

# Changing Faces in the Assessment and Treatment of Sexually Abusive Youth

**Phil Rich**

Specialized Consultancy and Training, USA

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## Abstract

*Over the past decade we have seen changes in the assessment and treatment of sexually abusive youth, some of which have been mirrored in our work with adult sexual offenders. In terms of assessment, we've seen movement towards a more comprehensive process that is contextually and developmentally informed, as well as recognizing the difficulties inherent in predicting future sexually troubled behavior, and especially in young people. In addition, we see risk assessment as an opportunity to assess needs and strengths, as well as risk, and its value as a tool for treatment planning and case management. With respect to treatment, we have seen a movement away from simplistic and largely psychoeducational models to practices that are developmentally sensitive, sensitive to issues of attachment and social connection, and more attuned to the relational aspects of therapy, the importance of the therapeutic environment, and underlying elements essential to all forms of effective treatment. Rather than being focused only on cognitive and behavioral aspects of sexually troubled behavior, treatment has become more rehabilitative, focused upon wellness and social competence rather than the reduction of recidivism as the sole goal of treatment.*

*Keywords: Juvenile sexual offenders, assessment, treatment, sexually abusive youth, social competence*

Over the past decade or so, an expanding and evolving literature had created a "new age" in the development and advancement of our thinking and practice, in which we increasingly have come to recognize sexually abusive young people as "whole" people. We've also come to increasingly recognize the need for a multifaceted and multidimensional approach to treatment, because the young people we work with are themselves complex and multifaceted, as well as a developmentally and situationally sensitive approach to risk assessment.

With respect to their developmental standing, we have long recognized that sexually abusive youth are not simply smaller, younger, and less experienced versions of adult sexual offenders, but are very different than adults, not only at the psychological, social, and emotional level, but the neurological level as well. The emotions, attitudes and ideas, cognitive capacities, and behaviors of adolescents at every level, are driven and motivated by very different experiences, forces, and factors than those of adults. Even though both adult and juvenile sexual offenders have engaged in similar behaviors, these behaviors are no longer attributed to the same causes or motivations. We understand, for instance, that a central feature of juvenile experience, including stress and the development of resilience, is "the dynamic background of developmental change" (Pless & Stein, 1996). Indeed, we recognize, perhaps more than ever, that "people don't come preassembled, but are glued together by life" (LeDoux, 2002). And our current thinking is that young people are *still* being glued together by life, not just in their homes and community, but also, and perhaps especially, while in treatment.

The way we think about sexually abusive youth has changed, including the way that we understand the forces that influence and drive adolescent engagement in behavior of all kinds, including sexually abusive behavior. Smallbone (2006), for instance, conjectures that adolescent sexually abusive behavior is related more to poorly developed social skills than sexual deviance, and that adolescents who have poorly developed social attachments are not well equipped socially, with fewer social and personal resources available to them than other adolescents. We see more clearly than ever that the social environment in which the young person was raised and lives is not just an important backdrop to the development of social connection, self-regulation, and moral behavior, but is an *active* ingredient in social development. And increasingly, we understand that this is true, not only in the development of sexually abusive behavior, but also in its treatment. That is, it's not simply what young people bring into treatment, it's also what they *find* in treatment.

With regard to assessment, we understand that risk assessment isn't simply about predicting risk for sexually abusive behavior, but is instead about understanding risk and how to protect against it. Similarly, treatment for young people isn't simply about containment, risk reduction, and protecting the public, but also about change and personal growth. This builds a link and direct connection between assessment and treatment, in which the assessment process doesn't simply point to future risky or harmful behavior but instead lays down the basis for the treatment process, including the goals, the direction, and the content of treatment. In this regard, assessment and treatment become different faces of the same process, in which each informs the other.

We see significant changes, not only with respect to the development and addition of new risk assessment instruments, but also and especially in how we think about and understand juvenile risk assessment and the assessment process, in our use of language and how we think of and refer to sexually abusive youth, and in our understanding of the young people we evaluate for sexual risk. We've seen movement toward a more comprehensive evaluation process that is contextually sensitive and developmentally informed, as well as a recognition of the difficulties inherent in predicting future sexually troubled behavior, and especially in young people. In addition, we see risk assessment as an opportunity to assess needs and strengths, as well as risk, and its value as a tool for treatment planning and case management.

With respect to treatment, we've seen a movement away from workbooks and simplistic and largely psychoeducational models to practices that are far wider in their reach and range, developmentally sensitive, and sensitive to issues of attachment and social connection. We have become far more attuned to the relational aspects of therapy, the nature of the treatment environment, and underlying elements essential to all forms of effective treatment. Rather than being focused only on cognitive and behavioral aspects of sexually troubled behavior, treatment has become more rehabilitative, focused upon wellness and social competence rather than simply the reduction of recidivism as the sole goal of treatment.

Perhaps more than ever, we recognize not just the problem of sexually abusive behavior, but also the nature of the sexually abusive youth as a person-in-development, a moving target very much influenced by his or her social environment, and not just thoughts and behaviors that are somehow intrinsically embedded inside of the young person. We see sexually abusive behavior resulting from an interplay between the youth and his or her environment, and are more than ever aware that sexually abusive behavior does not simply emerge from inside of the youth, but result from the interactive experiences of the youth in his or her social environment. And we understand that the results of these interactions are not fixed for all time but are changeable, and especially as young people themselves are passing through a period of natural developmental change.

Actually, it's not so much our models of assessment and treatment that are changing as much as our approach to assessment and treatment, and our beliefs about what we should be assessing and how we should be providing treatment. This evolution in our thinking most represents the face of change, which in turn, of course, changes the way we conceptualize and practice assessment and treatment. In any model of treatment, it is our view as practitioners that most influences our work in three broad and interacting categories, each of which build upon one another: (1) the way we think about and understand adult and juvenile sexual offenders, (2) our beliefs about what sexually abusive youth need in treatment, and (3) the manner in which we interact with and relate to our clients.

As in mainstream psychotherapy, we have come to see children and adolescents in context, engaging *with*, influenced *by*, and contributing *to* an interacting set of social forces and systems. Here, the attitudes, beliefs, social interactions, and behaviors of our children can only be more fully understood in the context of the ecological environment, in which there is a constant interaction between individuals and other individuals and between individuals and the systems within they live and function. In adopting a developmental and ecological perspective, we can more easily see the "fit" between the sexually troubled behaviors of young people and the social environments in which they were raised and with which they constantly interact.

Another emerging perspective, clearly related to the multifaceted nature of our clients, is our recognition that sexually abusive behavior neither develops in a vacuum nor follows a simple, one-size-fits-all pathway driven by factors common to *every* sexually reactive child or sexually abusive adolescent. We now more clearly understand and describe a multi-factorial pathway to the sexually troubled and abusive behavior of children and adolescents along which different individuals develop differently. Put another way, the root of juvenile sexual offending is multi-determined, involving individual, family, peer, school, and community variables, as well as other individualized variables such as biology, temperament, and socio-economics. In part, this helps us to increasingly recognize sexually abusive youth as a heterogeneous group, and not all the same.

Heterogeneity means understanding that, despite the many developmental commonalities and shared features in the lives of sexually troubled youth, sexually abusive behavior is a complex phenomenon that develops under conditions and through circumstances that are different for each client. This is precisely one of the difficulties we face in both assessment and treatment, although, paraphrasing Jerome Kagan (2006), we lust for simple and rigorous laws that explain the behavior of all people.

Instead, we've learned that even though the pathway for many sexually abusive youth often starts at a common point, we cannot predict the eventual outcome of the pathway because the pathway is influenced by many subtle factors, many of which we're unaware or cannot predict. There are no pre-determined pathways that inevitably set into motion any particular behavior, including sexually abusive behavior, and there is certainly no single pathway, or set of factors or events, that leads to the same behavioral outcome for every individual first stepping along a similar path. However, along this developmental path lies the acquisition of or the failure to acquire critical social skills and social competencies. These are the skills children and adolescents must develop in order to engage, compete, and succeed in the social world, and these also become the targets for assessment and treatment. Beyond the basics of treatment that addresses the sexually abusive behavior alone, in a rehabilitative approach to treatment we also recognize as central targets the development of metacognitive skills or reflective self-awareness and awareness of others, the fostering of empathy and awareness and concern for others, the deepening of moral reasoning, and the development of self-regulation, a central feature in many general models of criminology (Gottfredson & Hirschi, 1990), as well as developing the capacity for and experience of social connectedness and

meaningful interpersonal relationships.

## The Changing Face of Risk Assessment

With respect to risk assessment, we're seeing important changes and shifts in our thinking and in our practice, and in the way we measure and assess risk. We've come to recognize that it's not enough to accurately predict future behavior, although that is an enormously difficult task, but it's perhaps more important to understand what drives the potential for harmful behavior and what to do about it. Starting with the basics, though, one immediate issue is that in risk assessment ideas about and methods of research and practice are not uniformly agreed upon. There are substantial, long-standing, and on-going differences in models and designs of risk assessment instruments and processes that date back many years, and this is perhaps even more true in adult sexual risk assessment. Nevertheless, for the most part juvenile risk assessment has taken a different turn than adult sexual risk assessment. For one thing, assessments of juveniles take into account the still developing nature of the young person and the application of concepts that place adolescent sexual behavior in the context of the social environment, as well as the context of child and adolescent development.

Assessment for juvenile sexual offenders considers risk in light of developmental considerations regarding the biological, psychological, and social growth and the emergence of adolescence, and takes into consideration many elements that are involved in child and adolescent behavior but not likely to be relevant in the assessment of adults. Juvenile assessment focuses, not only on understanding the adolescent offender and his or her behavior, but also the systems within which young people live and are socialized, and upon which they depend for structure, guidance, and nurturance. Thus, in juvenile risk assessment, factors in the juvenile's social context play a more important role than they do in adult assessment. Peer groups, family dynamics, involvement in prosocial activities, and community factors are all carefully considered, or should be, in juvenile risk assessment.

In addition, most juvenile risk assessment instruments are clinical and dynamic in design, structured and built around risk factors identified in the literature as relevant to juvenile sexual recidivism. But in addition to attempting to estimate future risk, one important change in the face of juvenile assessment is that the risk assessment process is increasingly emphasized as a tool for well-informed case management and treatment planning. This process is dynamic and recognizes the potential for, and even the likelihood of, change, and avoids the potential that risk assessment instruments will simply be "passive predictions of limited practical use" (Boer et al., 1997).

Increasingly, we've shifted our expectations about the "shelf life" of juvenile risk assessment, in which we should consider assessments of risk for juvenile offenders reliable only over a relatively short period of time. Because juvenile risk assessment processes include a focus on development and social context, unlike adult risk assessment instruments the most current and widely used juvenile risk assessment instruments define time limitations, or expiration dates, for the assessment of risk, typically ranging from six months to two years. Here, we recognize that the further out we go the less accurate the estimate of risk, with recent research supporting the idea of relatively short-term horizons for assessments of juvenile sexual risk (Caldwell & Dickinson, 2009, Fanniff & Letourneau, 2012, Worling, Bookalam, & Litteljohn, 2011). This is because we see risk in juveniles as dynamic, changing, and fluid over time, largely because juveniles themselves change over time. Like adult risk assessment instruments, the static elements of risk assessment remain central, based on the historical nature of prior behaviors and experiences. However, the dynamic nature of risk assessment focuses on risk factors that are changeable, and most associated with reduced risk for recidivism. For this reason, for juveniles especially, on-going re-assessments of risk are not

simple repeats of past assessments, but are instead aimed at assessing changes in dynamic risk factors, which in turn are the targets of treatment.

Thus, in risk assessment we must remain aware of and sensitive to the developmental status and changeability of juveniles. For this reason, virtually without exception all designers and students of juvenile risk assessment agree that such evaluation should be comprehensive in design and contextual in application, and not based solely on static factors. That is, adolescent risk should not be assessed or understood based simply on the picture painted by static factors alone. Instead, "there is a consensus in the field that assessment of risk in juvenile offenders should include a comprehensive assessment of an array of individual and contextual factors" (Caldwell & Dickinson, 2009). The use of a risk assessment instrument is but one part of, and embedded within, a larger and more comprehensive process of assessment, the purpose of which is to understand the juvenile being assessed as fully and deeply as possible.

The Assessment for Safe and Appropriate Planning, an assessment protocol used in Massachusetts, for instance, offers a model for assessment that recognizes the limitations of sexual risk assessment when the primary, or perhaps only, purpose of the evaluation is to determine the risk or likelihood that a youth will sexually re-offend at some later point in time. The ASAP model instead recognizes that risk assessment on its own offers little value, and is not to be truly trusted with respect to its capacity to actually predict the future behavior of sexually abusive adolescents with any level of accuracy, and the dangers that inaccurate projections of high risk pose to the healthy and prosocial development of adolescents. The ASAP model instead advocates that we can only meaningfully understand juvenile risk from a situational perspective, understanding juvenile behavior only when placed in the context of each youth's life and environment. The ASAP takes the position that the only way to adequately and meaningfully assess juvenile risk is to take into account the full range of risk and protective factors, and the developmental, situational, and contextual aspects of each young person's life.

Hence, this shift in practice involves recognizing that juvenile risk assessment is not only an assessment of risk, but of needs as well... a construct fitting nicely with the increasingly well known principles of risk, need, and responsivity, a model strongly advocated for use in work with adult and juvenile sexual offenders (Hanson, Bourgon, Helmus, & Hodgson, 2009). This shift in our thinking recognizes that the purpose of juvenile risk assessment is not simply that of estimating risk, exceedingly difficult to do with any consistent level of accuracy, but also and perhaps more importantly to help us understand how to treat risk, and how to buffer adolescents against the effects of risky environments. An important aspect of this shift is our increasing recognition that assessing risk alone provides little in the way of meaningful information, other than a simple statement that a youth may or may not be at a higher or lower level of risk to re-engage. Further, as our research plainly shows, the ability to accurately estimate risk is difficult, inconsistent at best, and in many cases produces contradictory evidence. So far, our efforts to produce risk assessment instruments that accurately predict juvenile risk are weak.

In fact, our instruments seem to have hit the AUC barrier. The area under the curve (AUC) has become the most commonly used measure of predictive validity for risk assessment instruments, for several different reasons, and is actually a relatively simply measure to understand. An AUC value of 1.0, for example, represents 100% predictive validity; an AUC of 0.50 on the other hand represent a 50 percent chance of accuracy, or a chance level. It is rare to see AUC values for any juvenile risk assessment instrument that break the 0.71 barrier, and even that represents only a 71 percent chance of accuracy. For the most part, though, these values tend to fall between 0.63-0.69, ranging from pretty weak to at best mildly predictive. However, a thorough review reveals a research literature that at best is inconsistent and frequently contradictory. It would be an error to

consider any juvenile risk assessment instrument at this time as empirically validated. In fact, just the opposite. In terms of validation, the literature does not offer a great deal of statistical support for any of the risk assessment instruments. It instead largely describes risk assessment instruments failing to show high, consistent, or universal levels of reliability or predictive validity. In general, the bulk of the independent literature suggests that juvenile assessment instruments are far from empirically validated, raising concerns about their capacity to reliably and accurately predict the risk of juvenile sexual recidivism or inform public policy and debate, as well as juvenile court decisions (Caldwell, Ziemke, & Vitacco, 2008; Fanniff & Letourneau, 2012; Knight, Ronis, & Zakireh, 2009; Viljoen, Elkovitch, Scalora, & Ullman, 2009; Vitacco, Viljoen, & Petrila, 2009).

But, as we consider the changing face of juvenile risk assessment, we also ask whether AUC values are the only measure, and whether predictive validity is the only or best goal. Are juvenile risk assessments only about predicting future behavior or do they also serve some other, and perhaps greater, function? After all, we're really less interested in simply predicting what harm someone may do in the future than we are in preventing that harm. In the latter case, prevention rather than prediction alone, our interest lies in having a clear sense about risk in order to treat and rehabilitate the factors that create risk and lead to harmful behavior. Indeed, that use of risk assessment perhaps most clearly reflects a change in our thinking about juvenile risk assessment. For instance, despite weaknesses in the capacity of juvenile risk assessment instruments to accurately predict who is and who is not at risk, Jodi Viljoen and colleagues (Viljoen, Mordell, & Beneteau, 2012) argue that, despite the research focus on prediction, juvenile risk assessment instruments are also intended to help manage risk and plan treatment to prevent re-offense. They argue that increased attention to the utility of tools for these purposes allows us to move beyond simply predicting sexual re-offense and toward the prevention of sexual re-offense. Similarly, Robert Prentky and colleagues (2010) clearly tell us that juvenile risk assessment instruments are not predictive instruments upon which to make long-term decisions, but instead what they tell us may be especially useful for guiding and shaping effective treatment interventions. Bengis, Prescott, and Tabachnick (2012) sum it up well, in advising that the use of risk assessment measures to guide safety, manage risk, and develop treatment plans and interventions may be a better way to proceed than simply making statements about risk.

Thus, the field continues to grow and evolve. Over the past few years we have seen the development and addition of several new risk assessment instruments, with several more in development. This includes the recently introduced MEGA, and the in-development youth versions of the ARMIDILO-S and the Violence Risk Scale: Sexual Offender. These additions not only offer provide additional ways to assess risk, but importantly take into consideration and look more carefully at protective factors as well as risk factors, recognizing that assessing risk also means assessing those factors, circumstances, and relationships that protect against risk. These developments help us to recognize that "risk" for juveniles is not only about risk, but also about protection against risk. This work and focus is not entirely new. The AIM-2, a UK based risk and need assessment, has included an evaluation of protective factors and strengths for many years, and the J-RAT, another risk assessment instrument, has included a protective factors scale for several years. However, we now see an increasing focus on recognizing the importance and the power of assessing protective factors as we attempt to build better and more well-informed juvenile sexual risk assessment instruments. Jim Worling, the primary author of the ERASOR, one of the most commonly used and well known juvenile risk assessments, has developed a protective factors scale - the DASH-13 (Desistence for Adolescents who Sexually Harm), and Jim and Calvin Langton are in the process of collecting data on risk and protective factors for statistical analysis. Recognizing that understanding risk also means understanding protection against risk has found its dawn in juvenile sexual risk assessment.

Perhaps one last thing on juvenile risk assessment instruments. Current models and instruments are essentially variants of the same model. The same is true for the newest of our instruments and those in development, although they hold the promise of incorporating new, and perhaps better, research. And, for the most part, these instruments are clinical, essentially shaping human judgment about risk rather than estimating risk statistically. The one exception is the still in-development JSORRAT-II (Juvenile Sexual Offense Recidivism Risk Assessment Tool-II), which is the only actuarial juvenile risk assessment instrument. However, a major difficulty with any actuarial assessment is that it overlooks dynamic risk factors, and is a static instrument that fails to recognize or take into consideration situational, relational, or environmental risks. They necessarily see the individual as a member of a class, rather than as an individual. Despite all we've learned about the developmental fluidity of the adolescent experience, the need to include a focus on protective factors as well as risk, and the short-term nature of risk estimates, actuarial assessments are unable to recognize or respond to change in clients.

However, as we consider the changing face of assessment, we recognize that even this is changing. Increasingly, adult risk assessment schemes are becoming more flexible, with an increasing focus on recognizing that change is possible, assessed, for instance, through instruments like the Stable and Acute 2007.

On the horizon for juvenile risk assessment instruments, through, is perhaps a significantly different type of risk assessment instrument. Funded through the U.S. Dept of Justice, a sizeable grant was recently awarded to the Urban Institute, a Washington-based think tank, to develop a risk assessment process based on computerized machine learning, certainly a very different model when it comes to sexual risk assessment. However, the principal investigators understand the tradeoffs when it comes to statistical and computerized models of assessment versus clinical models, in which gaining greater predictive power may also result in a loss of interpretive power and the capacity of risk assessment to inform treatment. This possible tradeoff brings us back to the emerging face of juvenile risk assessment as an active, and not a passive, process and our need to understand the youth and what drives sexual and other social behavior problems, rather than just estimating risk. This new face sees risk assessment as a means and an opportunity to recognize the presence and influence of risk factors, assess needs, and find ways to treat our clients and build strengths. From this perspective, the comprehensive assessment of risk, and not just passive predictions about risk, serves as the foundation of a needs and strength based treatment.

## **The Changing Face of Treatment**

That's assessment. With respect to treatment, we've seen a broadening and deepening of our treatment horizons, and a movement away from psychoeducational and basic cognitive behavioral models of treatment that are often one-dimensional and simplistic. Instead, treatment has become more informed, incorporating treatment practices that are developmentally sensitive, sensitive to issues of attachment and social connection, and more attuned to the relational aspects of therapy, the importance of the therapeutic environment, and underlying elements essential to all forms of effective treatment. Rather than being focused only on cognitive and behavioral aspects of sexually troubled behavior, treatment has become more rehabilitative, focused upon wellness and social competence rather than the reduction of recidivism as the sole goal of treatment.

Sturmey and McMurran (2011) describe this as a constructive approach in work with offenders, by which they mean bringing the use of effective methods and techniques of behavior change into treatment. Part of this developing face of treatment involves case formulation, which simply put means understanding each and every case on an individual basis, or recognizing the heterogeneity of each client, despite similarities. Medoff and Kinscherff (2006) describe case formulation as an

intrinsic and critical aspect of assessment and treatment, writing that simply knowing a youth has sexually offended doesn't provide much useful information. Instead, as a basis for treatment, we want to understand each youth's developmental pathway and the dynamics and function of his or her sexually abusive behavior. Chris Drake and Tony Ward (2003) tell us that formulation-based approaches to treatment require that we understand the psychological problems and vulnerabilities for each client, rather than utilizing a manualized procedure or cookbook approach to understanding behavior and providing treatment. They argue that overlooking individual case formulations results in weak and poorly targeted treatment that fails to meet individual needs. Here, the focus is on understanding each client, and basing treatment on that understanding rather than a uniform model of treatment applied to all clients. Formulation individualizes treatment, and allows us to know the client. It provides the basis for treatment, and perhaps the therapeutic alliance that forms between client and clinician in all effective forms of therapy.

The changing face of treatment puts treatment into a rehabilitative, rather than a harm reduction and containment, mode. It moves treatment toward personal change and prosocial growth, moving the client toward personal, interpersonal, and social success. This in many ways is the heart of the Good Lives model, as well as the GLM model adapted for sexually abusive adolescents developed by the G-Map program in the UK (Print, 2013). The risk, need, and responsivity model has pointed us toward a more calibrated model of treatment, allowing us to see that not every offender is the same nor requires the same type or intensity of treatment, or responds to treatment in the same way. The Good Lives model, on the other hand, has pointed to interventions that build on and strengthen adaptive and emotionally fulfilling aspects of human behavior. It focuses on strengths and positive traits that allow people to grow and lead more satisfying lives, rather than focusing on deficits, weakness, and the damage done.

Of importance, the changing face of treatment in work with sexually abusive youth, and adult sexual offenders for that matter, incorporates the belief that it's the treatment process rather than treatment method or technique that is most effective, or at least most central. That is, it is the process of treatment, including the treatment relationship and the treatment environment, that drives effective outcomes in treatment rather than the techniques of treatment or the materials we use. In this model, despite using treatment interventions common to all clients, it's the individualized nature of treatment, the strength of the treatment relationship, and the collaborative nature of treatment that moves our clients toward change and desistance. This is a relational model of treatment, and a model that recognizes not only the importance of the therapeutic relationship and the collaborative working alliance, but also that the qualities, characteristics, and behaviors introduced into treatment by the treatment provider have a great deal of effect on the outcomes of treatment (Marshall, 2005). That is, client functioning improves, in part, because of us, and not just the client alone. It is a collaborative effort, in which the clinician is an active and essential part of treatment success, and not merely a disembodied clinician performing standardized procedures (Norcross, 2002). Indeed, McNeill, Batchelor, Burnett, and Knox (2005) write that adult sexual offenders respond well to clinicians who are genuinely interested and concerned, in which key skills for supporting change in sexual offenders include the ability to convey empathy, respect, warmth, and genuineness, and the ability to build treatment relationships based on mutual understanding and agreement.

Models of therapy have expanded as well, in terms of what we provide. In this regard, treatment for young people has moved beyond simply providing often simplistic cognitive behavioral therapies aimed more at instruction and psychoeducation than deep change, and we see more programs providing a far greater range of treatment services, and especially in group care and residential treatment settings. These include individual, group, and family therapies, as well as adjunct, but important, therapies such as expressive therapies, recreational therapies, pet-assisted therapies, and mindfulness-based and stress-reducing treatments, such as yoga and biofeedback. This



wider-ranging set of treatments addresses treatment needs in a more holistic and comprehensive manner, recognizing the "whole" nature of our clients and their range of treatment needs, beyond simply addressing only their sexually abusive behavior. It leads to integrative models of treatment that focus on broad areas of treatment and in multiple treatment domains, and gives rise to models of treatment such as Multisystemic Therapy (MST), which describes itself as an ecological treatment model, as well as the use of "third wave" cognitive behavioral models such as Acceptance and Commitment Therapy, Dialectical Behavioral Therapy, and Schema Therapy.

But, beyond these treatments and what we teach young people through cognitive-behavioral or psychoeducational treatments, we recognize that of great importance is the manner in which we approach and see our clients, and the way in which we help them to think about themselves and others. Although relatively new to our still developing field, few of these ideas are new to the larger field of mental health treatment in which sexual offender specific treatment is embedded. Accordingly, the treatment of sexually abusive youth, and to some degree the treatment of sexually abusive adults, has entered the larger arena of psychosocial and mental health treatment. In this regard, it's moved away from the black-and-white world of behaviorally-oriented and psychoeducational treatment models that formerly permeated the field of adult and juvenile work. Treatment has become a therapy of interaction and engagement, in which the clinician is not just there to teach, test for retention, and build relapse prevention plans, but becomes a conduit for self-realization and change in the client, in which the therapeutic relationship itself becomes a crucible in which growth is fermented and from which change emerges.

We see the introduction of treatment approaches that seek to build alliances, and engage, rather than models that try to direct, coerce, or teach clients into engaging in treatment. In many ways, we can most simply describe this as a shift toward therapeutic engagement. Motivational interviewing, for instance, is increasingly being applied as an approach to treatment, itself a collaborative and person-centered form of treatment used to elicit, guide, and strengthen the client's own motivation for change. Its primary premise is that there is a direct relationship between therapist style and client outcome, and that therapist style and practice can substantially improve or degrade client outcomes. It is characterized, not by technique or treatment curriculum, but by the interpersonal "spirit" or clinical "way of being" in the treatment relationship within which techniques are employed. It's based on three premises that themselves reflect the changing face of treatment for sexually abusive youth: collaboration between the clinician and the client, drawing out the client's own ideas about change, and recognizing and emphasizing the autonomy of the client. It draws upon the client's own thoughts and ideas, rather than imposing opinions, recognizing that motivation and commitment to change is most powerful and durable when it comes from the client (Miller & Rollnick, 2009, 2010; Miller & Rose, 2009).

Finally, we see the spirit of collaboration once again in a model of treatment for both sexually abusive youth and adult sexual offenders that emphasizes the need to understand the client's perspective and gather and take stock of the client's experience in therapy. Here, gathering feedback from clients about therapy and treatment in general, and thus making them part of the process in which they help to shape their own treatment, is yet one more face in a changing approach to treatment, in which treatment recognizes the contributions of not only the therapist and the treatment model, but the client him or herself.

In wrapping up, the changing face of assessment and treatment sees a shift away from passive predictions about risk and harm and away from one-size-fits-all treatments that are based strictly on cognitive behavioral treatment and psychoeducation. We are instead moving toward models that are developmentally sensitive, relationally-based, collaborative, individually driven, and rehabilitative and strength-based in nature, design, and implementation. Of special importance in this emerging

model of treatment is the manner in which we approach, see, and relate to our clients, the partnerships we build with them, and the way in which we help them to think about themselves and others. This shift validates the idea that treatment is about relationships and mutual engagement. Clients we work *with*, and not *on*. These relatively new ideas in sexual offender treatment are welcome. The perspective that we need to build therapeutic alliances with our clients, help instill hope in them, and help them grow, rather than simply confront, challenge, and judge them is welcome, and brings the treatment of juvenile and adult sexual offenders closer to therapeutic principles and processes already found in mainstream psychotherapy.

The changing face of treatment has moved us toward a model in which we recognize that although the sexually abusive behavior is the behavior of concern, the chances are that for most juveniles inappropriate and abusive sexualized behavior is just the tip of the iceberg. In this developing model, behavior of all kinds, including sexually abusive behavior, is seen as one possible outcome of a rich complex of ideas, emotions, social skills, and life history catalyzed by social forces that act upon each individual. This model is increasingly built on a recognition that for many of our clients, adverse developmental experiences have contributed significantly to their development, their behaviors, and their relationships, and our treatment must not only recognize this, but also be sensitive and respond to these experiences in a model we have come to call trauma-informed care. It's a model that moves away from saying "what have you done?" and asking "what's wrong with you?" to instead asking "what has happened to you?" (Bloom & Farragher, 2013), seeing clients as "neither sick nor bad, but as injured," and in turn injuring others. You may know that expression, "hurt people hurt people."

Returning to where we started, the changing face of both assessment and treatment leads to a model of practice that builds basic and important psychoeducational ideas and cognitive-behavioral principles into a larger integrated model. This model recognizes the uniqueness of the developmental pathways that lead to sexually abusive behavior and the individuality of each youth who enters assessment or treatment. The new face of risk assessment sees the process as an opportunity to assess needs as well as risk, and to do so in a manner that is both individualized and sensitive to the developmental and contextual nature of juvenile risk. Similarly, the new face of treatment not only recognizes the wholeness of the client, but also the holistic and multidimensional nature of treatment itself. This new face also recognizes the interactive and collaborative nature of treatment, and the central role played by the clinician in the process. Perhaps above all else, the new face understands juvenile risk as contextual, and effective treatment as a rich and engaged partnership between client and clinician.

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## Author address

**Phil Rich**

*Specialized Consultancy and Training, USA*

[philrich@philrich.net](mailto:philrich@philrich.net)