WHO ARE WE WORKING WITH, HOW DO THEY GET TO US, AND WHO ELSE IN INVOVLED?

- **WHO:**
- ADOLESCENT MALES 13-18
- ADOLESCENT FEMALES 13-18

HOW DO THEY GET REFERRED?

- CPS WORKERS – SAY (Sexually Aggressive Youth).
- LAWYERS – SSODA (Special Sex Offender Disposition Alternative).
- PAROLE– JR (Juvenile Rehabilitation).
- PROBATION OFFICERS – County referred for "SSODA Like" Post Adjudication
- Parents

WHO ELSE IS INVOVLED?

- PARENTS.
- ADOPTIVE PARENTS.
- FOSTER PARENTS.
- RELATIVES / CAREGIVERS .
- ADJUNCT THERAPISTS.
- VICTIM THERAPIST / ADVOCATES.
- VICTIMS.
- FRIENDS / COMMUNITTY SUPPORT.
- ROMANTIC PARTNERS.
- PAROLE / PROBATION OFFICERS.
- SOCIAL WORKERS.
- COURT OF CONVICTION.
- SCHOOLS (Principals, Counselors, coaches).

WHAT ARE WE ADDRESSING IN SEX OFFENSE SPECIFIC TREATMENT?

- WHAT ACTUALLY HAPPENED DURING THE OFFENSE (victim's and perpetrators versions), AND RECONCILING THE DISCREPENCIES BETWEEN THE TWO ACCOUNTS (WHEN APPLICABLE and if possible).
- HISTORY OF PROBLEMATIC SEXUAL BEAHVIORS.
- MOTIVATIONS / ATTITUDES that lead to MALADAPTIVE SEXUAL BEHAVIORS.
- VULNERABILITIES AND TRIGGERS ASSOCIATED WITH THE CHOICE TO SEXUALLY ABUSE.
- PREVENTATIVE MEASURES AND ADAPTIVE COPING / AVOIDANCE / REPLACEMENT SKILLS.
- PRO-SOCIAL / ADAPTIVE SKILLS AND INTERESTS.

WHAT TOOLS DO WE USE TO DETERIMINE WHAT IS AND ISN'T RELEVANT

- **BACKGROUND INFORMATION IEP's; police reports; criminal history…..) Collateral Contacts… Mental health and/or CD assessments**

- **ASSESSMENT TOOLS:**
- ERASOR (Estimated Risk of Adolescent Offense Recidivism) **Replaced by the Professor.**
- **PROFESSOR: Protective + Risk Observations For Eliminating Sexual Offense Recidivism (PROFESOR) is a structured checklist to assist in identifying protective and risk factors for adolescents and young adults (ages 12 to 25) who have offended sexually. The PROFESOR is intended to assist with planning interventions that can help individual enhance their capacity for sexual and relationship health and, thus, eliminate sexual recidivism. The PROFESOR is not intended to predict risk. There is currently no empirical support to suggest that the PROFESOR could inform predictions of future sexual offending. The PROFESOR contains 20 bipolar factors (i.e., both protective and risk characteristics) that were chosen based on a review of the available literature and on clinical experience with adolescents and young adults who have offended sexually.**

WHAT TOOLS DO WE USE TO DETERIMINE WHAT IS AND ISN’T RELEVANT 2

- Bumby Rape and Molest Cognitive Distortions Scale.
- Abel, Becker & Kaplan Adolescent Cognitions Scale.
- Are You Ready for Sex? Test.
- Worling Arousal Self Assessment.
- Depression Inventory.
- Anxiety Inventory Trauma Checklist.
- Trauma Check list (youth and child).
- PSYCHOLOGICAL TESTING:
  - MACI, MMPI-A
- OTHERS…….

BASIC "CORE" TREATEMENT AGENDA.

- Weekly Diary Card.
- Cognitive Distortions and Challenge Statements.
- Identifying Behaviors of Consent.
- Healthy Sexual Fantasy.
- WA State SO Laws and complete scenarios handout.
- Preconditions to Offense Assignment.
- BCA (Behavioral Chain Analysis) to offense(s).
- Dynamic Risks and Interventions.
- Victim Awareness / 20 questions and answers.
- Victim Clarification.
- Relapse Prevention & Wellness Plan.
- Relationship Continuum Assignment (describing your appropriate sexual partner [internal and external characteristics], timeline of events, relationship characteristics, and deal breakers.

DBT Skills Training

Basic DBT Skills Training: Core Mindfulness; Interpersonal Effectiveness; Distress Tolerance; Emotion Regulation.

DBT Skill training isn't the only way to teach these skills, but it is a package of skills that covers many of the risk factors in kids associated with not only sexual acting out, but general criminal acting out.

This is important because the sexual re-offense rates for these kids is low, but general non-sexual recidivism rates are significant

THERAPUTIC APPROACHES: GETTING THE BUY IN AND MEETING THE CLIENT WHERE THEY ARE AT.

- THERAPUTIC RAPPORT: Building the relationship by finding a “common ground” interest. At best, making some of the clinical work fun, and or at least interesting / tolerable.
- BE OBJECTIVE: Being Careful not to project our own judgements / assumptions / beliefs etc. on the juvenile client. Ex: “dismissive unempathetic teen” vs. shame based avoidance depressed teen. “ TRY NOT TO PATHOLOGIZE!
- FOCUS ON WHAT WORKS WITH THE CLIENT: Example: Self Preservation vs. Empathy.
- Harm Reduction strategies:
- Skills Transference:
- Positive Reframe:
- Identify Adaptive traits while decreasing maladaptive behaviors….

RESOURCES THAT I THINK ARE USEFUL FOR BEING AN EFFECTIVE TREATMENT PROVIDER.

- Good Supervision and Training.
- Colleague's. Consult groups, second opinions etc.
- Humility.
- DBT Skills Training TRAINING (and workbooks).
- Pathways.
- Roadmaps.
- Motivational Interviewing.
- Good Lives Model.
- Spare Me The Talk: A guys / Girls guide to Sex, Relationships, and Growing Up.

Some things that are important to keep in mind…

- The recidivism rate for youth caught for sexual acting out is very LOW for future sexual acting out. However, at least one study points to kids in "the system" appearing to have a slightly higher sexual recidivism rate.
- The recidivism rates for non-sexual acting out in the future in this population is MUCH higher. Providers and caregivers need to make treatment and rules focus not just on risk reduction for sexual acting out, but general criminal acting out behavior as well.
- People sometimes are worried that a youth is a "budding psychopath" because of acting out and/or "Conduct Disorder" diagnosis. Brain development continues well into the mid-20s. And the irony is that the part of the brain that is the "gas pedal" develops first, and the "brake pedal" i.e.: the frontal lobe – fully develops last. Before putting serious life-changing labels on kids, make sure it isn't a developmental stage they are going through.
- There is an irony that we call interventions we use with kids "rehabilitative" . This is because it is probably more accurate to call what we are doing "Habilitative". It is a reasonable assumption that many of these youth were never taught many of the skills before entering S.O. treatment. You can't rehabilitate what you never had in the beginning.
- The goal of treatment is in general to help the young person be a more respectful and law-abiding person in all their interactions in their day to day life. There are many pressures and influences that pull kids in the opposite direction. Our goal is to help them become strong and have skills to avoid giving in to temptation..