LEARNING OBJECTIVES

Participants will understand or be able to identify:

1. Identify variables often considered in the etiologies of juvenile sexual violence and general delinquency.
2. Gain a better understanding of the heterogeneity among youth who sexually abuse.
3. Identify some responsibilities of a social worker in working with sexually violent male youth.

The Problem

In 2009, youth accounted for approximately 15% of all arrests for violent crime in the United States, according to the Federal Bureau of Investigation (2010). Of those youth arrested for violent crime in 2008, approximately 83% were male. Juveniles arrested for sexual crimes other than forcible rape and prostitution were 90% male, while forcible rape arrests were 98% male (Puzzanchera, 2009). Given these statistics, it should come as no surprise that the most recent report on youth violence published by the United States Surgeon General identifies simply being born male among the top five risk factors for committing serious criminal behavior (U.S. Public Health Service, 2001).

Violent crime is distinct from other criminal behavior in that the offender uses or threatens to use violent force upon a victim, whether force is the object of the offense (e.g. assault), or the means to an end (e.g. robbery). Sexual violence is specific behavior which involves touching another person in a sexual way without consent, or with an inappropriately aged person, or with a person who cannot give consent due to power, age, or other differences. Juveniles who commit violent sexual crimes are of particular concern because they tend to be the most versatile and frequent offenders; they start younger, continue later, and have high instances of co-occurring, nonviolent criminality (Farrington & Loeber, 2000).

What is a social worker’s role in all of this?

The purpose of this article is to explore some of the issues which are relevant to social workers who work with male youth who commit acts of violence and sexual abuse*. It is focused on youth who have sexually abused at least one person and therefore received a “sex offender” label, although it calls into question how this label should be used and what conclusions social workers should draw when they see these words upon intake. It is not intended to be conclusive in assessment and formulation, nor exhaustive in treatment recommendations. In fact, it is anticipated that, upon completing the post-test, the reader will have far more questions than answers. Students of social work and clinicians who have had little or no experience with this population may find some of the theoretical constructs offered to be an appropriate launching point for some ways of thinking when working with violent and/or sexually abusive youth. Clinicians who are experienced with this population and program administrators may find some of the current cited studies useful to their work and perhaps find some utility in the cases provided for reflections on their own casework. It should also be noted

*The growing trend of female youth committing acts of violence and sexual abuse is deeply concerning as well, but is not addressed here. Studies of this population are fewer in number, although their reasons for offending seem to be distinct from male youth in many respects.
that, while researchers have focused an increasing amount of attention on juvenile violence and sexually abusive behaviors, to date, far more research has been done on the etiology of violent adult males and adult male sexual abusing than has been done on juveniles. Therefore, some research on adult male populations will be used here for comparative purposes (and noted, when done so).

### Regarding terminology

While there are some exceptions when citing extant studies, the majority of places where derivations of the term “sex offender” would commonly appear are replaced in this text with a derivation of “sexual abuser.” Offender is a term associated with law enforcement and the judicial system, whose job it is to arrest and to adjudicate (respectively) those whose behavior is deemed socially unacceptable. However, in the current media and political climate, sex offender has become a highly pejorative and pathologizing term, both devoid of empathy and wholly dismissive of all other dynamic factors which influence decision-making and character-development.

Additionally, there are a wide range of youth behaviors which vary in both severity and predictability of future sexual behaviors (e.g. coerced touch over the clothes of a child vs. rape of a peer) which all fall under this single term. Given that the majority of sexually abusive youth who we encounter in groups or individual therapeutic dyads will not continue to sexually abuse others as youth or adults (Bullens, van Wijk & Mali, 2006; Burton & Meezan, 2004), to call most youth who have sexually abused sex offenders seems unduly harsh and counter-therapeutic. As clinical social workers, our job is to focus on the behavior and/or mental health of the youth and systems with which we work. Therefore, the language we choose when describing our clients is important, as it sets the tone for treatment and provides opportunities to discourage non-clinically trained colleagues, collateral providers, and the youth themselves from assigning pathology to behaviors.

### A note on case details included

Cases of youth with whom I’ve worked directly as a clinician are included as examples of how research has been useful in informing my formulation and treatment of violent and sexually abusive youth. In order to protect client and victim privacy, names have been changed and each individual presented is a composite figure of two or more similarly presenting youth. Identifying details have been distorted or omitted.

**Readers should be aware that each case presented will include a reference to or a description of at least one act of violence or sexual aggression upon a child or an adult.** While some of the behaviors described are graphic, gratuitous details have been omitted. Details included have been done so as to illustrate the clinical relevance in knowing the nature of the violent and/or sexually abusing behavior in the young people we treat and will be discussed when provided. While there are many appropriate reasons for why not all information is present on any given intake, it is important to also know that it is never clinically appropriate to make diagnostic assumptions about a youth based on information such as “he sexually offended his sister five times,” as often appears in countless transfer notes from clinicians, DCF workers, or Probation Officers. Sometimes, no more is known because gathering this information would be harmful to the youth or otherwise inappropriate in early treatment. Sometimes a youth’s lawyer has requested that no details are disclosed pending an open case. However, many times this information is not procured simply because the person gathering the information didn’t think that it was necessary to ask, or was too uncomfortable to ask. (This is exemplary of how “sex offenders” have come to be largely regarded as a single population.)

As clinical social workers, it is sometimes part of our job to ask these difficult questions. However, there is a delicate balance to be aware of in doing so, particularly in initial interviews: First of all, we never want to jeopardize the therapeutic relationship by coming across as overly investigative (many of these youth have recently spoken to investigators, after all, and will be appropriately cautious of us), or seeming as if we are attempting to force a disclosure from a youth. A sense of the interviewer as a researcher (or negative parental figure) might not only trigger trauma in the youth, causing him to become increasingly distrustful, but also increases the risk for him to experience increased levels of shame, and minimize or lie about what he has done. On the inverse, one must also be aware of the degree to which a highly antisocial youth might become stimulated in reiterating his behaviors, or making an attempt to use the details of his past sexual acts to shock, threaten, or tantalize the interviewer. This is less common, but is important to be aware of. Any suspicion of this behavior needs to be addressed immediately before continuing with gathering these details.

### Why the distinction of “violence and/or sexual abuse”? Is there any such thing as nonviolent sexual abuse?

The quick and easy answer to this question is, of course, no, as any act which involves sexual contact with an individual who does not give (or is unable to give) consent is a violation and can be considered an act of violence. However, studies of adult male sexual abusers show that there seems to be a distinction between individuals who act violently (sexually or not) and those who do not act...
violently. Regarding sexual aggression specifically, there is a distinction between adults who commit violence in order to control a resistant victim (e.g. the rape of an adult in which the victim actively attempts to defend herself/himself) or commit acts of physical assault beyond what is necessary to control the victim to rape him/her (e.g. punching the victim after she/he is incapacitated) and those who only use sufficient coercion or force to gain sexual control over the victim (e.g. the sexual molestation a child who does not demonstrably protest to sexual activity and is not physically injured in the process of the offense). The former of these tend to be more universally aggressive, antisocial, and dangerous individuals who commit varied crimes, both violent and nonviolent (Harris, Mazerolle, & Knight, 2009; Lussier, LeBlanc, & Proulx, 2005; Smallbone, Wheaton, & Hourigan, 2003), while men who exclusively molest children, for example, tend to be otherwise nonviolent individuals and have fewer antisocial qualities than rapists and nonsexually violent men (Smallbone & Wortley, 2004).

Unfortunately, many studies on youth sexual abusing simply compare “youth sex offenders” to “non-sex offending delinquents” and do not make a distinction between youth whose sexually abusive behavior suggests higher risks for co-occurring violence and delinquency and those who do not. Also, most studies have not explored the co-occurring nonsexual criminality among “youth sex offenders,” as if to suggest that the negative behaviors of these youth are limited to an act (or acts) of sexual aggression. All of these factors not only inform the risk of harm these youth present to themselves and others but, more importantly, they inform the treatment needs of the youth. Therefore, unless specified, many studies which have found differences between youth who have sexually abused and those who have not, include individuals in the “sex offender youth” with drastically different presenting issues and risks for repeating sexual behaviors.

Did you know?
- The Massachusetts Sex Offender Registry Board (S.O.R.B.), the state agency assigned to hold hearings and assign “risk-levels” to youth who have been convicted of sex offenses, uses an assessment tool which makes no distinction between youth and adults.
- For adolescents who have sexually abused, no assessment tool exists which empirically validates the risk of recidivism.
- The S.O.R.B. does not require the presence of a serving member who specializes in the assessment of adolescents, despite that the S.O.R.B.’s decision has far-reaching and potentially life-altering impact on the youth who appear before it.

Do youth who sexually abuse others require special, “sex-offender” treatment?

It depends. Specialized treatment for youth who have sexually abused others has been shown to greatly reduce subsequent charges for sexual, nonsexual, violent, and nonviolent crimes (Worling, Littlejohn, & Bookalam, 2010). However, frequently overlooked by many treatment providers and state agencies is that the type and duration of treatment is best determined according to factors well beyond the “youth sex offender” label (Seto & Lalumière, 2010), as offense type and chronicity of offending have shown significance in predicting violent and sexual recidivism in youth across multiple studies (Worling & Curwen, 2000; Worling & Langstrom, 2006). Despite this, in most states, including Massachusetts, youth with a “sex offender” label are typically adjudicated similarly in many courts, including: mandated for standard, one-size-fits-all “sex offender treatment,” placement on the state sex offender registry (in Massachusetts, overseen by the Sex Offender Registry Board—commonly referred to as The S.O.R.B.), and physical removal from family support systems through incarceration, residential treatment, or specialized foster care.

Complicating this is that state agencies not only fund treatment but indirectly prescribe treatment. The clinics which bid for service contracts with DCF and the Department of Probation, and must agree to treatment protocols set by the referring agency (DCF and/or the Department of Juvenile Probation). Unfortunately, while very well intended, these state agencies often lack the internal resources to maintain the same level of expertise and up-to-date knowledge of assessment and treatment that experts at these clinics often have. In fact, like the Massachusetts S.O.R.B., most state agencies fail to acknowledge the heterogeneity in the population of youth who have sexually abused and, consequently, mandate a relatively narrow treatment focus, regardless of offense type.

As a result, clinics are often put in the uncomfortable bind of having to use outdated and sometimes contraindicated treatment modalities in order to fulfill the terms of a contract with state agencies, despite awareness of empirically tested, best-practice methods. Left with this reality, social workers must do the best they can for their clients in providing the most appropriate treatment while continuing to educate collaterals on best practice methods, one person at a time.

What accounts for all this violence?

Given the strikingly high percentage of juvenile violent crimes committed by males (and the U.S. Surgeon General’s warning already noted), it is understandable that researchers who study the etiology of youth violence and sexually abusive behavior sometimes consider variables which are endemic to being male, including the presence of elevated testosterone levels (Banks &
Dabbs, 1996; Ramirez, 2003; Sanchez-Martin et al., 2000) and the presence of masculine beliefs (Brown & Burton, n.d.; Hunter, 2004; Hunter, Figueredo & Malamuth, 2010). However, studies show widely varying results and have ultimately provided little conclusive evidence to suggest that either sex (testosterone) or gender (masculine identity) can account for sexual abusing or other acts of violence committed by male youth. Studies of masculinity and youth violence have been particularly problematic, as finding common denominators across measures of masculinity is quite challenging and the definitions used are often anecdotal (Honkatukia, Nyqvist & Poso, 2007). Some studies of violent and sexually abusive males refer to hostile masculinity or hypermasculinity specifically, both of which are defined similarly to Cluster B personality disorder traits (e.g., grandiosity, lack of empathy, aggressiveness, law breaking behavior, sexual impulsivity, recurrent fights, entitlement, exploitative of others, and arrogant attitudes). However, the direct connection between masculine beliefs and these traits is unclear.

It is interesting that studies which focus on hypermasculinity and hostile masculinity among youth do not define or operationalize normal masculine beliefs or traits. In fact, no empirically-validated scale to determine healthy gender identity in male youth currently exists. The suggestion that there is a direct association between masculine beliefs and the negative behaviors which define hypermasculinity and hostile masculinity is particularly disappointing in light of the tremendous gains made in the last 30 years by feminist authors in understanding how traditional feminine identity has engendered a culture of victimhood among some girls as they develop into adolescents (Brown & Gilligan, 1992; Ferraro, 1996; Gilligan, 1982; Lamb & Brown, 2007). Do the studies of hypermasculinity and hostile masculinity among violent youth suggest that traditional masculinity has engendered a culture of perpetration among some boys as well? If so, and if it is not related to testosterone levels, then what about being a boy might account for males representing 83% of all youth who commit violent crimes?

In terms of physical development milestones, “Tanner’s Stages” (Marshall & Tanner, 1970). (Figure 1) is perhaps the most frequently used pubertal staging system used in the identification of visible changes in the development of secondary sexual characteristics and illustrates the most visible of the rapid changes one can expect to observe in a typical male from early childhood to early adulthood. While these changes are happening, equally rapid changes are taking place with regard to body composition, and the cardiovascular and endocrine systems, among others.

Note that the growth stages shown here stop somewhere between the ages of seventeen and twenty-five, or roughly 1/3 of the lifespan of a healthy adult male. Therefore, if, for example, we were to line-up three healthy biological brothers, each 15 years older than the one before [i.e. a 9 y/o (Stage II), a 24 y/o (Stage V), and a 39 y/o (Stage VI)], we could expect to observe very little difference between the secondary sexual characteristics of the latter two, while the observable difference between either of them and their 9 y/o brother would be stark. What might these striking genital differences suggest about the rest of one’s development during this time period?

The less observable brain (Figure 2) is also rapidly developing, perhaps in consonance with (if not slightly behind) the secondary sexual characteristics of males. Last to mature is the prefrontal cortex (frontal lobe area), occurring in late adolescence/early adulthood. The prefrontal cortex is most responsible for executive functioning (Gogyay et al, 2004), encompassing a wide variety of high-level brain activities which are essential in initiating and completing tasks (e.g. deciding to practice basketball drills everyday in the summer in order to increase one’s chances of making the school team) and adapting to unexpected situations (e.g. not making the team and instead deciding to audition for the school play). Another role of executive functioning (and perhaps that most pertinent to those who work with violent youth) is in inhibiting inappropriate behaviors (e.g. feeling an urge to punch the coach in the face when one’s name isn’t on the team roster, but choosing to take a deep breath and walk away). When executive functioning is impaired, consequences can range from the rather benign (e.g. playing video games all summer instead of practicing free throws), to the severe (e.g. assaulting and injuring the coach, as well as facing severe legal and social consequences).
A recent study of incarcerated adult males shows that both the severity and the frequency of violent offending can be predicted by deficits in executive functioning (Hancock, Tapscott & Hoaken, 2010). For violent juvenile males, there is robust evidence to suggest that being a victim of violence predicts being a perpetrator of violence (Burton & Meezan, 2004; Tinklenberg, Steiner, Huckaby & Tinklenberg, 1996) or even the degree of violence severity over time (Brown & Burton, 2010). However, findings have also long indicated that most male juveniles who grow up in abusive environments will not become violent themselves (Widom, 1989). What other factors might then account for violence begetting violence if the majority of victims of violence do not go on to become perpetrators?

The word **allostasis** means “maintaining stability, or homeostasis” and refers to the process of how one adapts to stress, specifically as it relates to the output of stress hormones which are released to restore homeostasis in the face of a challenge (Sterling & Eyer, 1988). **Allostatic load** refers to either an excessive stress hormone response or a deficiency in stress hormone response when psychosocial or physical situations disrupt homeostasis (McEwen, 1999). According to the theory, when a person is under a great deal of stress, a chain of events is set off involving the endocrine and circulatory systems which, in turn, trigger imbalances in the neural system. A psychological side effect of stress as a chronic condition, therefore, is believed to culminate in psychological risk for executive functioning impairment. For example, if a boy grows up in a highly stressful home due to domestic battles between his parents, allostatic load might be responsible for his intolerance for everyday stressors and his inability to appropriately control himself in the face of these. (Think about a guy who gets out of his car with a golf club to attack the person who cut him off at the last intersection vs. the overwhelming majority of people who, no matter how angry, remain in their cars and move on with their days.) If it is true that allostatic load is at least partially responsible for executive functioning, it is certainly useful as a theoretical construct in explaining a great deal of behavioral reactions to stress in terms of executive functioning deficiency.

Noted psychiatrist and author Daniel Siegel in his 1999 book, *The Developing Mind*, explains the process this way:

…the beyond-the-window-of-tolerance state of hyperarousal leads, neurologically, to the inhibition of higher perceptions and thoughts in favor of the dominance of more basic somatic and sensory input. In this situation, we don’t think; we feel something intensely and act impulsively. What this means is that an individual who enters a state outside the window of tolerance is potentially in a ‘lower mode’ of processing, in which the reflexive responses to bodily states and primitive sensory input are more likely to dominate processing (pg. 259).

Exciting new research on trauma shows a direct link between trauma exposure and these deficits (DePrince, Weinzierl & Combs, 2009; Samuelson, Krueger, Burnett & Wilson, 2009), consistent with earlier...
studies of children diagnosed with posttraumatic stress disorder, who were found to have significant prefrontal lobe damage with no other known antecedents (De Bellis, Keshavan, Spencer & Hall, 2000; De Bellis et al., 2002). These studies seem to suggest that the relationship between trauma and executive functioning is clear. However, what this relationship is, exactly, remains opaque. While there is a growing body of scientific evidence to support the theory of allostatic and allostatic load playing a significant role in multiple domains of well being (Karlamangla et al, 2002; Gruenewald et al, 2006; Seeman et al, 2004), many researchers are not convinced of the relationship between biology and behavior (Ryff, Singer, & Love, 2004).

**Girls experience trauma too. What about their executive functioning?**

In fact, girls do experience high levels of trauma. Therefore, girls too must experience allostatic load and executive functioning deficits when under chronic stress. Yet, girls are not committing acts of violence in nearly the same numbers as boys. Why is this?

There is robust evidence to suggest that, in general, girls develop more quickly than boys, both physiologically and cognitively. Studies of brain development continue to show that males have a more protracted course than do females in the majority of brain region maturity (Asato, Tervilliger, Woo & Luna, 2010; Schmithorst, Holland & Dardzinski, 2008). Is it possible that one reason girls do not demonstrate evidence of executive functioning deficits in similar numbers to boys in adolescence is because, by the time boys and girls reach the stage of social maturity in which they traditionally have fewer restrictions placed on them (e.g., more time in the community unsupervised,) girls’ brains have typically matured sufficiently to serve as a protective factor against committing an act of violence when feeling stressed, whereas boys, whose brains are slower to develop, are more likely to act out? If so, then how might the speed in which executive functioning develops relative to social norms account for why we see higher rates of depression in girls (an illness characterized by an internal manifestation of symptoms unrelated to impulse control) and ADHD in boys (an illness characterized by an observable, external manifestation of symptoms which often include problems with impulse control and following through on tasks)?

**A few other brain-based possibilities**

Attention deficit hyperactivity disorder (ADHD) indicates an executive functioning deficit (e.g. unable to stay still, blurt out at inappropriate times, struggle to pay attention to the task at hand, etc.). This is not only diagnosed in greater numbers of boys than girls, but when girls are diagnosed with ADHD, it is predominately the inattentive type, rather than hyperactive (Biederman, Kwon & Aleardi et al. 2005; Weiss, Worling & Wasdell, 2003). Is being male predictive of hyperactivity, as it is for becoming violent? If so, might there be a relationship between violence and hyperactivity, as there is between violence and trauma?

Psychopathy is another issue worth exploring in the pathway to violence. In general, psychopathy is the combination of many traits, including: superficiality, lack of remorse, callousness, and impulsivity, combined with a general violation of social norms (Hare, 1996; Hare, 2003). Much remains unknown about what causes psychopathy, although, when multiple traits are present in adults, psychopathy has consistently shown a strong relationship to many poor outcomes, including repeated violence and sexual abuse (Leistico, Salekin, DeCoster, & Rogers, 2008; Walsh & Kosson, 2007). Although studies of psychopathy up to this point have been largely limited to adults in whom it is already present, a rudimentary pathway to psychopathy appears to be taking form: Adults with psychopathic traits in the criminal justice system typically started their antisocial behaviors as juveniles (Forth & Burke, 1998), and conduct disorder, which seems to be the biggest predictor of youth delinquency (Frick & Marsee, 2006), shows significant hereditability (Young et al., 2009). However, studies also indicate that specific life experiences impact some of the neurobiological development contributing to psychopathy (Guay, Ruscio, Knight & Hare, 2007). Boys have traditionally been exposed to more violence than girls. Boys also are more likely than girls to have the presence of a socially approved male role model who is aggressive and encourages aggressive displays of behavior (e.g. professional wrestlers, hard-hitting football players, and Ultimate Fighting Champions) (Lopez & Emmer, 2002). Does this suggest a dulling effect to violence? Is something epigenetic contributing to violence? If so, why is this link stronger in males? Or, is the formation of psychopathy the consequence of an insidious and slowly moving accumulation of antisocial input that it is more likely to become occluded by the female brain due to the same myelination process that might also be responsible for more rapid mastery in executive functioning? Is it possible that there is a relationship between the timing of increased autonomous functioning

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“I love my girlfriends; I mean, spending time with them is cool and everything. But most days, I’d just rather hang-out with my guy friends to keep it simple. Whenever it’s just me and a bunch of guys, I just feel so smart! I don’t want to sound mean, but even my smartest guy friends are so stupid. For example, my friend, Jacob, broke his arm last week when he rode his long-board off the roof of his garage. His garage! He said that he thought it would be fun... and that’s what I’m saying—I don’t know a single girl my age who would do that. Do you? Then again, does it really surprise you? Because, honestly, that could have been most of the guys I know.”

—A 15 year-old female Honors Student in Western Massachusetts (Personal conversation, August, 2010).

Because of their own interest in their genitalia, it is often difficult for men to understand that women are typically not that interested in seeing male genitalia. (Kinsey, 1948)
in the community (the age at which young people are expected to manage themselves more independently) and the development of psychopathy? Is being born female a protective factor against psychopathy, like being born male is a risk factor to commit acts of violence?

A Theoretical Perspective

To provide a framework for better understanding these and other questions regarding violent and sexually abusing youth, Bronfenbrenner’s Ecological Systems Theory (Bronfenbrenner, 1999) provides a useful theoretical construct. Bronfenbrenner’s model begins by dividing an individual’s spheres of influence into three tiered categories, separated according to what he refers to as “higher-level(s),” which can be thought of as the degree of physical distance from the individual. Respectively, these are called 1) the microsystem—or immediate sphere (e.g. immediate family, probation officer, case worker, peers, psychotherapy group members, foster or group home, therapist, etc.), 2) the exosystem—or processes taking place away from the youth which indirectly influence processes within his immediate setting—(e.g. judges, school administrators, researchers who study “youth sex offending,” DCF supervisors, the sex offender registry board, etc.), and 3) the macrosystem or overarching ideology which the youth likely has little awareness of as an entity, but ideology which frames the context in which the youth is considered, informing the way decisions are made (e.g. cultural assumptions about youth sexuality, mental health, gender and age norms, etc.). Bronfenbrenner then describes a forth system, called the mesosystem, which identifies the sphere of relationships that are formed between two or more independent microsystems (immediate sphere) interacting separately from the individual, yet whose relationships to one another have a primary impact on the individual (e.g. private telephone conversations between a youth’s therapist and his probation officer, each an independent microsystem; they sometimes have an extraordinary impact the youth’s life, as a youth on probation who is ‘noncompliant with treatment’ is always at the risk of being locked-up), despite the fact that the youth is not present for these conversations and, in many cases, is unaware of their individual occurrences.

Given the strongly pejorative and deeply pathologizing label “youth sex offender,” now a macrosystem construct, the exosystem of a youth with this label has little cultural pressure to increase empathy, regardless of subtype or age. This is markedly unique to “sex offenders,” as nearly all exosystem institutions (e.g. courts, schools, government service agencies, etc.) draw a dividing line (typically 18 y/o) and create different expectations for (and consequences to) behaviors, accordingly. With “sex offenders,” this is not the case. This might explain why Massachusetts, among many states with sex offender registry boards (an exosystem sphere) do not have a single member with experience in treating or evaluating adolescents and children, despite that both the mental health system and the judicial system evaluate youth distinctly in all other domains. Also, despite that it is the law to do so, school systems are far less inclined to accommodate youth “sex offenders,” sometimes delaying entry without the provision of home tutoring for months at a time, or not allowing a youth with a felony conviction to enroll in school if the attempt is made after his 16th birthday (e.g. a youth who is post-incarceration and in a foster home out of his parents’ district). For foster care youth, there is no choice in these cases but to stay at home on GPS confinement, with little or no interpersonal stimulation aside from weekly visits to therapy.

While the macro—and exosystems provide opportunities to examine the effect of distal relationships on these youth, the mesosystem—or the impact of microsystem interrelationship, allows an opportunity to explore the degree to which proximal processes affect development. Perhaps the most nuanced of the systems, the mesosystem is also arguably the one which provides the
discussion in the first or second session is arguably highly beneficial to the therapeutic alliance and ultimately expedites treatment. I have never felt that it has gotten in the way of truth-telling or disclosures over the long term. In fact, having this frank discussion and I have legal permission to do so. I tell them that this always includes my supervisor and other mental health colleagues at the agency with whom I collaborate, as well as the client’s case manager at the agency. I tell them that this will sometimes include parents, foster parents, residential staff, DCF personnel, probation officers, and others involved either directly or peripherally in the case. I offer examples of when and what type of information might be shared, and I assure the client that he will never be in a position in which he is caught off guard by someone knowing something I might share (e.g., if the client discloses a secret addiction to amphetamines, we will discuss why the legal guardian needs to know and the client will be given a choice as to how this is information is shared. If, however, my 17 y/o client tells me that he experimented with marijuana once or twice when he was 14 y/o, he doesn’t need to fear that his mother will confront him in the car one day out of the blue, ‘So, you told Adam that you smoked pot? Why didn’t you ever tell me that you smoked pot? What else don’t I know about you?’) With the exception of youth with atypical levels of oppositional defiance, youth almost universally accept this explanation without protest or further discussion and I have never felt that it has gotten in the way of truth-telling or disclosures over the long term. In fact, having this frank discussion in the first or second session is arguably highly beneficial to the therapeutic alliance and ultimately expedites treatment.

Particularly for youth who have been neglected and/or abused at some point in their lives (which is the majority of this population), making the effort to set clear boundaries in a direct and empathic way can go far in providing the sense of containment that most are seeking. Also, for youth who are more concrete thinkers (e.g., those with executive functioning deficits), it is very risky to promise confidentiality. For example, I had a 15 y/o client who became furious with me and called me a “liar” for promising confidentiality when, during a post-session chat with mom in the waiting room, I asked her what she thought of the film that her son told me they had seen the night before. Innocuous as the exchange with mom was, it is true that I didn’t keep my end of the bargain when I gave him the Tarasoff Warning, but did not bother to explain that this did not suggest universal confidentiality. After all, I was not mandated to talk about the movie he mentioned seeing with his mom, and yet here I was, casually referring to it with her when the session was over. If I couldn’t be trusted with something so simple, what would I say when he revealed more intimate details of his life?

Mandated reporting

Whenever a previously undisclosed allegation of child abuse (or elder abuse)—either as a victim or a perpetrator—is disclosed to a social worker in the State of Massachusetts, the social worker is legally obligated to call the Department of Children & Families hotline within 24 hours of the disclosure and fax or mail a written report within 48 hours.

While it is good practice as a professional courtesy to also call the client’s DCF worker to advise him/her of the report before it shows up on his/her Virtual Gateway account the next day (the computerized tracking and reporting system used by MA-DCF), this contact does not preclude filing. Even in cases when the client’s DCF worker says that it is not necessary to file because he or she will look into it, it is the legal responsibility of a mandated reporter with first hand information (and not the DCF worker, in this case) to call and let the screeners decide whether or not to take the report.

Is the goal to eventually get them to disclose everything they ever did?

It depends. The practice of pushing a youth who has sexually abused into making a full disclosure used to be one of the primary treatment goals in sex offender treatment and, unfortunately, is still practiced by many providers today. However, whether or not a youth ultimately admits to his therapist that he has sexually abused someone does not seem to have any effect on whether or not he recidivates sexually (Worling & Curwen, 2000). Perhaps this is the case because the client intuitively understands that, for most who are referred for “sex offender evaluation” the sexual offense is not the issue, it is a symptom of a larger issue. As therapists, making ourselves available to the client to hear their disclosures can be an invaluable part of the therapy and overall mental health of the youth. However, we need to be very mindful of our motivations for seeking disclosures and always be asking, who is this serving right now?, particularly if we find ourselves feeling a certain amount of personal pride when a defiant youth suddenly becomes compliant, or a youth who chronically lies starts telling the truth, or a youth who denied a criminal act admits guilt, etc. ‘Gosh, I’m...
we have said to ourselves once or twice while later reading over our case notes. Whether or not we are, in fact, good, attaching worth as professionals to the behaviors of our clients is a perilous trap. This is a collaborative process and, in the case of youth, one which requires a collaborative effort from many individuals, including the client, in order for it to work.

A well-contained holding environment with various pro-social adult influences eventually tends to yield disclosures of sexually abusive behaviors in the therapeutic dyad, more often than not, even from the most ardent deniers. However, as has been previously noted, the admission itself does not speak to a lowered risk level per se, but in many cases to the therapeutic alliance. Therefore, if it is the primary goal (or one of the primary goals) of the therapist to cull admissions of guilt from a resistant youth, the therapeutic relationship is more likely to become strained, which will likely worsen the treatment outcome, whether an admission is made or not.

### Treatment modality

In studies of sexually aggressive adult males, therapeutic alliance has the greatest predictive quality in treatment efficacy, regardless of treatment modality (Marshall et al. 2003; W.L. Marshall, L.E. Marshall, Serran & Fernandez, 2006). Note to social work students: despite this, don’t use this as your answer to the question, “What treatment modality do you plan on using?” when interviewing for positions. Even though most of us are eclectic in our approaches to therapy, knowledge of and comfort with cognitive behavioral therapy (C.B.T.) is essential to confronting the many thinking errors and problematic behavioral repetitions that you will encounter in this client population: confronting client thinking errors and the use of a directive approach, when necessary, will be important tools in working with a client population with 100% of clients coming involuntarily (only at first, hopefully). Regardless of initial resistance, most youth understand that they are suffering and will respond to straightforward, cognitive-behavioral treatment focusing on the identification of cycles of thoughts, feelings, and behaviors (Prochaska & DiClemente, 1986).

For those unfamiliar with motivational interviewing, reading the book *Motivational Interviewing* (Miller & Rollnick, 2002) and learning paradoxical interviewing skills (Kaplan, 2008) will be very useful. Many clients who are ambivalent about changing their ways respond well to motivational interviewing, while the most treatment-resistant youth might respond better to paradoxical interventions. (Please note: paradox needs to be closely supervised with an experienced paradox practitioner, as it can be quite risky if not executed appropriately—see resources for a training recommendation.)

As a Smith College School for Social Work alumnus, the psychodynamic model always informs my thinking, although strict adherence to the psychodynamic style is less likely to be effective in once-per-week therapy with youth who are neither motivated for treatment, nor have good insight into their issues.

Beyond modality, of course, there are times when we as clinicians will have misleading information (e.g. clients who deny any wrongdoing or greatly minimize details) and other times when we have no confirmation of information at all (e.g. clients with open cases whose lawyers have advised them not to disclose anything even remotely related to the relationship between the alleged victim and the client). In the former cases, denial and minimization are often protective factors commonly employed at the beginning of treatment and can, in fact, be quite useful to the client as he eases into treatment. In nearly all cases, there are usually enough other behaviors/issues to be addressed which will later become salient to the issues surrounding the alleged sexually abusive behaviors. However, in cases in which an attorney is advising his client to not discuss the alleged behaviors, unless a gag order is obtained, treatment is not always useful—particularly when a well-defended client can actually hide behind his lawyer’s recommendation to remain silent.

As clinicians, we should never encourage a youth to go against his lawyer’s recommendation. We should however, discuss with the lawyer the futility of treatment when a youth is in the position of having to withhold information he may otherwise wish to process—or the possible detrimental psychic effects on a young person who feels as if he must choose an allegiance with either his lawyer or the mental health providers whom he is mandated to see. Given the potential legal implications for youth convicted of sexual offenses in Massachusetts, those who have lawyers involved in a meaningful way are the lucky ones. With very little exception, lawyers want what is best for their clients over the long term and, because they are not mental health professionals, simply need to be educated on the potential negative side effects of treatment avoidance. In general, most are highly amenable to becoming a part of the youth’s treatment team and working toward a solution which both protects the client legally and serves his best interest clinically.

### Case Examples

Tony, Walter, and Demetrios are adolescent males who received individual “sex offender treatment” from me as a condition of either specialized foster care (Tony and Walter) or juvenile probation (David). All three committed acts of sexual abuse and therefore mandated for the same, narrowly focused “sex offender treatment” by their respective state agencies. However, these cases are presented to demonstrate the heterogeneity in the “youth sex offender” population and the need of state agencies to reconsider uniform treatment protocol with highly prescriptive outcome expectations. Readers are advised to be mindful of how Brofenbrenner’s systems are represented in each of the cases and how these systems impact the youth’s life.

### TONY

**Tony,** 16 y/o Caucasian, is a slightly-overweight, exceedingly polite young man with one blue eye and one brown eye. He walks with a noticeable limp due to a car accident that he was involved in as 5 y/o, when his mother drove off an embankment and hit a tree. According to reports, the tow truck driver and an ambulance attendant at the scene smelled alcohol on her breath, but charges
were not filed and Tony went back to his mother following the hospitalization. The subsequent Department of Children & Families (DCF) investigation was closed after one year. Years later, Tony was placed in foster care in Southeastern Massachusetts, shortly after his school filed a Child in Need of Services (CHINS), after Tony stopped showing-up and the school’s attempts to reach mom were unsuccessful. DCF determined that mom had left Tony on his own at home for the winter while she went to Florida with her new boyfriend. After approximately two weeks in foster care, Tony was removed from the home and placed in specialized foster care, after the 7 y/o biological son of the foster parents told his parents that Tony asked if he could, according to the intake, “kiss his pee-pee,” a claim which Tony flatly denied, insisting that the child must be confused. In the DCF report, the foster parents said that they suspected their biological son of making it up. Although their son had no history of lying, they believed him to be lying in this case “because Tony is such a sweet, gentle kid.” In fact, they only reported the accusation because the first-time foster parents were advised in foster parent training to report “anything strange, even if it’s nothing big.”

Prior to this, Tony was arrested once, when he was 14 y/o, after physically assaulting three 8 y/o boys at a skate park who, Tony maintained, were “taunting him.” When asked why he didn’t just walk away and leave them alone, given the age disparity, Tony nearly came to tears as he kept repeating, “They just kept picking on me and calling me names and stuff, so I went off on them.” He has no other documented history of violent behaviors.

He states to have been stealing money, drugs, credit cards, and many other things, for many years—“from my mom and the guys who come over, drink with her, go have sex with her and pass out.”

Tony stated that he has always struggled to make friends his own age and that he prefers to “hang-out with little kids, because they’re nicer than all them asshole kids my age.” As was the case in his first foster placement, he immediately bonded with his new foster parents, who were 20 year foster parent veterans who have literally fostered hundreds of youth. After a scant two weeks in the home, Tony stated in therapy, “They’re the only people who ever cared about me. Now I finally know what it’s like to have people who look out for me and love me.” The foster parents even briefly discussed adoption.

Tony enrolled in a highly supervised “behavioral school,” where he was an immediate favorite among the staff and, according to all reports, doing well and keeping himself out of trouble. His foster family also stated that Tony adhered to all rules of the home and that he was as well behaved as any kid they’ve ever known. In therapy, whenever the subject of the allegation by the child in his first foster home came up, Tony insisted that the child was mistaken. The focus of treatment initially was processing trauma related to being neglected by his mother and abandoned by his father. Then, increasingly, Tony wished to discuss the anxiety he was feeling regarding his sexual orientation, as he was sexually attracted to males exclusively, but also highly homophobic. “I’m definitely gonna’ have a wife and kids and all that, but I gotta’ find a wife who will be okay with me having sex with guys on the side. Either that (he laughed), or I’ll need to find a real dumb wife who won’t know if I go and do that stuff.” Tony acknowledged that this was an unusual plan, but insisted that it would work in his case for reasons that he could not explain, he said.

“I can’t stand [gay people],” he said one day. “So there’s no way in hell I’m gonna’ be one. Anyways, my mother would kill me if I ever became a [gay person].” Much of Tony’s formulation of himself and his relationships with others was rife with thinking errors, although it wasn’t clear to me then that these were just a sampling of the far more grave distortions in his thinking.

Eight months into treatment, the foster parents reported that “they knew it wasn’t true, but” a five year old boy in the neighborhood told his parents that he and Tony “liked to get naked and roll around together” when Tony would “go over there to earn extra money by cleaning the house.” The foster parents stated they knew that Tony did not have permission to be unsupervised at any time around children, but followed this by stating “you guys don’t understand, he’s just such a nice kid; we know there’s no way he’d ever do anything like this; it’s total bull.”

Although Tony’s foster parents knew Tony’s file, including the allegation of the 7 y/o in the previous foster home, the parents of the child whose house he was cleaning were not privy to this information. They often ran errands when Tony was there cleaning, leaving him to supervise their son for periods of time that sometimes lasted an hour or more. For five months, Tony had been engaged in genital fondling and oral sex with the boy, who told his parents what had been happening after Tony attempted to anally penetrate him with his penis.

After he was threatened with a polygraph from his DCF worker, Tony disclosed to me in session that the allegations of both boys were true, “except it’s not as bad as it sounds, because they wanted me to do it.” Tony went on to say that he had more than 15 victims in the last two years, all boys under the age of 9 y/o. Tony insisted that he never used force on the boys. “I never had to, because I only did it with the ones who wanted to do stuff with me.” He became quite self-righteous during this disclosure: “If they didn’t want to, I said okay.” He admitted, however, that after some of the assaults took place he would threaten to hurt the pets or parents of the children if they told anyone what they did. “Not that I ever did (hurt their pets or parents); I just wanted to make sure that they wouldn’t tell nobody, so I wouldn’t get in trouble and end up in [juvenile detention].”

“...we can provide an ‘appropriate intervention’ without the collateral damage of pathologizing or being complicit in wrongly criminalizing clients. Psycho-educational programs may be an appropriate alternative for a large percentage of adolescents referred for an adjudicated or un-adjudicated offense. Some guys, of course, need substantial treatment, but others deserve a speedy exit. We all know that the [sex-offender] label is so damaging that these guys cannot get their lives back without our help.”

Jon Brant, LICSW, St. Paul, MN, as posted on the list-serv for the Association for the Treatment of Sexual Abusers, posted September 22, 2010. Used by permission.
Tony went on to disclose more details of his single arrest after assaulting the 8 y/o boys in the skate park: “One of the kids was one who I was [being sexual with] and he told the other ones and they were saying that they were gonna’ tell (an adult). So, I got real mad and pushed one of ‘em to the ground. The next thing I know, the cops came, but I guess [the kids] never said anything, thank God.”

Tony stated that his history of sexual assaults with the various boys consisted of mutual oral copulation and fondling, but that he anally penetrated a few of the boys after having assaulted them for a month or more, “They’re the ones who I had to threaten—’cuz they sometimes said it hurt afterwards and I didn’t want them to say anything to their parents and I’d get in trouble.”

Tony was moved to another foster home on the day of the phone call from his foster parents, but it took a few weeks to get him referred for a higher level of care. During our termination session, something very interesting happened as we were reflecting on our time together:

At one point, Tony shifted his body position in the chair and began to look at me in a way that I can only describe as seductive. When I asked what was going on in that moment, he stated “I always kinda’ hoped that we coulda’ done stuff.” When I asked him what he meant by “stuff,” he became coy and said, “Oh come on, Adam, you’re not my type—no offense, but you know I think you’re cute.”

Tony’s history of thinking errors and the look he was giving me in that moment suggested that he likely believed there to be a strong possibility that I might consider taking him up on what seemed to be an offer to become sexual in that moment. Despite what must have felt like very high stakes in that moment from Tony’s vantage point, he was remarkably at ease; it was as if we were two adults in a bar somewhere and not a teenager sitting across from his therapist in an office building full of people.

I gently stated to him that he and I would never, under any circumstances, have sex, “not today, not ever. It’s perfectly okay for you to wish it could happen, or wonder what it might be like, but it’s something that can never happen. Do you understand?”

He didn’t seem the least bit phased by this. After approximately ten seconds of silence in which he continued to stare into my eyes and smile expectantly, I asked him what he had expected my reaction would be to his solicitation.

He smiled, held my gaze, and stated, “You wanna show me?”

Returning the gaze, unsmiling, I stated, “I am showing you, Tony.”

With that, he shifted out of his seductive stance as quickly as he’d gotten into it. Immediately, he was all at once the sweet and vulnerable teenager that all of his teachers and other adults who knew him loved so much and could not believe would actually hurt a child.

“Well, I just wanted to see what you’d do. It’s not like I really wanted to [have sex with] you. I mean, I probably would have if you wanted to, but, like I said, you’re old—and I like ’em young!” He laughed and looked away, “Reeeal young!”

**SALIENT RISK FACTORS FOR ONGOING SEXUAL ABUSE FOR TONY:** Atypical sexual interest (burgeoning pedophilia), belief that children can give consent for sex, multiple victims, exclusively male victims, psychopathic traits (devoid of empathy, grandiose, extremely charming, etc.), hypersexual, low social maturity.

**HIGH RISK TO REOFFEND:** APPROPRIATE FOR ONGOING, INTENSIVE SEX-OFFENDER TREATMENT

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**WALTER**

Walter, 14 y/o, African-American, is an underweight young man with mediocre-to-poor grooming habits. On intake, his dreadlocks were long, unkempt, and covered his face. He was referred to specialized foster care after being removed from his mother’s care voluntarily, subsequent to an accusation by a 4 y/o girl who Walter’s mother babysat in their home. According to the report, Walter’s mother saw them coming out of the bathroom together after she had gone outside for a cigarette. Walter insisted then, as he did for the first ten months of treatment, that the girl came into the bathroom when he was sitting on the toilet, “I forgot she was here, so I didn’t lock it when I went in.” Walter’s mother didn’t believe him though. A week later, she asked the girl to tell her “what really happened.” At that time, the girl stated, “Walter touched me down there,” prompting mom to call DCF.

Walter grew up in Springfield, MA, and is missing the index finger on his right hand. It was shot-off when he was 7 y/o by a neighborhood friend who came over to Walter’s apartment one day with a gun he’d found on the walk over. Walter stated that he asked his friend if it was loaded and the friend pulled the trigger to find out, which blew the finger clear off. “Yo, we couldn’t even find my finger. That was crazy! I was like, ‘Is it loaded?’ and he tried to squeeze the trigger, but it was mad hard for him so, (pantomimicing a struggle with a trigger), my boy had to squeeze with two hands, yo, and then it was like, BOOM!”

Walter liked to say ‘BOOM’ and did so, often, and at unpredictable times. While doing so, he would make a shooting gesture with his left hand, aimed at the space on his right hand where his finger was missing. When around peer-aged youth, he typically made sure that the story of how he lost his finger worked its way into whatever dialog was happening. At one point in treatment, he began to refer to himself in the third person simply as ‘Boom,’ and asked his peers to do so as well. Observations of him in milieu with peers showed that he tried too hard to fit-in and was awkward. Others were tolerant of him, but barely so.
Early treatment with Walter was characterized by his highly defensive stance whenever the subject of his alleged sexual assault (or other problematic behaviors from his life) was brought up by me. More than one session contained long stalemates, when the only way to not have Walter argue with me was for me to not speak at all. Walter wouldn’t speak either. He said, “So you wanna play the quiet guy now? That’s cool; I can be quiet too.”

Walter’s earliest memories are of his mom hiding drugs in his pull-ups when the police raided their apartment, where she based her drug-selling and prostitution business. His stories revealed that he had very little concept of age or timelines (e.g., he stated remembering an event occurring when he was one year old [a time he would not be able to now recall], when he was more likely 4 y/o or 5 y/o).

Walter doesn’t remember his first exposure to sex, but his early memories of his mother are populated by images of watching her have sex with various men. “At first, I didn’t know what I was seeing. She was like, mad loud though, so I thought that guys were beating on her. (Reflecting, he laughs.) I remember this one time, I must have been, like two? This dude kept slamming my mother with his body in the living room, so I ran up to him with my mother’s boot and I was screaming and crying, telling him to leave my mom alone. (He laughs.) My mom got all mad at me and said, ‘Sit your ass down, Walter.’ Then, she must have seen me all confused or whatever, because then she was like, ‘Watch and learn, baby, watch and learn.’ (Walter thinks for a few seconds, now no longer laughing.) That was confusing, because I was like, when she talked, I knew she was okay, but then she was all loud again and I didn’t know what was going on.”

Walter has no significant history of violence, although he describes a life which included frequent acts of delinquency, which is unsurprising, given his antisocial role modeling, a lack of supervision, and antisocial peers. He stopped attending school after the 3rd grade. When he was 10 y/o, he watched as his teenage sister was gang-raped at gunpoint in their apartment by three men who were using drugs with Walter’s mother at the time. The police came, prompting a call to DCF, which removed Walter from the home, almost two full years after his last day attending school. Upon entering the foster care system, he continued to run away and go home to his mother, until finally DCF stopped taking him back. By the time he was 12 y/o, his mother was clean and sober and gainfully employed.

As Walter’s mother became well, her expectations for Walter increased. Walter was no longer free to roam the streets with his friends. Walter’s rebellion took the form of spending all of his time in his room. He neglected his hygiene. At first he spent hours upon hours in his room playing video games. After discovering pornography online, he would watch countless hours while masturbating 10-15 times daily, sometimes damaging the tissue of his penis.

“I watched mostly guy/girl stuff, but the more I watched, the weirder it got.” Walter denied having ever seen child pornography. “By weirder, I mean like girls with dogs and stuff. None of that kiddie-porn stuff. I mean, animals with girls was gross, but I’d watch anyway. Sometimes, I kinda’ hoped that my mom would come in, just to see what she’d do. She never did though.”

(It is not uncommon among individuals who watch excessive amounts of pornography to become desensitized to “regular sex” and watch more extreme images. For some adult males, this is believed to be one of the pathways to viewing child pornography.)

Walter’s oppositional presentation responded well to paradoxical interviewing (Kaplan, 2008). By agreeing enthusiastically with everything that Walter said, even the most outrageous things, I limited his ability to argue, which had the secondary effect of Walter becoming more thoughtful about what he said. After three sessions of straight P.I., Walter began to gradually become more conversational and less argumentative, at which point I stopped using P.I. and returned to a more ecletic style of engaging him.

In the meantime, Walter was in a foster home with very rigid boundaries. Although this was frustrating to Walter and he complained constantly, it was also clear that he took comfort in the rituals and consistency—something he was not accustomed to in his home of origin. Also, I made a referral for a therapeutic mentor who began taking him places twice weekly (a wonderful new state-funded service, similar to Big-Brothers/Big-Sisters, although clinically supervised and with a mental health treatment plan). Eventually, his hygiene improved; he cut his unkempt dreadlocks and began a bi-weekly barber shop ritual, which he really enjoyed. “The old dudes who hang out in there all day are cool.” He also tried out for the track team at school and started to keep himself clean without prompting. He even stopped calling himself ‘Boom’ and went back to ‘Walter.’

Treatment focused on Walter’s long term goals and on examining how the issues from his past might be creating obstacles to achieving his goals. Walter continued to struggle socially, although he was making a few pro-social friends and reported that a particular girl in his math class has her eye on him, “She’s giving me the eye; I want to go up to her and be all, ‘Whazzup?,’ but, I’m scared!”

Approximately 11 months into treatment, without any specific prompting by me, Walter came in and said:

“Okay I’m ready to tell you what I did to Latasha.”

“Who?”

“Latasha, the girl my mother babysits—or babysat for, whatever.”

“You told me that you didn’t do anything, that she was lying.”

“I was lying to you, dude, because I wasn’t ready to tell you! But now I am.”

Walter started by talking about how angry he was at his mother back then:

“All of a sudden, she’s like all holier-than-thou, saying ‘You need to do this, you need to do that. I was like, ‘Did you forget that I used to watch you smoke crack and [have sex with] dudes while I was eating cereal? Do you
David, 17 y/o, is a handsome, athletic Latino, with a deficit in language-processing. David was referred for treatment by his probation officer after his mother filed a CHINS, because she felt fearful that David’s violent outbursts in the home were increasing such that he would hurt her or his siblings: a 14 y/o female and a 12 y/o male. During the CHINS evaluation, probation determined that David needed “sex offender treatment,” because, one year earlier, he got in a fight with an 11 year old boy in the neighborhood, pulled the boy’s pants and underwear off, squeezed the boy’s genitals, and took the boy’s garments home, leaving the boy to make his way home through the neighborhood, naked from the waist down.

In exploring David’s past, I discovered that his mother previously placed him in residential care, out-of-state for four years, beginning when David was 10 y/o, immediately following the sudden death of his father. She stated that she was not able to care for David, who was frequently running away from home, beating-up other kids in the neighborhood, breaking into neighbors’ homes and stealing from them, and not listening to her, whatsoever. While in residential care, David had fewer behavior problems and was discharged home in stable condition. In his file, it was reported that he participated in reciprocal oral sex with a boy his age while there. When I asked about this, David became very angry and said, “I’m not [gay]. That’s in the past. I like girls!”

Likely due in large part to the language processing deficit, David said very little in treatment and made even less eye contact. Sessions were largely spent playing cards, with David saying very little. Although it was not clear to me what effect the treatment was having on David, his mother assured me that she noticed the difference, as he was calmer following sessions. He continued to struggle with some antisocial behaviors and spend time with antisocial peers. He also continued to bully his younger siblings and the smaller children in the neighborhood, who were afraid of him, according to both David and his mother. At one point during the treatment, he and some friends broke into an abandoned factory and set it on fire, although no one was hurt.
Approximately fourteen months into treatment, David disclosed an atypical fixation on sex and pornography. He said that he was masturbating multiple times daily and watching pornography on the family home computer for hours at a time, which was a laptop that he would bring into the bathroom and lock himself in. The reason he wanted to tell me, he said, was because, the day before our session, he literally beat his sister’s bedroom door down upon realizing that she and a friend were in her room on the laptop. Upon barging through the door, “I looked and saw in my sister’s eyes how scared I made her, and it scared me.” David agreed that he needed to make a change, although he stated that he wasn’t so sure that he could.

At approximately the same time, he also revealed a crush that he had on a female teacher at his school. Although he stated he understood that a more intimate relationship with this teacher was not an option, he also expressed a fair amount of distress due to the distracting impact of his attraction for her. (Situations like these are not unusual for adolescents, as negotiating the new experience of unexpected and powerful sexual urges into one’s system can be quite disorienting.)

Sadly, David surprised us all one day when, while working in close proximity at his desk with the teacher, he leaned over and whispered in her ear, “I want to rape you.”

Aside from causing an understandable amount of distress to the teacher (who was 7 inches shorter and 50 lbs lighter than David), this comment, which was overheard by other students, resulted in a lengthy suspension and ostracized David from his peers upon his return from school.

Life continued to get more difficult for David. Approximately one week after his return to school, he beat-up and stole the bike of a 12 y/o boy who David though was laughing at him.

The case terminated following this incident, as his probation officer received one too many bad reports and put him in lock-up.

RISK FACTORS FOR ONGOING VIOLENT & MULTIVARIATE CRIMINAL BEHAVIOR FOR DAVID: Antisocial peers; violent; bullies; ongoing rule-breaking and violation of others despite sanctions (conduct disorder).

AREA OF CONCERN: Hypersexuality; fire-setting; self-injury (to his penis).

HIGH RISK FOR ONGOING VIOLENT BEHAVIOR: MODERATE/HIGH RISK FOR SEXUAL ASSAULT: NOT APPROPRIATE FOR SEX-OFFENDER SPECIFIC THERAPY AT THIS TIME

Summary

Clinical social workers who assess and treat juvenile males who have committed sexual abuse face a true dilemma, as they are forced to strike a balance in protecting their communities from juveniles who pose legitimate threats while also providing treatment to those whose post-offense needs are best met with careful integration back into their communities. Each of the above cases described fairly unique typologies of youthful sexual abusers, yet all three were referred for “sex-offender treatment,” by state agencies which largely base treatment contracts by determining the cost of providing bulk service to an incredibly heterogeneous group with far-reaching treatment needs. Despite the fact that the majority of youth who commit sexual offenses and go on to commit future crimes disproportionately do so with crimes that are nonviolent in nature (Burton & Meezan, 2004; Caldwell, 2007; Nisbet, Wilson, & Smallbone, 2004), there are those who present with factors (e.g. Tony’s hypersexuality, attraction to children, low social maturity, etc.) which, in absence of appropriate treatment, will increase the likelihood of continuing to turn to children to get intimacy needs met in adulthood (Miner, Robinson, Knight, Berg, Romine & Netland, 2010), or continue to commit multivariate acts of violence and criminal behavior (like David).

What’s the problem with traditional sex-offender treatment?

The traditional Relapse Prevention Plan (RP) and the Good Lives Model continue to be valuable tools in the treatment of sexual abusers (Hanson et al, 2002; Ward & Gannon, 2006; Ward, & Marshall, 2004). However, these tools have their limitations, particularly as they apply to youth treatment, as youth were not the population that these tools were designed for. Relapse Prevention, in particular, is problematic for youth in treatment, as it focuses heavily on how to stop negative behaviors (more punitive), instead of promoting positive behaviors (empowering). Nevertheless, because it was deemed the best tool at the time whenever treatment recommendations were last written for statewide dissemination, Relapse Prevention continues to be the gold standard treatment asked about in most meetings with collateral providers. In quarterly meetings with state agency officials, the question often asked of youth not making progress is ‘Where are you in your RP plan?’ As if, somehow, the client’s answer to this will shed light on his lack of progress and reveal a solution.

Some clients can learn and regurgitate Relapse Prevention concepts better than others. This seems to have more to do with IQ and/or rote memorization skill than insight or overall functioning. Indeed, there are some youth who can describe their RP plan better than most clinicians, yet continue antisocial behaviors. Others (e.g. Walter) cannot read or write enough to create a RP plan, but have learned valuable tools to keep themselves from spiraling out of control.

It is not the DCF worker or Probation Officer’s fault that Relapse Prevention becomes a default question. It is what their supervisors will be asking them when they get back to the office with a negative progress report. If something is broken, it is natural.
to want to fix it as efficiently as possible. Unfortunately, in the case of youth with violent and sexually abusive behaviors, there is no single, efficient plan to change behaviors for all youth.

So what now?

When we have good treatment for those who commit violent and sexual assaults, we have fewer victims. As care providers, we understand that the individuals who are ultimately helped the most are the ones we will never meet, because even they won’t know who they are: the boys, girls, women and men who will not be sexually abused or violently assaulted because of the treatment that we provided to an individual who might have otherwise gone on to hurt them. Unfortunately, sensationalist depictions of violence often incite well-intended policymakers to design increasingly punitive measures, which not only create a false sense of security, but also engender an intellectual vacuum for the mounting empirical data that reveals these measures as ineffective at best and, in many cases, indicative of increased risk for recidivism among youth (Ashkar & Kenny, 2008; Craun & Kernsmith, 2006; Letourneau & Miner, 2005).

Massachusetts is lucky to have two excellent professional organizations whose members are committed to conducting highly sophisticated research on how to best treat these individuals and then communicate this research to treatment providers and legislators: The Association for the Treatment of Sexual Abusers, MA Chapter (MATSA) and The Massachusetts Adolescent Sex Offender Coalition (MASOC). Together, they hold one of the largest conferences in the country each spring dedicated to the dissemination of information and training related to the effective treatment of youth and adults who have sexually abused. For anyone who is interested in learning more about how to serve this population, I highly recommend starting by attending this conference.

About the Author

Adam Brown, LICSW, is a licensed clinical social worker in the State of Illinois. His clinical work and research focuses on sexually abusive and delinquent behavior in youth and young adults, and particularly as these relate to issues of attachment, state involvement, and mental health. He is currently a doctoral student at The University of Chicago, School of Social Service Administration.

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References


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**Resources**

- **Massachusetts Association for the Treatment of Sexual Abusers (MATSA)**
  
  A non-profit state chapter of the national parent organization, the Association for the Treatment of Sexual Abusers (ATSA), it is an international, multi-disciplinary organization dedicated to preventing sexual abuse through research, education, and shared learning.  
  www.MATSA.ORG

- **Massachusetts Adolescent Sex Offender Coalition (MASOC)**
  
  MASOC is a coalition of professionals committed to stopping sexual abuse through early and specialized intervention, assessment, treatment and management in the lives of sexually abusive children and youth. 
  www.MASOC.NET

- **NEARI Press**
  
  For over 20 years, NEARI has been providing nationally recognized “cutting edge” work with seriously emotionally disturbed children and youth as well as providing “state of the art” resources about sexual abuse prevention.  
  www.NEARIPRESS.ORG

- **Center for Sex Offender Management (CSOM)**
  
  A national clearinghouse and technical assistance center that supports state and local jurisdictions in the effective management of juveniles and adults who have sexually abused others.  
  www.CSOM.ORG/INDEX.HTML

- **Stop It Now!**
  
  An organization which seeks to change the social climate and foster the prevention of child abuse using a combination of research-based public education materials and social marketing campaigns.  
  www.STOPITNOW.ORG

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**Victim Resources**

- **National Sexual Assault Hotline**
  
  The National Sexual Assault Hotline provides live, secure, confidential and anonymous crisis support for victims of sexual assault, their friends, and families free of charge, 24 hours per day, and 7 days per week: 1-800-656-HOPE (4673)  
  www.RAINN.ORG/GET-HELP/NATIONAL-SEXUAL-ASSAULT-ONLINE-HOTLINE

- **Jane Doe Inc., The Massachusetts Coalition Against Sexual Assault and Domestic Violence**
  
  This organization brings together organizations and people committed to ending domestic violence and sexual assault.  
  www.JANEDOE.ORG

- **Child-at-Risk Hotline**
  
  To report abuse or neglect, call the Child-at-Risk Hotline anytime of the day or night at 800-792-5200.

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**Training for specialized modalities featured**

**Motivational Interviewing:**

- **Motivational Training Network of Trainers (MINT)**
  
  HTTP://MOTIVATIONALINTERVIEW.ORG

- **David S. Prescott, LICSW**
  
  www.DAVIDPRESCHOTT.NET

**Paradoxical Interviewing:**

- **Eliot P. Kaplan, PhD, LCSW, CAS**
  
  www.PARADOXPSYCHOLOGY.COM
1. What is the percentage of juvenile males arrested for all violent crimes committed by juveniles?
   a. Approximately 52%
   b. Approximately 63%
   c. Approximately 83%
   d. Approximately 98%

2. According to the United States Surgeon General, which of the following is a risk factor associated with committing violent crime for youth?
   a. Not having sisters
   b. Being born male
   c. Being born African American
   d. All of the above

3. Which of the following have been shown to be consistent predictors of violence among male youth, across multiple studies?
   a. Excessive testosterone
   b. Strong masculine identity
   c. Both A and B
   d. Neither A nor B

4. Historically, youth violence has been much more thoroughly studied by researchers than adult violence, because youth are more malleable and therefore easier to help.
   a. True
   b. False

5. Which the following is a true statement regarding youth sexual abusers:
   a. Typically, they start by killing/torturing animals before they become sex offenders.
   b. In absence of immediate intense treatment, most will become child molesters or rapists in adulthood.
   c. Most who commit acts of sexual abuse should remain in treatment for the rest of their lives in one form or another: once a sex-offender, always a sex-offender.
   d. None of the above

6. A youth’s Probation Officer and social worker have a phone conversation in which the social worker reports on the youth’s compliance with treatment. This is an example of which of Bronfenbrenner’s Ecological Systems?
   a. Microsystem
   b. Exosystem
   c. Macrosystem
   d. Mesosystem

7. Violent crime is distinct from other criminal behavior:
   a. When force is the object of the offense (e.g. assault).
   b. When force is the means to an end (e.g. robbery).
   c. Because the victims of crimes have worse mental health outcomes.
   d. Both A & B

8. Studies of adult males show that:
   a. Men characterized by violence tend to commit more varied crimes, both violent & nonviolent.
   b. Men characterized by molesting children tend to specialize in molesting children.
   c. Men who attend their sons’ team athletic practices more than once weekly are more likely to bully their children.
   d. Both A & B

9. Executive functioning plays which of the following important developmental roles:
   a. It augments one’s intelligence quotient (I.Q.).
   b. It contributes to a more sophisticated vocabulary.
   c. It allows individuals to adjust to unexpected circumstances.
   d. None of the above
10. It is problematic for clinicians to closely identify a client with a negative behavior by using common colloquial labels such as “sex offender,” “fire-setter,” or “addict” because:
   a. Pejorative labels often increase the already considerable shame that many clients carry.
   b. Use of these labels has been shown to encourage the behavior in some clients.
   c. N.A.S.W.’s Code of Ethics forbids the commingling of legal descriptions of clients with clinical ones.
   d. All of the above

11. The term **allostatic load** refers to:
   a. Lightweight composite alloy leg and wrist restraints currently used by youth detention center staff in lieu of the more traditional steel.
   b. The atypical hormonal response in psychosocial or physical situations which disrupt homeostasis and contribute to feelings of dysregulation.
   c. The potentially explosive charge that is sometimes (though very rarely) created when a youth becomes violent in metal-shop.
   d. Literally, “allow (an increase in) static load:” a common esoteric expression used by probation and court officials which means that permission has been granted by a judge to a registered sex offender to take on more everyday responsibilities (e.g. see his children, take a full-time job, etc.).

12. For youth who have committed acts of sexual aggression, evidenced-based treatment targeting the needs of an individual shows far better outcomes in youth (and, as a result, fewer victims) than does standard, “sex offender treatment,” and/or punishment, which is sometimes effective, sometimes ineffective, and sometimes leads to worse outcomes in youth.
   a. True
   b. False

13. In the last 30 years, feminist authors have:
   a. Made great gains in understanding the relationship between traditional feminine identity and a culture of victimhood.
   b. Explained how hormones contribute to violent traits in both males and females.
   c. Largely ignored issues relevant to males.
   d. All of the above

14. Seventy to ninety-five percent of children living in inner cities in the United States have witnessed:
   a. The entire Twilight series.
   b. An increase in tobacco use among their peers.
   c. A violent assault.
   d. None of the above

15. When a youth has been accused of or discloses the commission of a past sexual assault, it is important to ask the nature of the offense and the number of offenses because:
   a. You’ll need this information if you have to testify in a trial later.
   b. Complete disclosure of all details is the best way to help the client feel unburdened by what he’s done and to move-on in treatment.
   c. Not all sex offenses are the same; the nature of the sexual abuse can have significant clinical implications.
   d. Both A & B

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Please indicate whether this course’s learning objectives have been achieved by circling the most appropriate number below.
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1. I can identify variables often considered in the etiologies of juvenile sexual violence and general delinquency.
   Achieved in full 5 4 3 2 1 Not Achieved

2. I have gained a better understanding of the heterogeneity among youth who sexually abuse.
   Achieved in full 5 4 3 2 1 Not Achieved

3. I can identify some responsibilities of a social worker in working with sexually violent male youth.
   Achieved in full 5 4 3 2 1 Not Achieved

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