CHAPTER ONE

CURRENT PERSPECTIVES: WORKING WITH YOUNG PEOPLE WHO SEXUALLY ABUSE

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"Good people do bad things."

Introduction

The treatment of youth with sexual behavior problems has advanced in directions few could have imagined two decades ago. Of primary importance has been the development of a public health perspective in understanding sexual abusers (Freeman-Longo & Blanchard, 1998). Researchers and practitioners alike have come to recognize that the widespread problem of sexual abuse requires global prevention (Longo, 2003; Longo & Blanchard, 2002, Freeman-Longo, 1998; Freeman-Longo & Blanchard, 1998; Klein & Tabachnick, 2002). Specialized organizations such as Darkness to Light and Stop it Now! have worked to increase public awareness, the latter specifically partnering with treatment provider organizations such as the Association for the Treatment of Sexual Abusers (ATSA).

Within the past five years, organizations such as the National Adolescent Perpetrator Network (NAPN) and ATSA have also acknowledged the need to address sexual abuse as a public health problem. However, it was former Surgeon General C. Everett Koop who had the vision to look at all violence, including sexual violence as a public health problem. In 1985, Dr. Koop wrote:

> *Identifying violence as a public health issue is a relatively new idea. Traditionally, when confronted by the circumstances of violence, the health professionals have deferred to the criminal justice system. Over the years we've tacitly and, I believe, mistakenly agreed that violence was the exclusive province of the police, the courts, and the penal system. To be sure, those agents of public safety and justice have served us well. But when we ask them to concentrate more on the prevention of violence and to provide additional services for victims, we may begin to burden the criminal justice system beyond reason. At that point, the professionals of medicine, nursing, and the health-related social services must come forward and recognize violence as their issue, also, one which profoundly affects the public health ... Henry David Thoreau in his book, "Walden," wrote: "It is characteristic of wisdom not to*

do desperate things." I think we have worked with patience and wisdom. And hopefully the time of desperation is over.

In order to grasp the full spectrum of sexual abuse, we must understand that it exists in our own neighborhoods and communities, perhaps even in our own families. We cannot afford to take an "us-against-them" approach toward sexual abusers, especially youthful sexual abusers. It is natural to be horrified by sexual aggression. However, believing ourselves to be superior to abusers can only make our attempts to foster change more problematic. Accepting sexual abuse as a public health issue enables us to distinguish youth from their actions, and provides the support and encouragement necessary for them to confront their harmful behavior. At a societal level, this perspective allows society to go about the work of healing and prevention.

The trickle-down phenomenon

The trickle-down phenomenon is the importation of adult treatment strategies to the juvenile field. At present, this has continued for well over two decades (Developmental Services Group, 2000), and has pervaded our field (Chaffin & Bonner, 1998). The influence of adult models can keep youth in treatment longer than necessary because youthful sexual abusers are often perceived in a one-size-fits-all perspective inherited from "the adult world". Youth are too often considered as a high risk to the community, untreatable, and as "predators". Chaffin and Bonner (1998) note that many adult treatments are controversial and may include involuntary treatments (i.e., phallometry, polygraphy, and arousal reconditioning) for purposes of public safety, rather than for rehabilitative reasons. Further, there is no shortage of evidence that, in North American samples, the base rate of sexual recidivism by youth is considerably lower than among adults (Alexander, 1999; Prescott, in press; Worling & Curwen, 2000).

Unlike their adult counterparts, sexually abusive youth are still developing at the rapid pace that defines adolescence. Yet in a growing number of jurisdictions, many youthful sexual abusers are being waived into adult courts, based in part on the public's growing concerns for personal and family safety (Hunter, Hazelwood, & Slesinger, 2000; Levesque, 1996). Whatever the crime, these young people are still growing physically, cognitively, morally, and emotionally. In our experience, they can often be far more idealistic than their behaviors would suggest.

Younger children's beliefs and values can be altered or distorted through exposure to family violence and abuse. One often hears the phrase "children without a conscience", with respect to sexually abusive and violent youth. However, children leaving this impression often have understandable reasons for behaving as they do (see Schwartz et al., Chapter 18). Although they must become responsible for their behaviors, it is vital to remember adolescents aged 13-18 are still in development, can change rapidly, and can be better served without pejorative labels.

Histories of abuse, neglect, and trauma do not make growing up any easier. Even healthy youth are clarifying their understanding of what it means to be responsible. Society does not give them the full complement of adult responsibilities, and practitioners should not think that we can arbitrarily single out particular behaviors (criminal or otherwise) to selectively treat them as adults. Chaffin and Bonner (1998) write:

"To the extent we can identify those truly at risk and work productively with them, our communities will be safer. But in the process, we should not forget that these are our children. And as professionals committed to children's rights and welfare, we should think carefully about their rights and welfare before responding to their behavior."

Sadly, over the course of the past two decades, our field has been subject to the pendulum effect, swinging back and forth between the rehabilitation and punishment of youth (Leversee & Pearson, 2001). While treatment strategies have become more effective (Hanson, Gordon, Harris, Marques, Murphy, Quinsey, & Seto, 2002), we have also witnessed greater emphasis on punishment in many jurisdictions. Rehabilitation of youthful sexual abusers must take into account their developmental abilities as well as potential developmental lags. Many adolescents with sexual behavior problems also have learning disabilities (see Creeden, Chapter 16). These youth, as well as their families and communities, would all benefit if the legal and mental health systems took such factors into account.

Typologies and risk assessment

Typologies of sexual abusers provide useful information for assessment and treatment planning. Initial typology research suggests two broad categories of youthful sexual abusers, those who rape peers and adults, and those who sexually abuse children (Hunter et al., 2000; Hunter & Longo, 2004; Hunter, this volume). The current state of these typologies is discussed further in Chapter Two.

Further typological research will help to guide the development of risk assessment tools. There are several scales currently in use, including the Juvenile Sex Offender Assessment Protocol (J-SOAP-II; Prentky & Righthand, 2003) the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR; Worling & Curwen, 2000, 2001, 2002), the Juvenile (Clinical) Risk Assessment Tool (J-RAT; Rich, 2003), and the Juvenile Sex Offender Reoffense Risk Assessment Tool (J-SORRAT; Epperson, Ralston, DeWitt, & Fowers, 2005). The Protective Factors Scale (Bremer, 2001) examines the various assets a young person possesses in order to assist in placement decisions. While the current tools all show promise, additional research is necessary for further development and validation (Prescott, in press). There remains no empirically validated means for accurately assessing the risk of a young person to recidivate sexually.

At this time there is no empirically validated typology or risk assessment tool for children (ages twelve and under) who sexually abuse, With the growing number of programs treating children in this age group, this is essential for advancing the field.

As our field grows, ongoing research will continue to help refine typologies, and clarify risk factors for youth. Ryan (in press) states:

"Emerging research has demonstrated that: (1) childhood neglect, physical abuse, and witnessing family violence may precede sexual offending even more often than sexual abuse; (2) many child victims recover without long-term damage or dysfunction, even without treatment; (3) sexually abusive youth are less at risk for sexual offense recidivism than for non-sexual reoffense; and juveniles reoffend less often

than adult sex offenders, especially after treatment; and (4) only a small portion of juveniles who sexually abuse have deviant sexual arousal patterns. Combining offense-specific theories with developmental, contextual, and ecological theories, a new set of hypotheses developed and were described by Ryan and Associates."

Risk assessment and the need for evidenced-based strategies are further addressed by Chaffin (Chapter 28).

Static and dynamic risk factors

Current investigation into risk factors for sexually abusive youth suggests there are two types of risk factors associated with them (Andrews & Bonta, 2003; Rich, 2003; Prescott, in press). Static risk factors are established in an individual's history and are permanent in nature (i.e., previous sex offense convictions, age of onset, numbers of victims, histories of abuse and neglect). Dynamic risk factors are those factors that can be changed over time (e.g., low self-esteem, poor anger management skills, self-reported and/or documented sexual arousal to paraphilias, treatment experience).

Ryan (in press) recommends that practitioners consider three types of risk factors:

1) Static (e.g., permanent disabilities, family of origin, early life experience);
2) Stable (life spanning, but potentially changeable) risk factors (e.g., temperament, intellectual potential, physical attributes, heritable neurological characteristics); and
3) Dynamic risk factors (e.g., situational, cognitive, emotional, and behavioral factors that may change throughout the individual's life).

Some common etiological factors associated with sexually abusive youth include prior sexual aggression, entrenched patterns of deviant sexual arousal, stranger victims, having child victims, a history of child abuse, general delinquency, deficits in self-esteem, deficits in assertiveness, inadequate interpersonal skills, poor life management skills, and lack of family support (Worling, & Curwen, 2000; Worling, & Curwen, 2002; Prentky, Harris, Frizzell, & Righthand, 2002; Caldwell, 2002). However, the factors that contribute to first offense are not necessarily those that signal a propensity for re-offense (Prescott, in press). Ryan (in press) considers other factors when addressing static risk factors:

Defining static factors as those which are retrospective/historical variables, we know that these factors cannot be changed because we cannot change history. Such factors might include: (1) the condition at birth; (2) permanent disabilities; (3) family of origin; and (4) early life experience.

Ryan proposes that an additional type of risk factor, "stable" risk factors, should be considered in assessing youth. She describes stable risk factors as, "risk factors, which may be relevant to the risk of dysfunctional behaviors, may include such things as difficult temperament, low intellect or learning disabilities, negative internal working model, heritable psychiatric disorders, and chronic PTSD reactivity" (Ryan, in press).

The need to clarify our understanding of dynamic risk factors for children and adolescents who sexually abuse is apparent. Some of the risk-assessment scales men-

tioned above include dynamic risk factors, but are not comprehensive. Many are simply "laundry lists" of risk factors, and do not address the interactive effects of static and dynamic risk factors.

Some of the dynamic risk factors for adolescents with sexual behavior problems that are now being recognized include attitudes toward offending, negative peer influence, emotional self-regulation, general self-regulation, intimacy deficits, resistance to treatment, anger management, deficits in self-esteem, deficits in self-confidence, deficits in independence, deficits in assertiveness, deficits in self-satisfaction, deficits in competency skills, inadequate interpersonal skills, inadequate social skills/social competence, and poor life management skills.

Ryan (in press) notes:

> *Risk assessment and treatment models based solely on unchangeable risk factors in the past are likely to over-estimate risk, as well as miss important opportunities in treatment to change what is changeable. By balancing offense specific interventions with preventive interventions to increase healthy functioning, outcomes may improve, and iatrogenic risks may be reduced.*

Many of these risk factors have their origins in child maltreatment and neglect. These have a demonstrated role in the etiology of aggressive conduct problems (Ryan & Associates, 1999). Further, the impact on the brain of abuse and neglect is established (Creeden, Chapter 16). Childhood maltreatment is a crucial treatment need. It can contribute to biologically based vulnerabilities (such as impulsivity and hypervigilance) as well as the thoughts, beliefs, and attitudes that contribute to re-offense.

Unfortunately, some of the impact on the brain is not reversible. However, children are resilient (Gilgun, Chapter 15), and we can promote health and recovery by addressing dynamic risk factors.

Finally, there are risk factors previously thought to be associated with sexual recidivism among youth whose roles are questionable or not supported by research. These include denial, empathy deficits, and victim penetration (Worling & Curwen, 2002). Although each of these is worthy of a volume itself, they serve as a reminder that what may appear important is not always supported empirically. There are several possible reasons why these elements have not been found to contribute to sexual recidivism. The first is that denial and empathy deficits are so common among sexually abusive youth as to provide no discrimination between high and low risk. It is also possible that by looking at denial and empathy deficits, practitioners are distracted from understanding their contribution to risk. Although they might stand as proxies for genuine risk factors under some circumstances, they are not necessarily markers in themselves. For example, denial might in one situation mean only that the practitioner has not provided a supportive environment where the youth can disclose. In other circumstances, denial might signal the very attitudes that contribute to re-offense. On its own, victim penetration has been found to be more indicative of future violence (Langstrom & Grann, 2000).

Other research cautions us that the sexual arousal patterns of youth are "fluid" and

dynamic, and may be less of a concern in youth than in their adult counterparts (Hunter & Becker, 1994). Many of us practicing in this field twenty years ago discovered that much of what we believed turned out not to be true.

Female sexually abusive youth

Our field has only just begun to focus on special populations. The development of strategies for treating young females (Robinson, Chapter 11; Frey, Chapter 10) is particularly important. While strategies inherited from adult programs may inform work with young people and vice versa, they are not necessarily appropriate for female children and adolescents with sexual behavior problems (Robinson, 2002; Guambana, 2001). The treatment needs of males differ from those of girls in several areas. Boys and girls develop and experience life differently, and cognitive and emotional differences exist between them (Robinson, 2002). The growth of programs for young women has been sporadic, and Guambana (2001) notes a lack of gender-specific programs for adolescent females.

Statistically, the majority of adolescent sex offenders are male. However, research during the past ten years has shown that female adolescents also engage in harmful sexual behaviors. Studies of hospital, child welfare agency, and treatment programs have found that females comprise between 3% - 10% of the sex offender population (Bear, 1993). Importantly, however, Risin & Koss (1987) note that general population and victimization surveys report significantly higher numbers and extend the range up to 50% and some report higher figures depending on the victim sample population studied (Johnson & Shrier, 1987).

Sexual abuse by female adolescents is often hard to detect because few people question the close interactions of females with children. Frequently, sexual abuse by female adolescents occurs when they are babysitting. Their victims are predominantly acquaintances and young children. Adolescent females, like males, also offend against partners in same sex relationships (Bear, 1993; Davin, Hislop, & Dunbar, 1999).

Developmentally delayed sexual abusers

Developmentally delayed clients (also referred to as lower functioning, MR/DD, intellectually disabled) are another population requiring specialized attention and the development of resources (O'Callaghan, Chapter 12). Often, this type of patient is most difficult to serve. Community-based programs are often reluctant to take these clients, and not all foster homes or group care situations have adequate training for their needs.

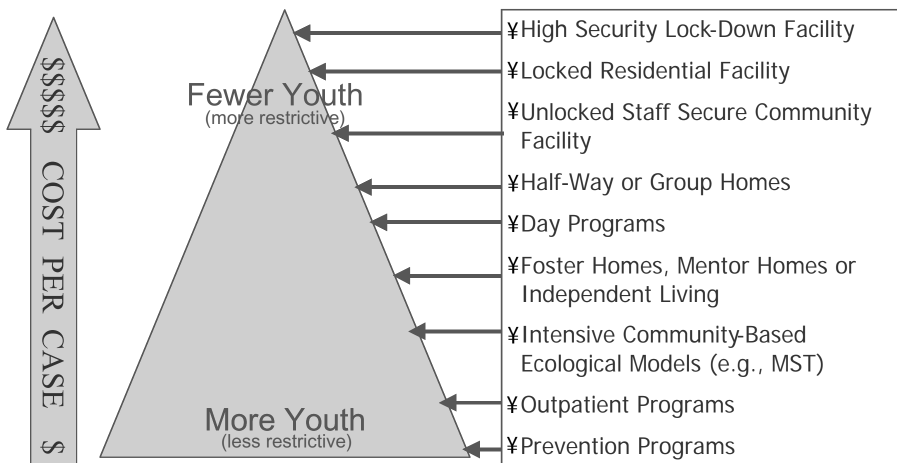
Professionals face many challenges with youth. Age, developmental and contextual issues, learning abilities and styles, etiology, cultural issues, spirituality, and gender differences must all be taken into account. Our field still needs programs that work within these areas while improving sensitivity to cultural issues (Lewis, 1999).

Families

The lack of investigation into helping the families of sexually abusive youth reflects poorly on our field. Despite the vast literature on family therapy, there is precious little research into successful family interventions. One might attend any number of conferences and not find a workshop on this topic. While this often reflects the egregious circumstances in which youthful abusers are raised, the fact remains that our field is better at the short-term solution of separating family members rather than the longer-term solution of reconciliation and growth. While the former is often necessary as an initial measure, the latter is too often left out of both research and practice.

Continuum of care

Sexually abusive youth are best rehabilitated with a continuum of care (Bengis 1986, 2002a). The NCSBY proposes a continuum developed by Chaffin and Longo (2003):



Examples of Continuum Levels of Care[1] (beginning with least restrictive)

At the base of the continuum is the Prevention Level.[2] Prevention consists of two types:

> 1) Primary Prevention Programs are public and private school systems that provide age-appropriate or educational program on human sexuality and human sexual behavior, including materials on sexual assault and child sexual abuse.
>
> 2) Secondary Prevention Programs are community-based mental health, behavior problem, victim treatment, or delinquency programs that provide a short-term age-appropriate collateral psycho-educational module on human sexuality and human sexual behavior, including detailed material on sexual assault and child sexual abuse definitions, consequences, and strategies for identifying, avoiding and coping with risky sexual behavior situations.

Next, the Outpatient Program Level generally provides individual, group or family

therapy providing traditional ad hoc mental health services (with variations in focus, model, and duration). These programs usually practice in an abuse-specific fashion, employing cognitive-behavioral models. They often include modules based on relapse prevention, increasing self-monitoring of behavior, and understanding patterns, consequences and strategies for managing inappropriate sexual behavior, etc.

The next level is Intensive Community-Based Intervention Level, such as Multi-systemic Therapy (MST) or Functional Family Therapy (FFT). These are short-term (four months in some models), highly intensive (sometimes including daily in-home contacts, low caseloads, 24-hour availability) interventions designed for seriously delinquent adolescents and their families. Both emphasize the role of families and obtaining immediate and maximal behavior change on assessment-driven goals.

The fourth level is Foster Home and Independent Living Home Level. Foster parents are usually lay individuals who have been screened and provided with brief basic training. Youth in foster care attend school in the community, and live a more normal family life. Foster homes are not physically secured and cannot realistically provide constant supervision.

The fifth level is Day Program Level. In most cases these programs are attached to a residential or inpatient milieu program, where youth participate in the treatment milieu and programming, but live in the community and return home in the evenings and on weekends. Day programs usually incorporate specialized classroom schooling/vocational training and therapeutic components similar to those found in residential programs.

The sixth level is Group Home Level. A group home is typically a small, structured, home-like facility, often in a residential neighborhood, housing a group of adolescents under 24-hour staff supervision. Group homes may be locked at night, and the activities of residents generally supervised, but they are not physically secure facilities designed to contain inmates, provide constant supervision, or prevent escape. Group home residents may attend school in the community, or may hold jobs in the community, but typically there are rules that do not allow them to move freely in and out of the facility. Group homes may provide on-site counselors or offer on-site services such as group therapy, or they may arrange for those services off site.

The seventh level is the Unlocked Staff-Secure Residential Program Level. These programs are typically year-round structured program with staff-supervised dormitories or cottages designed to provide therapeutic, educational, recreational, and behavior management services to children and adolescents who have long standing emotional and/or behavioral difficulties, but are not acutely psychiatrically ill. Residents commonly receive weekly individual/group/family therapy and periodic medical or psychiatric services. Residents are usually restricted to the campus, but may have "grounds privileges" based upon behavior and treatment plan progress. Lengths of stays in these facilities are often quite long term. Some of these facilities have specialized sex-offender cottages or campuses segregated from other youth and/or specialized sex-offender programming.

The eighth level is Locked Residential Treatment Centers. These centers are generally

a locked controlled-access unit, either freestanding or a more controlled unit within an overall residential campus, where resident activities and movements are controlled or monitored by staff on a 24-hour basis, and there is a strong emphasis on structure, intensive behavior management, and containment. These facilities provide on-site schooling as well as frequent and intensive psychological or psychiatric services delivered by on-site professional staff. These facilities often have seclusion and restraint capacity and rely upon behavioral systems or level systems to gain compliance from residents.

The ninth and final level is High-Security Lock Down. Most common are juvenile correctional facilities with guards, high security, and multiple barriers preventing escape (e.g., razor wire fences, remote-controlled hardened doors or gates, etc.). These facilities may provide some professional psychological or psychiatric treatment services and may use a level system. Participation in school or GED services usually is required for residents. Behavior change is often pursued via control and application of sanctions. Staff are typically security officers rather than treatment or nursing staff.

Bengis (2002 a, b) notes that use of a continuum requires special attention to the following criteria as a guideline for placement of clients:

1) The placement should correspond to the level of risk posed by the patient.
2) The level of client risk should be determined by examining both:
   a) the client's level of self-control (the bottom-line acting-out which the
   b) placement has been designed to contain), and
   the staff-client ratios present on-line to contain these behaviors.
3) Whenever legally possible, movement along the continuum should be based on the competency level achieved by the patient.
4) Required competency levels should correspond to the level of internal-control required for safe placement at each level of the continuum.
5) Initially, clients can be referred to any level of the continuum that corresponds to their diagnosed level of risk. However, decisions regarding movement to less restrictive placements should be competency-based.
6) The entire continuum of care should use the same sex abuser-specific assessment and treatment criteria. While specific placements may emphasize different aspects of sex abuser-specific treatment (e.g., one program may emphasize learning the assault cycle and another may emphasize arousal reduction) all placements should adhere to the guidelines established by the National Task Force On Juvenile Sexual Offending (1993). Sex abuser-specific treatment that takes place in other than outpatient settings, i.e., residential or day programs, should incorporate sexual abuser-specific milieu treatment. As such all staff in those placements should be trained:
   a) to provide abuser-specific interventions as part of their work on-line with youth;
   b) to integrate the basics of abuser specific treatment into interventions that do not involve sexually abusive behaviors; and
   c) to integrate abuser-specific issues into vocational and educational curricula.

Programs offering specialized assessments and specialized groups, but do not provide specialized milieu treatment, should not be considered sex abuser-specific programs.
7) Whenever possible, caregivers should remain consistent as a youth moves from one level of the continuum to another (i.e., probation officer, case worker, therapists).
8) Placements along the continuum should be evaluated:
a) by professionals trained in both evaluation methodology and abuser specific assessment and treatment; and
b) according to sex abuser specific criteria agreed to in advance by eval uators and those being evaluated.
9) The continuum should include long-term self-help and require community relapse prevention components.
10) Day programs and educational placements should be thoroughly integrated into the continuum of care and be required to provide sex abuser specific treatment.
11) All youth placed in programs anywhere along the continuum should receive pre and post abuser specific evaluations. These evaluations should be the basis for initial placement and for discharge to less restrictive settings. These evaluations should also screen the patient according to more traditional clinical criteria (i.e., thought disorders, clinical depression, ADHD, and other neurological criteria).
12) In unlocked settings, failure to meaningfully participate in treatment over reasonably appropriate periods of time should be criteria for discharge from a program. Ideally, such a discharge would also constitute violation of probation and/or court orders and subject the youth to placement in a more restrictive and/or locked setting. For youth who are not court involved, such discharge should also result in placement in a more restrictive setting.

In locked correctional settings, treatment should be considered a privilege. Youth refusing to meaningfully participate in treatment over reasonably appropriate periods of time should be discharged from treatment groups and not be provided with additional benefits or perquisites. They should also be required to serve the maximum sentence imposed by a judge. However, the option of participating in treatment should be available to these youth at any time during their incarceration.

Best practice

The definition of best practice in treating sexually abusive youth is still in question (Chaffin & Bonner, 1998; Developmental Services Group, 2000, Hunter & Longo, 2004). While the field is not new, conceptualization of what constitutes effective treatment for this population is still evolving (Chaffin, Chapter 28; Hunter and Longo, 2004).

All too often, clinical approaches have overlooked developmental and contextual issues. Many programs have focused treatment on areas that may not be relevant for the juvenile sex offender population, such as deviant sexual arousal (Freeman-Longo, 2002; Hunter, 1999; Hunter & Becker, 1994). Techniques and modalities used in treating adult sexual offenders have been directly applied to youth, or modified only

slightly to make materials more easily understood, without taking into consideration learning styles and intelligence variations of these clients (Gardner, 1983). High levels of confrontation are still used in many programs. When used with traumatized youth, these techniques may serve to re-traumatize them instead of promoting healing, forgiveness, and respect for self and others. Even the recent research with adult sex offenders demonstrates that warm, empathic, rewarding, and directive therapeutic styles can produce better treatment outcomes than harsh and confrontational methods (Marshall, Fernandez, Serran, Mulloy, Thornton, Mann, & Anderson, 2003).

As of 2002, the majority of juvenile sexual offender treatment programs still adhere to a traditional adult sex-offender model (Burton & Smith-Darden, 2001). According to national surveys, the most popular treatments for both adult and juvenile sex offenders include relapse prevention, the sexual abuse cycle, empathy training, anger management, social and interpersonal skills training, cognitive restructuring, assertiveness training, journaling, and sex education (Freeman-Longo, Bird, Stevenson, & Fiske, 1995; Becker & Hunter, 1997; Hunter, 1999; Burton, Smith-Darden, Levins, Fiske, & Freeman-Longo, 2000; Burton & Smith-Darden, 2001). Questions about the appropriateness and effectiveness of these approaches requires the development and testing of juvenile-specific intervention programs (Hunter & Longo, 2004; Prescott, 2002).

Throughout this book, we endorse the use of a holistic/integrated approach to treating youthful sexual abusers (Longo, 2001; Hunter & Longo, 2004). This approach blends traditional aspects of sexual abuser treatment into a holistic, humanistic and developmentally consistent model for working with youth (Morrison, Chapter 13). While cognitive-behavioral treatment methods appear promising, treatment must go beyond the sexual problems, and address "growth and development, social ecology, increasing health, social skills, resiliency, and incorporate treatment for the offender's own victimization and co-occurring disorders" (Developmental Services Group, 2000). If successful risk reduction involves changing thoughts and behaviors, then a holistic, integrated model prepares the youth to make these changes while respecting his long-term development.

Standards of care

The first standards of care for sex offender treatment appeared in the late 1980s, when ATSA published its first set of standards and guidelines for its members. Since then these standards have been revised several times to its current version (ATSA, 2004). Although comprehensive, its focus is more oriented to adult sex offenders than children or adolescents. ATSA is currently establishing guidelines specific to youthful sexual abusers. Coleman and Dwyer (1990) proposed a set of standards for care for the treatment of adult sex offenders. These standards were later revised and updated in 1996 and again in 2001 (Coleman, Dwyer, Abel, Berner, Breiling, Eher, Hindman, Langevin, Langfeldt, Miner, Pfafflin, & Weiss, 2001). These standards have also focused specifically on adult sex offenders.

In 1996 the National Offense-Specific Residential Standards Task Force was developed and over the course of three years this small independent group researched, developed, and published standards of care for the residential treatment of juvenile

sexual abusers (Bengis, Brown, Freeman-Longo, Matsuda, Ross, Singer, and Thomas, 1999; Longo, 2002b). This was the first successful attempt to produce and publish standards for juvenile sexual abusers.

While there have been several independent efforts to establish standards of care, there is no national standard that is endorsed by a national agency or organization. Even the independently published standards do not provide consistently applied standards across the country.

Summary

One may well argue that the field of treating children and adolescents is itself barely out of adolescence. The past two decades have seen the recognition of sexual abuse by youth, but it is only recently that research and treatment have come to appreciate the heterogeneity of this population. We have imported many of our strategies for understanding, assessing, treating, and managing youth from adult populations. However, youth are, by definition, different. They exist in a different context and at different developmental stages. They often have unresolved histories of trauma, both physical and psychological.

Although treatment strategies aimed at thoughts and behaviors are promising, we cannot expect youth to respond to them without also attending to their needs at a more holistic level or incorporating the assets they bring into treatment (Longo, 2002a; Longo, 2004). We believe that the best practitioners are warm and empathic, addressing all aspects of the youth's functioning, while maintaining a focus on those areas demonstrated to be associated with risk. We also believe that interventions that do not take the youth's family circumstances into consideration may well do harm in the long run.

Finally, the field has struggled to develop standards and a continuum of care based on treatment needs and community safety. While many decisions around sexually abusive youth have been, and remain, driven by public fear and furor – not to mention economics – we remain confident and optimistic that efforts in these areas will continue to bear fruit in the long run. To that end, we hope the chapters that follow are helpful.

End Notes

[1] We recognize that this continuum is not exhaustive and that the points along it may not accurately characterize a particular individual facility. This continuum does not include all existing, necessary, or desirable levels of care. Also, an individual facility may or may not fit the description we have offered for that type of facility. For example, there may be group homes that provide a much higher level of security, or a juvenile correctional facility that provides far more services.

[2] In this continuum, the prevention level describes services that would be appropriate across a range of populations, including some identified case populations as well as general populations of children (primary prevention levels) and at-risk populations (secondary prevention levels).

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