings of failure and decreased motivation
- Promote honesty, disclosure, comfort in treatment
- Recognize all-or-nothing behaviors
- Build self-regulation skills – utilize internal controls rather than relying on external controls
- Teach approach vs. avoidance
- Promote healthy behaviors that align with Good Life Model goals



We get it wrong when we

- Assume that Relapse will happen
- Foster an identity of a "sexual offender" "different" or "deviant"
- Limit pro-social supports
- Apply too much external control



Effective Strategies

- Collaborative
- Involves Family, Supervision Officers, Pro-social support, Mental Health, other community resources
- Foster a “normal” identity
- Increase Pro-social Activities

Effective Treatment

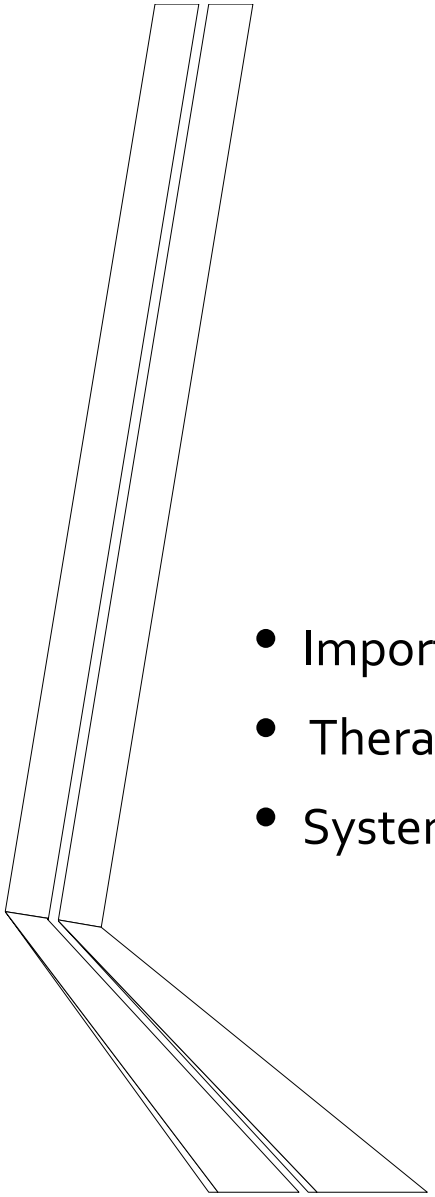
- Is client-focused
- Is individualized
- Is goal-driven
- Includes psycho-educational component
- Does not last too long
- Risk and needs are continually being assessed
- Intervention is proportional to risk
- Includes family and other support persons

Family Therapy

- Success of the youth is influenced by family involvement, support, structure
- How involved are parents/caregivers?
  - Look at PROFESOR (Worling, 2017) and YNPS (Prentky et al., 2020) items
- What are the values of the family? Family rules? Family motto? Boundaries?
  - Are these posted anywhere? Were they created as a family?
- Involving parents in the discussion can provide an opportunity for
  - Everyone to be heard, concepts to be understood by all
  - The youth to feel supported and safe when discussing difficult things
  - Teaching parents how to support their child as they continue to grow

Motivational Interviewing

- Goal is for the client to voice the argument for change, not the therapist
- Ambivalence is normal and should be expected and embraced
  - I need to, but I don't want to
  - I want to, but I don't know if I can
  - I will eventually, but not right now
- *"Scrolling on Tik Tok helps me relax before bed, but I end up staying up really late and I sleep through my alarm."*



Important Factors to Keep in Mind

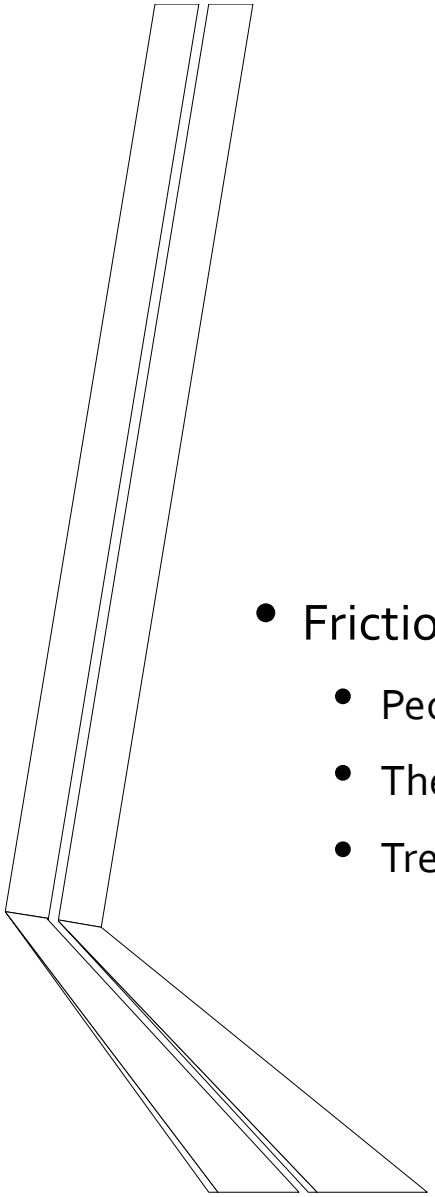
- Importance of assessment
- Therapeutic approach
- System Issues

An example: Assessment

- Therapist: “We need to do an assessment before we put this kid in treatment”
- Supervisor: “In a perfect world yes, but we don’t have time – so just assign him to a group”

Impact on Treatment Planning

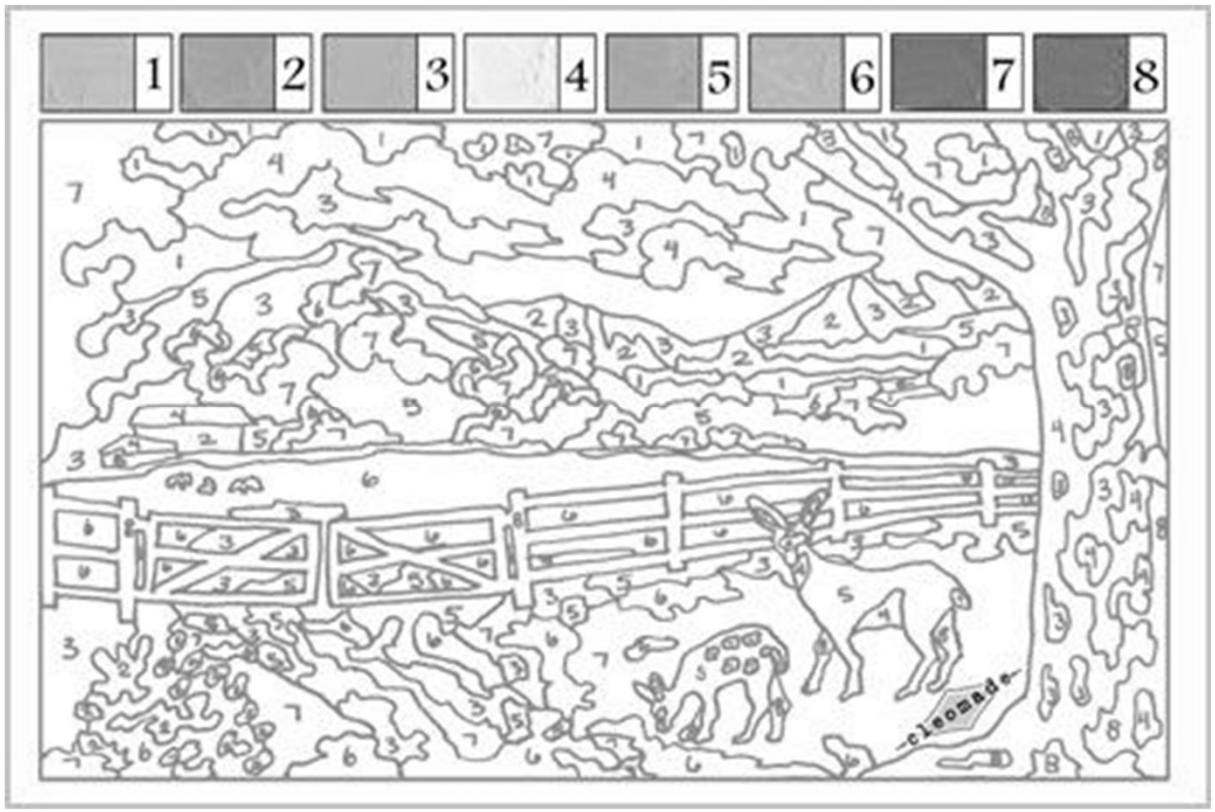
- When assessment is dispensed with – due to expedience, finances, or lack of resources
  - Outcome is less than ideal
- The treatment plan is meant to have a therapeutic (net positive) effect



Therapeutic Approach

- Friction arises when
  - People don't believe that treatment is supposed to be therapeutic
  - Therapists aren't allowed to be…therapists
  - Treatment by checklist

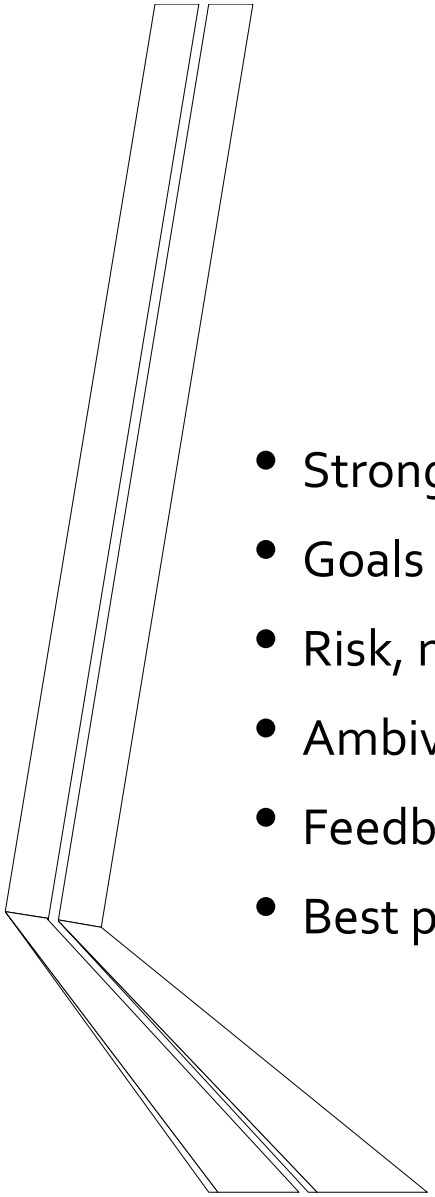
Paint by Numbers?



Background vs. foreground

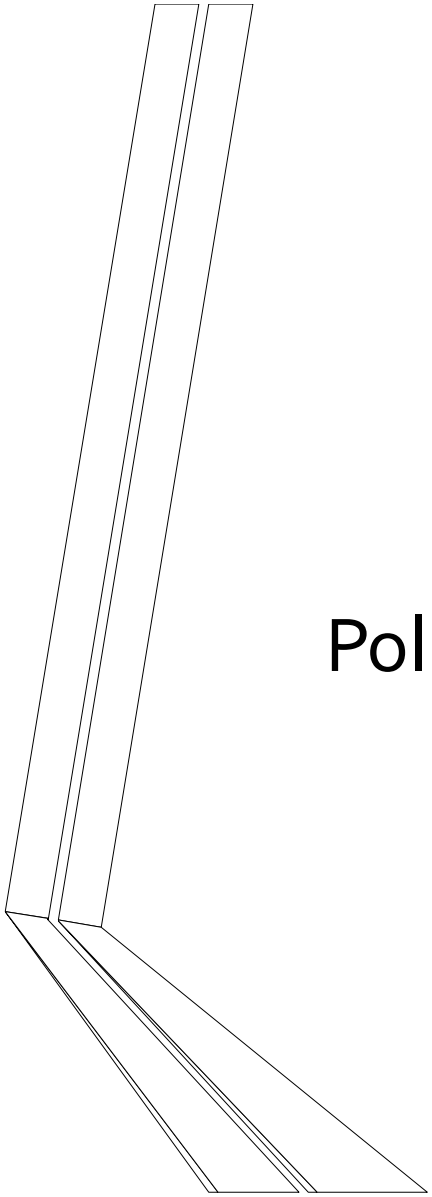
Where are we going?

Remember, *how* we deliver the message matters



Ideally…

- Strong therapeutic alliance, partnership between therapist/client
- Goals are individualized, relevant, developed together
- Risk, need, responsivity *and* protective factors
- Ambivalence is expected and worked through
- Feedback is welcomed
- Best practice guidelines are followed



System Issues

Policy – Best Practice = Systemic Tension

What does our treatment plan look like?

- 16-year-old has a no contact with anyone <18 and cannot attend in-person school, must attend online
- 14-year-old is unable to live with parents because victim is in the home
- 17-year-old cannot use electronic devices due to adjudication for soliciting nudes from classmates

Keep going forward!

Having conversations with teens

- Educating ourselves about the facts
- Learning the lingo
- Validating the emotions, struggles, and desires
- Discussing principles of healthy sexuality (consent, differences between porn sex and real sex, masturbatory practices)
- Learning about social media trends and what is important to teens
- Setting realistic and relevant expectations

Realistic expectations in therapy

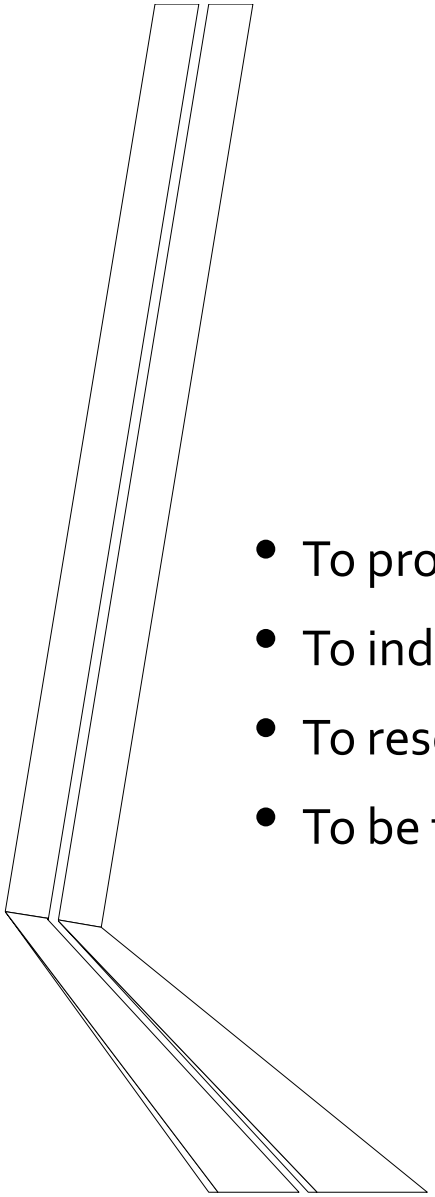
- Adolescence is a time of change, exploration, and individuation
- Understand sex is a part of development
  - Don’t expect teens to be asexual
- Promote sexual health, developmentally-appropriate
- Recognize the impact of ACEs and attachment

Be careful not to confuse

- Attachment-seeking for attention-seeking
- Ambivalence for denial
- Normative behaviors for deviance

What really matters

- If our primary goal is to create a world without sexual violence, we must
  - believe it is possible
  - speak the same language
  - agree on the facts
  - focus on rehabilitation and prevention



How do we do that?

- To promote evidence-informed decision making, we must learn the evidence
- To individualize treatment plans, we must eliminate one-size-fits-all practices
- To resolve ethical issues, we must be guided by research
- To be therapeutic, we must be what we were all trained to be - therapists