

CASE STUDY: A STRENGTHS-BASED APPROACH

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Given the option, most of us avoid being around people who focus on our mistakes and problem behaviors. The same holds true for youth who have sexually offended. Youth are more open, honest, and engaged in assessment and treatment when there is an emphasis on strengths and exceptions to problems. A strengths-based approach (SBA) focuses on the identification, creation, and reinforcement of strengths and resources within individuals, their family, and their community (Powell, 2010a, 2011, in press). SBA emphasizes the importance of forming positive relationships and creating an environment in which youth feel safe and supported. It is an eclectic mix of psychological theories and interventions, which includes components that focus on “What to do” as opposed to “What not to do.” Any intervention that emphasizes strengths and healthy development can be classified as “strengths-based.” SBA also emphasizes accountability and repairing harm for sexual offenses but in a non-antagonistic manner.

The purpose of this chapter is to highlight the importance of a strengths-based approach to working with at-risk youth, including those who have sexually offended. I will describe a variety of SBA components in an actual clinical case with an adolescent male named “Jim,” with the identifying information modified to ensure anonymity.

Case Description

I am the clinical director and a licensed psychologist at a maximum security youth services facility. Jim (age 13) was mandated to receive treatment for sexually offending against his younger brother and for multiple probation violations. I was Jim’s primary clinician during his stay.

Jim had had a very difficult childhood. His uncle sexually abused him repeatedly between the ages of two to five. In response to this early victimization, Jim began exhibiting disruptive behaviors at home and school. He was defiant towards authority figures, and there were incidents of poor boundaries in which he would touch or attempt to touch his classmates (both boys and girls) in sexual ways. At age eight, Jim was caught sexually acting out on his younger brother (age 6), which resulted in Jim being placed in a residential home. Jim had limited contact with his parents while in placement due to their own mental health issues. When Jim returned home approximately one year later, his disruptive behaviors continued. At age 12, Jim once again sexually acted out on his younger brother. His sexual offending occurred multiple times over a two month period. He would bribe his brother to participate and to not tell, by giving him toys and other valued objects. Jim was placed out of the home again, first in a foster home and then in a residential group home. His defiant and hypersexual behaviors eventually led to his mandated treatment in our facility.

Upon his arrival, Jim was desperate for his parents’ support and frequently asked to make phone calls home in hopes of setting up family visits. Attempts by myself and other staff to establish a positive, collaborative relationship with Jim’s parents were unsuccessful. They never visited the facility and usually would not answer their phone. During the two phone calls in which I did reach them, they presented as emotionally distant and disinterested. Approximately two months into treatment, Jim’s parents broke off all contact and moved out of town without leaving a forwarding address. This parental

abandonment was very hard on Jim. He was angry and oppositional. In several incidents, Jim resorted to self-injury (cutting on his arms and choking himself with his clothing). He also struggled with hypersexual behaviors including chronic masturbation and poor boundaries with other impulsive youth.

Case Conceptualization

Human behavior is complex and influenced by multiple variables, which is why I use a strengths-based, holistic perspective (Leversee & Powell, 2012; Powell, 2011) to better understand youths' treatment needs. I gathered information about Jim's disruptive and abusive behaviors, as well as his strengths, resources, and goals for the future that could help him develop into a psychologically healthy young man.

One of Jim's great strengths was his desire to connect with others. Although initially he was guarded and mistrustful, it was clear that he wanted social connections, and he responded positively when staff recognized his strengths and interests. Jim's overall intelligence and his academic skills were other assets. Even though his schooling was fragmented due to multiple out-of-home placements, his reading and writing were at or above grade level. These strengths were incorporated into his treatment via journaling and reading assignments. Jim's identified life goals (described later in the chapter) provided another area of strength. Initially, Jim was so preoccupied with the rejection from his parents that he could not identify any hopes and dreams for the future; however, as his social support developed and strengthened, his capacity to identify short- and long-term goals improved.

Jim's presenting problems included his sexual offending; his self-injurious behaviors; his angry, oppositional actions; and his hypersexual impulses. These problem behaviors were clearly influenced by his adverse childhood experiences, including sexual victimization, multiple out-of-home placements, family history of mental health problems, and abandonment by his parents. These issues each negatively impacted Jim's view of himself (low self-worth) and others (interpersonal mistrust and anger) and skewed his understanding about what is "normal" and "healthy" in relationships and sexuality. His childhood adversity also appeared to alter Jim's emotional regulation and sexual responses. We know from research that childhood exposure to environments that are neglectful, chaotic, and abusive can alter the brain, which results in an over-reactive nervous system (Bremner, 2003; Creeden, 2009; De Bellis, 2001, 2005; De Bellis & Thomas, 2003; Perry, 2002; Perry, Pollard, Blakely, Baker & Vigilante, 1995; Streeck-Fischer & van der Kolk, 2000; Teicher, Andersen, Polcari, Anderson & Navalta, 2002). We also know, however, that behaviors and brain processes can be changed in positive ways. Exposure to environments that are safe, nurturing, consistent, and predictable, and that encourage repetitive practice of healthy emotional regulation strategies can lead to good outcomes (Biglan, Flay, Embry & Sandler, 2012; Bryck & Fisher, 2012; Perry, 2006; Winerman, 2012). A strengths-based approach helps to create such an environment.

Key Components of a Strengths-Based Approach

Segments of Jim's strengths-based services sought to:

- *establish a positive relationship with Jim

- *establish a positive relationship with his primary caregivers
- *assess and meet his basic human needs

- *emphasize individual and family therapy

- *promote hope for him

- *utilize “positive reinforcement” and “bonus response-cost” to help stabilize his behaviors

- *utilize a functional behavior assessment to identify factors linked to prosocial vs. abusive acts

- *assess and promote protective factors to enhance his resiliency

- *meet prerequisite factors to enhance openness to sensitive topics

- *educate Jim about the reciprocal nature of relationships

- *maintain a solution-focused orientation for him

- *explore his life goals

- *assist Jim and his family to become “informed consumers”

- *educate him about healthy relationships and sexuality

- *utilize meta-talk to enhance Jim’s openness about sensitive topics

- *educate him about the delayed gratification to help manage sexual reactivity

- *practice healthy coping skills with him

- *address his childhood victimization in a trauma-responsive manner

- *be proactive and prevention-oriented for the next generation beyond Jim

- *conduct clarification work

- *provide transition services for him

Establish a Positive Relationship with Youth: Jim was understandably guarded and mistrustful in the initial phase of treatment. He viewed the world through the lens of a boy whose life experiences had taught him that adults cannot be trusted. My primary focus was to establish a trusting, therapeutic relationship with him. Psychotherapy outcome research has identified the therapeutic relationship as a critical component to effective services (Duncan, Miller, Wampold & Hubble, 2010; Karver, Handelsman, Fields & Bickman, 2006; Kazdin, Marciano & Whitley, 2005; Norcross, 2001; Norcross & Lambert, 2006; 2011). It is also an essential component in sex offense-specific services (Blanchard,

1995; Marshall, et al., 2002; Powell, 2010b). I used several strategies to establish a positive relationship with Jim.

Focus on Strengths and Interests. I initially focused my attention on getting to know Jim better, asking questions about his life and what he liked to do in his free time. He identified playing basketball and listening to classic rock 'n' roll music as two of his favorite activities. We would regularly shoot baskets while talking. I also brought in some classic rock music that we would listen to during sessions.

Show Patience and Understanding. I regularly demonstrated my commitment to Jim by hanging-in-there with him even when his behaviors were disruptive. I did not always like his behaviors, but I never held a grudge and always communicated my unconditional acceptance for Jim as a valuable human being. I had to set limits on some of his behaviors, but I always did it in a respectful manner. I would regularly remind myself that his disruptive behaviors were the result of a very difficult childhood. Every hour was a new hour, and every day was a new day bringing opportunity for Jim to make positive changes.

Establish a Collaborative Relationship. Building a sense of togetherness and a collaborative atmosphere has been linked to positive treatment outcomes (Creed & Kendall, 2005; Karver, et al., 2006; Russell, Shirk & Jungbluth, 2008; Shirk & Karver, 2011). I kept Jim actively involved by asking him questions, exploring his insights, and presenting his treatment as a *team effort*.

Establish a Positive Relationship with Primary Caregivers: A necessary component to successful youth services is establishing a positive relationship and communication with caregivers. Attempts to involve Jim's biological parents were not successful, but fortunately, his former foster parents stepped in to provide stable support. Several interventions helped to establish and maintain a positive relationship with his foster parents.

Give Caregivers Compliments. Jim's foster parents truly showed their genuine care and compassion when they took on the primary caregiver role in response to Jim's abandonment by his biological parents. I praised them for their compassion and highlighted their value as critical supports in Jim's life.

Place Caregivers in an Expert Role. When it comes to learning more about youth, caregivers are a great source of information. Jim's foster parents had previous experience living with him; therefore it was important to explore their insights into how to best help him. Acknowledging their expertise as caregivers to Jim and as foster parents in general, helped forge a positive, collaborative relationship.

Ask Caregivers about their Own Self Care. The stress associated with parenting a youth who has sexually offended and is exhibiting other disruptive behaviors can be emotionally taxing. Jim's foster parents took on a lot of responsibility when they re-established contact with him. I regularly checked in with them and asked questions about their own support system to ensure that their needs were met. Asking about their own self-care helped communicate my support for them.

Keep Caregivers Informed and Actively Involved. Jim's foster parents were actively engaged in his treatment via phone calls, visits, and family therapy sessions. Keeping them informed about Jim's treatment communicated their value to the process and helped build a good relationship. Their consistent, supportive involvement was a key element in stabilizing Jim's behaviors.

Assess and Meet Basic Human Needs: Our basic needs are very potent, and humans are motivated to fulfill unmet needs (Maslow, 1970). These basic human needs include *physiological needs* (i.e., need for food, water, sleep), *safety needs* (i.e., need for our surroundings to be predictable, safe, and free from fear, anxiety and chaos), *social needs* (i.e., need to love and be loved, to be accepted, to belong to a group or family and to avoid loneliness, alienation, and rejection), and *competency needs* (i.e., need to feel competent and have some mastery of our environment).

In the initial phase of treatment, Jim's basic social needs were seriously depleted. His family had moved out of town without giving a forwarding address. Jim's anger and self-injurious behaviors were an understandable reaction to abandonment and unmet social needs. There was no way Jim was going to be receptive to treatment until his basic human needs were addressed. I would regularly ask myself, *"Which of Jim's basic human needs are currently not being met, and how can I help meet those needs?"*

The first several months of treatment primarily focused on meeting Jim's need for social connections (social needs), and his need to feel good about himself and to have successful experiences (competency needs). Jim's basic human needs were bolstered by setting up regular visits with his foster parents, facilitating social connections with staff and prosocial peers, and praising Jim for his identified strengths including his basketball skills, knowledge of classic rock music, and academic accomplishments. In addition, several members of his multidisciplinary team rallied around Jim in response to the parental abandonment. It was a great example of the old adage, "It takes a village." As his social support strengthened and self-confidence grew, his capacity to engage in treatment and focus on issues beyond his basic needs also improved.

Emphasize Individual and Family Therapy: An important treatment objective was to establish a safe environment in which Jim could let down his guard and openly participate. In order to create such an environment, sensitive topics including Jim's sexual offense and sexual victimization history were only addressed in individual and family therapy sessions, never in group sessions. This is a practice we employ with all youth participating in treatment within our multi-purpose facility. SBA therapists have several reasons for our emphasis on individual and family services over group intervention. Within a group format, the risk is higher for other group members to *not* respond in a healthy, prosocial manner due to their own interpersonal deficits and traumas. Additionally, the risk increases for having group members violate confidentiality by telling other youth in the facility about the happenings within the group. A violation of confidentiality would have significantly impeded Jim's ability to feel safe while openly participating in treatment. Another reason for caution regarding group intervention was the potential negative effects of exposing Jim to group members with even more serious histories of sexual offending. Research has raised concerns about exposing lower-risk youth to environments that serve higher-risk youth (Andrews & Bonta, 2010; Lowenkamp & Latessa, 2004). Congregating youth who have delinquent histories can increase the risk of delinquent behaviors, which is referred to as "deviancy training" (Dishion & Dodge, 2005; Dishion, McCord, Poulin, 1999; Dodge, Lansford & Dishion, 2006; Gifford-Smith, Dodge, Dishion & McCord, 2005; Leve & Chamberlain, 2005; Poulin, Dishion & Burraston, 2001). Although this deviancy training effect has not been found in all studies (Huefner, Handwerk, Ringle & Field, 2009; Weiss, et al., 2005), enough evidence exists about the potential risk (particularly with younger youth) that we are cautious about the composition and content of the groups we provide. Jim did participate in some groups, including our Healthy Relationships group, Victim Empathy group, and Aggression Replacement Training group. All of these groups have a psycho-

educational, skills-building emphasis, with no forced disclosure about offense histories or other sensitive topics.

Promote Hope: Jim's initial demeanor at the beginning of treatment was understandably hopeless and non-caring. To counteract this hopelessness, treatment introduced several *reasons for hope* to Jim and his foster parents.

Reason for Hope: The Low Sexual Re-Offense Recidivism Rate. I explained to Jim and his foster parents that it was a good thing he was getting the opportunity to participate in treatment, because the research indicates that the large majority of youth who receive treatment do not sexually reoffend in the future (Caldwell, 2010; Langstrom & Grann, 2000; Reitzel & Carbonell, 2006; Worling & Curwen, 2000; Worling, Littelljohn & Bookalam, 2010). According to a large meta-analysis that included data from 63 different studies and 11,219 youth who had sexually offended, the average sexual recidivism rate was 7.08% (Caldwell, 2010). Jim and I talked about how treatment could help him go on to live a healthy, successful life with no more jail time or legal problems. We discussed how his past and present problem behaviors do not define who he is as a person and do not dictate who he will become in the future.

Reason for Hope: The Maturation of the Brain's Prefrontal Cortex. I shared information about the prefrontal cortex region of the brain. I pointed to my forehead and informed Jim that this part of the brain helps us to manage our emotions, to control our sexual impulses, and to think before we act. We talked about how important these abilities (executive functions) are for living a happy, healthy, productive life. I explained that this part of Jim's brain is still maturing and will get stronger as he ages into the teenage and early adulthood years (Baird & Fugelsang, 2004; Casey, Giedd & Thomas, 2000; Diamond, 2002; Giedd et al., 1999; Luna & Sweeney, 2004; Sowell, Thompson, Holmes, Jernigan & Toga, 1999a; Sowell, Thompson, Holmes, Jernigan & Toga, 1999b; Sowell, Thompson, Tessner & Toga, 2001; Sowell, Trauner, Gamst & Jernigan, 2002; Spear, 2000). While the brain naturally matures with age (e.g., synaptic pruning and myelination); humans can strengthen this maturation process through their day-to-day actions. I made sure to educate Jim about the neuroplasticity of the brain (described in the next section) so that he would not mistakenly assume he should passively wait until his brain matured with age.

Reason for Hope: The Power of Neuroplasticity. Educating youth and families about the plasticity of the brain is one of the most effective interventions I have found for promoting hope. Our brain is not really plastic, but it is plastic-like in that it can change structurally and functionally in response to experience. This process is referred to as *neuroplasticity*, and when I explain the process, I use the metaphor of hiking up a mountain path to educate a youth about it. I draw a picture of a mountain with a pathway going to the top. Using this same approach, I explained to Jim that his brain functioned similarly to a mountain path. Just as mountain paths get bigger as we repeatedly hike up and down it, so do brain pathways we use every day. The brain/neural pathways we use on a regular basis become strong and thrive while the pathways we do not use regularly become weaker (Bennett, Diamond, Krech & Rosenzweig, 1996; Bryck & Fisher, 2012; Cicchetti & Tucker, 1994; Diamond, 2001; Nelson, 2003; Nelson & Bloom, 1997; Winerman, 2012). Jim and I talked about how he could overcome his sexual offending and other problems by staying off those brain pathways and instead by practicing healthy alternative behaviors every day. For example, he could use self-timeouts and thought-substitution strategies each time he felt tempted to act out sexually. Just as Jim wired his brain to dribble a basketball better with practice, he could learn to better regulate his sexual thoughts, feelings, and behaviors with

practice, too. Sharing this information about neuroplasticity heightened Jim's hope and his motivation in treatment.

Use Positive Reinforcement and Bonus Response-Cost to Help Stabilize Behaviors: Jim's behaviors were so disruptive to himself and others in the beginning of treatment that basic stabilization was a primary goal. Two behavior modification strategies that helped stabilize his behaviors were "positive reinforcement" and "bonus response cost."

Positive Reinforcement. A core principle of a strengths-based approach is providing positive reinforcement for stable, prosocial actions. Our staff frequently provided verbal praise and attention (positive reinforcement) for Jim's behaviors that were stable or at least less disruptive. An unfortunate dynamic that sometimes occurs in residential facilities that have high caseloads of youth struggling with disruptive behaviors is the squeaky wheel phenomenon. Youth learn they get more attention from staff when they are in crisis. In order to counteract this tendency, we were very deliberate about providing Jim with much more attention when he was stable, as opposed to in crisis.

Bonus Response Cost interventions (Cooper, Heron & Heward, 2007) can help decrease the frequency of problem behaviors (under the right conditions). This intervention involves prescheduling pleasant reinforcers that motivate youth to avoid acting out in order to obtain the reinforcer. A key to a successful bonus response-cost intervention is identifying pleasant reinforcers that are personally meaningful. For Jim, his interest in playing basketball was a strong reinforcer. Jim was motivated to *not* exhibit problem behaviors in order to keep his scheduled basketball time. Jim did not have to earn this pleasant reinforcer, because it was already scheduled to occur. All Jim had to do to *keep* it was not exhibit the specified problem behavior. One of Jim's problem areas was his hypersexual behaviors including incidents of violating others' physical boundaries. If Jim violated someone's personal space, the prescheduled pleasant reinforcer (shooting baskets) was removed or at least a portion of it was. When Jim lost the basketball time, we would still meet but for a briefer amount of time. We would talk about our mutual disappointment about the lost opportunity to shoot hoops and then we would problem solve how to ensure the next prescheduled basketball time would occur. This bonus response-cost intervention increased Jim's motivation to practice healthy prosocial skills every day.

Use a Functional Behavior Assessment to Identify Factors Linked to Prosocial vs. Abusive Acts: A Functional Behavior Assessment (FBA) is a useful tool for better understanding behavior (Cooper, Heron & Heward, 2007; Iwata & Worsdell, 2005). FBA considers what thoughts, beliefs/values, feelings, behaviors, and situations occur before (antecedents), during (behavior), and after (consequences) a youth's sexual offenses or other problem behaviors. In addition, I use FBA to focus on a client's strengths and to clarify what factors play a role in that client's prosocial behaviors. That is, we focus on what thoughts, beliefs/values, feelings, interests, behaviors, and situations support healthy prosocial living. FBA has a lot of similarities with Relapse Prevention (RP), which is a commonly used practice within sex offense-specific services. Both FBA and RP help assess and target factors that will reduce risk and promote a healthy prosocial lifestyle. This information is beneficial for making well-informed treatment plans and safety plans. Jim and I talked about times in his life when he has been positive and has regulated his sexual impulses well. According to Jim, his behaviors were most positive when his parents spent one-on-one time with him. In order to create a similar environment, we set up a weekly schedule of frequent check-ins with supportive staff, as well as regular visits with his foster parents. Rather than only meeting with Jim for one 50-minute session per week, I met with him 3 or 4

times a week for 15 to 20 minutes each time. These frequent contacts helped to manage one of Jim's identified risk factors, feelings of social isolation. Jim's feelings of alienation had triggered his poor boundaries and hypersexual behaviors in the past. Another risk factor was Jim's altered beliefs about acceptable boundaries and sexual behaviors. Jim's own victimization experiences shaped his beliefs and behaviors in maladaptive ways, which we were able to work through in treatment.

Assess and Promote Protective Factors to Enhance Resiliency: I explained to Jim that some kids experience hard times in life, which then leads them to bad outcomes (i.e., substance abuse; poor relationships; legal problems; prison time). Other kids, however, experience hard times but then go on to lead positive, well-adjusted lives. These kids are referred to as "resilient." I told Jim that most people have the capacity to be resilient if they have enough protective factors in their lives (Masten, 2001). Protective factors are the opposite of risk factors, in that they are conditions that increase the likelihood of healthy development and outcomes, as opposed to negative outcomes (Child Welfare Information Gateway, 2014; Masten & Coatsworth, 1998; Masten, Cutuli, Herbers & Reed, 2009; Masten & Reed, 2002). Those protective factors serve as a buffer against life's stressors. I talked to him about the many resilient youth I have worked with over the years who overcame their problems (including sexual-offending behaviors) and then were able to lead positive lives. I introduced Jim and his foster parents to a checklist that describes protective factors commonly linked to resiliency. We explored which protective factors Jim already possessed and which ones he could develop if he and his foster family worked on that development in treatment. Refer to www.kevinpowellphd.com under the Handouts tab for the most up-to-date version of this checklist entitled, *Resiliency Protective Factors Checklist: Resilient Youth (and Adults)*.

Meet Prerequisite Factors to Enhance Openness to Sensitive Topics: Talking openly and honestly about our mistakes and problem behaviors is not easy. If I had required Jim to talk about his sexual offenses and other problem behaviors at the onset of treatment, it would have increased his defensiveness and instability. Several prerequisite factors had to be met before addressing these sensitive topics. These factors include *the formation of a trusting, positive relationship* and *meeting basic human needs*, which have already been described. Other prerequisite factors include *good ego strength*, *emotional calmness*, and *no audience*

Ego Strength can be defined as our internal sense of security and personal confidence to tolerate stress and frustration. We all have circumstances in our lives when we feel insecure and emotionally vulnerable; that is, when our ego strength is weak. At these times, our willingness to hear feedback and talk about problem behaviors can be quite low. In contrast, when ego strength is strong, our ability to address sensitive issues is much better. Many of the strengths-based interventions described in this chapter helped boost Jim's ego strength.

Emotional Calmness. When emotions escalate with anger, sadness, or shame, people's capacity to communicate openly and to hear feedback from others is impaired. Although Jim's disruptive behaviors sometimes required immediate limit-setting, in-depth discussions always waited until he was calm and in a good head space.

No Audience. It's hard to talk about personal mistakes and struggles in the presence of people you do not trust. Whenever possible, Jim and I addressed sensitive topics without a peer or staff audience. This approach increased Jim's feelings of safety so that he could talk openly and honestly about these issues.

Educate about the Reciprocal Nature of Relationships: Relationships are a two-way street, but Jim had limited insight into how his unstable, disruptive behaviors and sexually abusive actions were impeding his ability to establish and maintain social connections. I utilized a multi-sensory metaphor of “throwing a ball against the wall” to help Jim better understand this interpersonal dynamic.

“Throwing a Ball Against the Wall” Metaphor. Step 1: I had Jim stand approximately six feet away from the wall, and I gave him a soft, hand-held ball that bounces (Note: a soft stress ball usually works best. Do not use a ball that is too hard and could cause injury if it hits you). *Step 2:* I asked Jim to throw the ball softly against the wall and catch it. When he did this, the ball bounced softly against the wall and he easily caught it. *Step 3:* I then asked Jim to throw the ball as hard as he could against the wall and catch it. When Jim did this, the ball bounced off the wall hard and he was unable to catch it. *Step 4:* I explained to Jim that throwing a ball against the wall is a lot like relationships. When we throw the ball softly (when our interactions are stable and respectful), the ball comes back softly (people are more likely to be respectful back). When we throw the ball hard (when our interactions are unstable and disrespectful, including sexual offending), however, the ball comes back at us hard (people, as well as the legal system will respond back in a hard manner). This metaphor helped Jim to understand how his disruptive behaviors were pushing away people who cared about him and were causing negative consequences within the legal system.

This metaphor was also beneficial for me as a youth service provider. It reminded me not to be reactive to Jim’s disruptive behaviors. Jim had had the ball thrown hard at him during his many adverse childhood experiences. I needed to hang in there with him and interact in a respectful, empathic manner (throw the ball softly), even when he was throwing the ball back hard. Over time, Jim began throwing the ball back more softly.

Maintain a Solution-Focused Orientation: An emphasis on solutions and exceptions to problems helped lessen Jim’s interpersonal mistrust. Rather than focusing immediately on Jim’s sexually abusive behaviors and other problems, we explored his prosocial actions and exceptions to problems. *Tell me about times when you have been helpful/ kind to others (your peers, family members, other adults) and Tell me about times when you felt like violating someone’s personal space but did not do it. How did you stop yourself?* Solution-focused, strengths-based interventions have contributed to positive treatment outcomes (Berg & Steiner, 2003; Corcoran & Stephenson, 2000; De Shazer, et al, 1986; Lethem, 2002; Ward, Gannon & Yates, 2008).

Explore Life Goals: In order to help motivate Jim, it was important to explore his life goals and integrate them into treatment. I asked Jim questions such as, *What do you want your life to look like in the future? What do you hope to be doing 1 year (2 years; 5 years) from now?* and *What do you think are the most important things for you to learn in treatment to reach your goals?* During the initial phase of treatment, Jim could not identify any short- or long-term goals; however, as his behaviors stabilized he was able to get more in touch with his hopes and dreams for the future. His primary career goal was to become a carpenter. We looked on the internet to learn more about becoming a carpenter. Jim also talked about his hope to get married and have a family one day. We discussed how his work in treatment would help him learn the skills needed to reach these goals.

Rather than focus only on avoidant goals (i.e., not sexually reoffending), an emphasis was placed on goals Jim wanted to achieve (approach goals). This focus on approach goals not only helped motivate

Jim in treatment but also has gained more empirical support (Ward, et al., 2008; Mann, Webster, Schofield & Marshall, 2004). For youth whose approach goals are directed towards antisocial behaviors (e.g., wanting to become a high-ranking gang member), I encourage them to explore the pros and cons of that lifestyle for their future. The outcomes for people who lead a criminal life are never good. Fortunately for Jim, all of his approach goals were oriented towards prosocial behaviors.

Assist Youth and Families in Becoming Informed Consumers: For youth like Jim, who have a childhood history of victimization and limited support, life can feel out of control. Providing Jim with information about his treatment services—including what to expect and why it is relevant—gave him a sense of personal control. Broadening Jim’s understanding of his treatment helped reduce his anxiety and enhance his engagement. Jim became an informed consumer about a variety of treatment concepts, including the maturation of his brain’s prefrontal cortex, the power of neuroplasticity to wire his brain in healthy ways, the low sexual re-offense recidivism rate for youth who participate in treatment, and the power of protective factors to bolster his resilience. Jim’s foster parents also became informed consumers so they could reinforce his progress both in and out of treatment sessions.

Educate about Healthy Relationships and Sexuality: Jim’s childhood adversity skewed his worldview of what is healthy in relationships and sexuality. In order to address this deficit, Jim and I had discussions about what factors help create a healthy relationship, including mutual support, respect, trust, compromise, humor, laughter, and balanced communication between the talker and the listener. Being a good listener is important in relationships. Unfortunately, Jim had a tendency to talk much more than he listened. His exposure to caregivers who were abusive and/or non-responsive created a sense of desperation for support, which prompted him to talk much more than he listened in relationships. To improve Jim’s listening skills, I used a talker-listener exercise. We took turns being the talker and the listener while discussing the events of the day. Jim would describe part of his day in a few sentences, and then I would respond back with what I heard him say. Then we would switch roles so that Jim could practice listening while I shared information about my day. Another technique I used during sessions was to ask Jim periodically to repeat back what he had just heard me say, in order to strengthen his in-the-moment listening skills. Improving Jim’s ability to listen and form healthy social connections was an important treatment topic. We know from the typology research (Hunter, Figueredo, Malamuth & Becker, 2003; Leversee, 2007, 2010a, 2010b; Miner, et al., 2010) that psychosocial deficits is a characteristic commonly associated with sexual offending, which was a contributing factor in Jim’s case.

Another method for promoting healthy relationships and sexuality was educating Jim about three factors that distinguish what actions are prosocial versus abusive or exploitative. An interaction is considered prosocial and non-abusive when there is equality, consent, and no coercion (Ryan, 2010). *Equality* considers the differences and similarities between people, as it relates to their age, physical size and strength, cognitive ability, emotional development, assertiveness (vs. passivity), position of authority, and/or level of self-confidence (vs. inferiority). *Consent* occurs when both parties have similar knowledge, understanding, and choice. *No coercion* involves interactions that are free from pressures that could deny a person free choice in the relationship. Coercion can involve verbal threats, physical violence, social rejection, and bribes. Jim had utilized bribes as part of his sexual offending. I presented Jim with a variety of scenarios to help him gain a greater understanding of what represents equality versus inequality, consent versus non-consent, and coercion versus no coercion in relationships.

Prosocial Behaviors: Everything is Not Grooming. Historically, the field of sex offense-specific services has erroneously assumed that all prosocial actions exhibited by a person who has previously committed a sexual offense are grooming behaviors used to set up future sexual offenses. If I had automatically labeled every prosocial behavior exhibited by Jim as grooming, without first considering the situational and developmental circumstances, Jim would never have been allowed opportunities to practice caring, helpful actions. Jim is a social being and it is normal and healthy to be kind to others, to want to make friends, to have a crush on someone, and want to have a boyfriend or girlfriend.

Use Meta-Talk to Enhance Openness about Sensitive Topics: A strategy I used to enhance Jim's openness and honesty about sensitive topics was meta-talk. Meta-talk, as it is used in mental health services, can be defined as having discussions regarding the *about* and *how* of potential experience before actually doing it.

Meta-Talk: Communicating Unconditional Acceptance. Youth who have sexually offended often worry about how others will think and feel about them. Making meta-talk statements about this common concern and communicating my unconditional acceptance of Jim increased his openness and sense of safety within treatment sessions. Prior to asking Jim questions about his sexual offending history, I made several meta-talk statements that included:

- *Sometimes youth I work with are hesitant to talk about their past mistakes, because they are worried I might think negatively about them. But that is not true at all. I have a lot of respect for people who have the courage to talk openly about their mistakes and problems*
- *We all have issues, regrets, and make mistakes in life.*
- *Your problem behaviors/past mistakes do not define who you are as a person. What will define you is what you learn from it and how it helps you to lead a positive, non-abusive life.*
- *Your honesty and ability to take responsibility for your sexual offenses and other problems is a strength, not a weakness. It is a sign of maturity and something for which I have a lot of respect.*

These meta-talk statements helped increase Jim's openness and honesty about his sexual offending and his other problem behaviors.

Meta-Talk: Facilitating Open Communication about Sexual Orientation. Jim was sexually abused by an adult male and had a history of sexually acting out with both males and females. I was concerned that he might have some confusion and anxiety about his sexuality. Jim's sexual victimization may have disrupted where he would naturally fall along the sexual orientation continuum. Before exploring this topic with Jim, I used meta-talk to let him know I am a safe person to talk with about this subject. I drew a horizontal line across a piece of paper to illustrate the sexual orientation continuum. I then explained (and wrote down on the continuum) that one end of the continuum represents people who are only attracted to the same sex, while the other end represents people who are only attracted to the opposite sex. The portion in the middle represents people who are attracted to both the opposite and same sex to various degrees. Research has found that it is normal and natural for people to be anywhere along this continuum (Epstein, McKinney, Fox & Garcia, 2012; Hird, 2006). Some people are only attracted to the same sex (homosexual, gay, lesbian), some are only attracted to the opposite sex (heterosexual), and some are attracted to both the opposite and same sex and fall at various places along the continuum

(bisexual). I then asked Jim, *If you feel comfortable sharing can you tell me where you see yourself on the continuum?* Jim identified himself as primarily heterosexual, but not completely. We discussed how his early sexual victimization experiences may have altered where he would naturally fall along the continuum. I normalized this and talked about how he would gain more clarity about his sexuality as he advanced into adulthood.

Meta-talk: Facilitating Open Communication about Masturbatory Practices. Another issue that needed to be addressed was Jim's chronic masturbation, which was so frequent at times, his penis would bleed. Talking openly about masturbatory practices is often difficult for youth, which is why I never start conversations by bluntly asking, "Do you masturbate?" Instead, I made the following meta-talk statement to help Jim feel safe talking about this sensitive topic, *I want to talk with you about a topic that some people feel uncomfortable discussing, but it really is nothing to feel uncomfortable about because it is related to healthy sexuality, which is one of our goals, right? The topic I want to talk about is masturbation. Masturbation can be a very healthy method of sexual expression under the right conditions, and research has found that the majority of people do masturbate or have masturbated* (Herbenick, et al., 2010). *If you don't mind me asking, how many times a day do you masturbate?* Following this meta-talk introduction, Jim openly talked about his masturbatory practices. We were able to have frank discussions about healthy rules for masturbation (i.e., use only prosocial, non-abusive fantasies; only masturbate in private settings; use good hygiene; do not masturbate when angry; masturbate at a frequency that does not interfere with daily activities and does not cause injury to self). We talked about how Jim's sexual reactivity, including his chronic masturbation, most likely developed in response to his childhood sexual victimization experiences. I provided Jim with information about how he could better manage his sexual behaviors by strengthening his ability to delay gratification.

Educate about Delayed Gratification to Help Manage Sexual Reactivity: To help manage Jim's sexually abusive behaviors and sexual reactivity, I advised him on delayed gratification and how he could strengthen this ability within himself. I explained that delayed gratification is the ability to resist temptation for immediate rewards in order to gain something better in the future. For example, in order to earn a high school diploma or college degree, you must have the ability to sacrifice more immediate pleasures to study for exams and attend classes. In order to become a skilled athlete or musician, you must practice for long hours over the course of many years. To become a skilled carpenter (one of Jim's life goals), he would have to first work lower paying jobs and maybe take some classes in order to learn from more experienced carpenters. We talked about how people who have a strong ability to delay gratification often achieve great things in life (American Psychological Association, 2012; Casey, et al., 2011; King, Fleming, Monahan & Catalano, 2011; Mischel, Shoda & Rodriguez, 1989; Moffitt, et al., 2011; Shoda, Mischel & Peake, 1990; Tsukayama, Toomey, Faith & Duckworth, 2010).

Jim and I talked about how delayed gratification could help him better regulate his sexual thoughts, feelings, and behaviors, so they do not lead to negative consequences in his future. We identified specific strategies to help strengthen his ability to delay gratification, including thought and behavioral substitution and distraction techniques. Self-induced changes in thinking and attention can help improve delayed gratification (Mischel, Shoda & Peake, 1988; Painter, Wansink & Hieggelke, 2002). I encouraged Jim to use this strategy to interrupt any abusive thoughts or fantasies he might experience. We talked about how Jim could wire his brain in healthy ways (neuroplasticity) by practicing delayed gratification in a variety of situations each day. Each time Jim stops himself from violating someone's personal boundaries, for example, he is wiring his brain in positive ways. Regular practice can

strengthen an individual's capacity for self-control and delayed gratification (Muraven, 2010; Muraven, Baumeister & Tice, 1999; Oaten & Cheng, 2006).

We also discussed how Jim could use delayed gratification to better manage his masturbatory practices. Although Jim's masturbation was healthy in many ways, the extreme frequency was detrimental. In order to strengthen his delayed gratification, Jim decided he would try to limit his masturbation to only once a day. Jim and I talked about redirecting his attention away from masturbating by thinking about non-sexual topics and activities. We also set up behavioral substitution strategies, including doing something else with his hands by squeezing a stress ball. These interventions helped decrease Jim's masturbation to a frequency that no longer caused self-injury.

Practice Healthy Coping Skills: Over the course of treatment, I introduced Jim to a variety of coping skills to improve his emotional regulation and prosocial interactions. These coping skills included thought-stopping and thought-substitution strategies, positive self-talk; self-timeouts, behavior substitution strategies, physical exercise, journaling, reading/bibliotherapy, drawing, listening to music, diaphragmatic breathing (belly breathing), progressive muscle relaxation, and regular check-ins with his support system.

Address Childhood Victimization in a Trauma-Responsive Manner: In recent years, research on the prevalence of childhood victimization has identified trauma-informed care as an important component within sex offense-specific services (Jespersen, Lalumiere & Seto, 2009; Levenson, 2013; Levenson, Willis & Prescott, 2014). Jim was resistant to talking about his past sexual victimization. He reported having only vague memories, most likely due to his young age at the time of the abuse and/or his reluctance to revisit these victimization experiences. Although his sexual victimization clearly influenced his hypersexual and sexually abusive behaviors, he denied experiencing any symptoms that would suggest he was struggling with unresolved trauma. In order to honor Jim's assessment of his needs, I did not force him to talk about his past sexual abuse experiences. Instead, I made meta-talk statements to educate him about the possible issues and symptoms that could arise in the future. I explained that if he began experiencing lots of thoughts, feelings, and/or nightmares about his past abuse and it was disrupting his life (e.g., poor sleep, anxiety, depression, relationship problems), it could be his mind and body's way of telling him he needed some extra support. We talked about the importance of seeking out a treatment environment in which he felt safe.

Be Proactive, Prevention-Oriented for the Next Generation: In the latter part of Jim's treatment, he expressed his hopes and dreams about getting married and having his own family some day. This topic led to some conversations about what it means to be a healthy husband and healthy father. We talked about what he could do to create a safe, healthy environment for his children to prevent them from being sexually abused like he was as a child. Prevention and health promotion is an important area to target within youth services. Many factors and resources can help promote healthy development and reduce the risk of childhood sexual victimization for the next generation (e.g., Brown & Tavener, 2002; Hindman, 1983; Powell, 2014a; 2014b).

Conduct Clarification Work: A restorative justice process, including clarification sessions, is an important part of treatment (for both the offender and the victim). Unfortunately, it was not possible to conduct any clarification work directly with Jim's brother, due to the family leaving town with no forwarding address. However, we still did some journaling assignments to help Jim acknowledge his

personal responsibility for his offenses, communicate his insight into the potential impact it had had on his brother, and describe how his behaviors will be different in the future. Although none of Jim's writings were shared with his brother and biological parents, it was still a useful exercise to facilitate empathy and to promote his thinking about how he will be different upon his return to the community.

Provide Transition Services: Because relationships are so critical for effective services, they must be considered at all phases of treatment. Jim spent 18 months in our facility and then transitioned to a group home. In order to help Jim establish a positive relationship with his new staff, I made several phone calls and visits to the group home to educate the staff about Jim's treatment needs. Several members of Jim's multidisciplinary team (MDT) stayed involved in his case during his transition to the group home and his eventual transition to his foster parents' home. This consistent support from MDT members was a key protective factor.

Outcome

During the time Jim resided in our facility, his behaviors became increasingly stable. He gained insight into his strengths as well as his problems behaviors, and his emotional regulation and interpersonal skills improved. Jim successfully transitioned to a group home and then to his foster parents' home. After Jim had been off parole for a year with no incidents of sexual reoffending, a court hearing was scheduled so that Jim could be removed from the juvenile sex offender registry. This recommendation for removal from the registry was part of the psychological/sex offense-specific evaluation I completed just prior to Jim's discharge from our facility. There is growing evidence that far-reaching registration and public notification laws, which do not consider individualized needs and risks, do not improve community safety and can negatively impact clients' reintegration back into the community (Human Rights Watch, 2013; Justice Policy Institute, 2008; Letourneau & Armstrong, 2008; Letourneau & Caldwell, 2013).

Jim is now in his mid-twenties and still calls to check in. He is employed in the carpentry field just as he had hoped and has not had any more run-ins with the law. He appears to be making good life choices. He still has not had any contact with his family of origin and seems content with using the alternative supports he has established over the years.

Obstacles and Lessons Learned

One of the biggest obstacles was the abandonment by Jim's parents and his subsequent unstable behaviors. Jim's anger, sexual impulsivity, and self-injurious behaviors were challenging to manage. Our direct care staff were frustrated with his chronic instability and looked to me for answers. I felt a huge responsibility to stabilize Jim's behaviors, which did not happen quickly. I found myself experiencing feelings of frustration and self-doubt.

I learned several lessons from this case including the importance of being empathetic and not personalizing Jim's disruptive behaviors. I regularly reminded myself that Jim's problem behaviors were the result of a very difficult childhood. These experiences negatively impacted Jim's ability to emotionally regulate, and they skewed his understanding of what are healthy, prosocial coping skills and relationships.

My work with Jim underscored the importance of maintaining an optimistic, hopeful attitude. A great deal of change occurs during adolescence and young adulthood, including brain development, social-emotional development, cognitive development, and psychosexual development (Lerner & Steinberg, 2009). Just as Jim's sexual offending and other problem behaviors were learned, they could be unlearned and replaced with healthy alternatives. I did not give up on Jim. I remained cognizant of all the positive changes that occur as youth mature into adulthood and of the low sexual offense recidivism rate for those who participate in treatment (Caldwell, 2010; Worling, et al., 2010).

Another lesson learned was the power of social support to stabilize behaviors and to help heal past traumas. When Jim's biological parents skipped town, I seriously questioned whether or not treatment could be effective. His behaviors were so disruptive and his social support so limited, the prognosis seemed grim. The consistent support, however, from foster parents, facility staff, and MDT members was instrumental in stabilizing Jim's behaviors and in promoting healthy development. The love and support of others is a powerful protective factor.

I also learned the importance of youth service providers having a good support system. Jim's chronic instability in the initial phase of treatment was stressful, and I experienced a great deal of frustration, anxiety, and insecurity. I was fortunate to have a supportive supervisor and colleagues who helped me maintain an optimistic, strengths-based outlook. It took a healthy team (village) to support each other during the course of treatment, which resulted in positive outcomes for Jim.

Conclusion

A strengths-based approach is not a set curriculum, but rather an underlying foundation to guide services with an emphasis on what to do in treatment. It is a principle-based approach that includes many components that are supported by research, while also allowing for flexibility to utilize clinical expertise and consider the individualized needs of each youth and family (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006). The consideration of Jim's individual needs (i.e., trauma history, social support, capacity to emotionally regulate, adaptive and maladaptive coping skills, ego strength, and intellectual capacity to benefit from various interventions) helped determine the pace and content of services. One of the most appealing features of a strengths-based approach is how effective it is for reducing defensiveness and increasing engagement in treatment. This is especially important within the field of sex offense-specific services, which commonly work with youth who are legally mandated into treatment and can be resistant. The strengths-based components used in this case helped create an environment in which Jim felt safe to address his offending behaviors and other issues. It also focused attention on what factors could help him develop into a well-adjusted member of society. Establishing and maintaining a strengths-based foundation was critical for helping Jim to overcome his problem behaviors and setting him on a healthy, prosocial trajectory.

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