Developmentally Informed Community Treatment for Adolescents with Problem Sexual Behavior

by

Janet Lyons Walker

B.A. Central Connecticut State University, 1987
M.A. Antioch New England Graduate School, 1989
M.S. Antioch University New England, 2007

DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of Doctor of Psychology in the Department of Clinical Psychology at Antioch University New England, 2012

Keene, New Hampshire
DEVELOPMENTALLY INFORMED COMMUNITY TREATMENT FOR ADOLESCENTS WITH PROBLEM SEXUAL BEHAVIOR

presented on July 11, 2012

by

Janet Lyons Walker

Candidate for the degree of Doctor of Psychology
and hereby certify that it is accepted*.

Dissertation Committee Chairperson:
Susan E. Hawes, PhD

Dissertation Committee members:
David Hamolsky, PsyD
Randall Wallace, PsyD

Accepted by the
Department of Clinical Psychology Chairperson
Kathi A. Borden, PhD
on 7/11/12

* Signatures are on file with the Registrar’s Office at Antioch University New England.
Dedication

For my husband Rob who makes life joyful

Your abiding love, encouragement, humor and support made this project possible.

The comfort of our union tends to the mysteries in store for tomorrow.

Did you hear that? It sounds like thunder...
Acknowledgments

Thank you, Rob, for your patience, generosity, and for your boundless love. Thank you Libbey & Grey, for making me laugh at all the right moments ~ I love you, so much and more. Thank you, Leanne, my dear friend and confidant, for your love, your cheers, your ear, and for your shoulder. Thank you Leah, Cathy, Jodi, and Kristen for gal-pal email threads that provided hours of healing laughter, and for outstanding group projects with excellent results. Thanks to my committee, Dr. Susan E. Hawes, Dr. David Hamolsky, and Dr. Randall Wallace for your unique and compelling participation in both my education and in this project. And thanks also to the families who shared their struggles with me. Your stories kept me company as I worked on this project.

My mother, Celeste Louisa Libbey Lyons, gave me roots and wings, inspired me to aspire, and loved me just the way I was. Always in my heart, I miss her beyond words.
# Table of Contents

Dedication.......................................................................................................................... ii  
Acknowledgments .............................................................................................................. iv  
Table of Contents............................................................................................................... v  
List of Figures....................................................................................................................... vii  
Abstract.................................................................................................................................. 1  
Preface ..................................................................................................................................... 2  
Chapter 1: Introduction ........................................................................................................ 4  
  Statement of the Problem ................................................................................................. 5  
  Four Case Vignettes ......................................................................................................... 7  
  Summary ............................................................................................................................ 12  
  Purpose of Study ............................................................................................................... 13  
Chapter 2: Review of the Literature ..................................................................................... 15  
  Developmental Psychopathology ..................................................................................... 15  
  Developmental Neuroscience ......................................................................................... 17  
  Adolescent Development ................................................................................................. 21  
  Problem Sexual Behavior ............................................................................................... 24  
Chapter 3: Program Design ................................................................................................. 38  
  Mission .............................................................................................................................. 38  
  Program Structure ........................................................................................................... 40  
  Integrated treatment planning ......................................................................................... 62  
  Program Evaluation .......................................................................................................... 70  
Chapter 4: Discussion .......................................................................................................... 74  
References............................................................................................................................ 83
List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1</td>
<td>Range of sexual acts and levels of threats, force or violence</td>
<td>25</td>
</tr>
<tr>
<td>Figure 2</td>
<td>Integrated theory of sexual offending</td>
<td>31</td>
</tr>
</tbody>
</table>
Abstract

The sexual abuse of children often results in profound intrapersonal and interpersonal dysfunction or difficulties for the victims. In 2010, sexual assault was perpetrated upon more than 63,000 children in the United States, and in more than 35% of those incidents, adolescents were the perpetrators. Research suggests that adolescents with problem sexual behavior act from their own vulnerabilities. Understanding the developmental seeds and pathways that become etiological factors in the commission of sexual assaults against children is only one important step in a mission to protect them. The treatment that emerges from a comprehensive understanding of adaptive and maladaptive adolescent development and its behavioral expression provides a framework from which to address both the diverse and unique characteristics of these youth. This dissertation intends to contribute to the field of the treatment of adolescents with problem sexual behavior with an outpatient program design, theoretically rooted in the discipline of developmental psychopathology and aligned with the Ward & Beech Integrated Theory of Sexual Offending. A review of literature explores the discipline of developmental psychopathology, developmental neuroscience, adolescent development, and facets of the fields related to the study of problem sexual behavior, including characteristics of problem sexual behavior in adolescents, various risk factors and theories, and current treatment models. Together these foci will function as the groundwork for the program design. Implementation of the program could contribute to a reduction of recidivism for successful adolescent participants, and so also a reduction in incidences of children perpetrating assaultive, sexual acts upon other children, by providing tools to heal wounds, and promote growth, consolidation, competency and opportunities for adolescents to re-direct their developmental trajectories.
Preface

Questions related to the etiology, treatment, and public policy implications of adolescent problem sexual behavior emerged for me first through a classroom discussion early in my doctoral program. A classroom discussion wrestled with the broad topic of child sexual abuse at the theoretical, clinical, sociopolitical, and perhaps, personal levels. I began my inquiry after finding a small news article about a 19 year-old recently arrested on charges of having sexually molested about a half-dozen boys. Through the investigation however, it was discovered that he had molested more than 40 boys. I wondered what had happened in that young man’s life, in the life of his family, his victims and their families, their community, and our society.

As it turns out, a growing legion of committed, passionate, educated professionals have for decades been studying the phenomena related to juvenile and adolescent problem sexual behavior. These researchers and clinicians, many of whom you’ll find referenced on the following pages, would be among the first to note that like so many areas in the study of human behavior, there remain untold unanswered questions. Researchers around the world pursue every conceivable facet of minute, important aspects of questions related to this: What causes a human being to sexually abuse a child? That question is important because of our society’s larger question: How do we stop the sexual abuse of children?

In the years prior to the pursuit of my doctorate, I worked in a variety of clinical settings, with both adults and children. I studied the phenomenon of child sexual abuse from the perspective of one who provided psychotherapy to survivors and their families. I recall wondering how a therapist could work empathically with perpetrators. More precisely, I was not sure I could do that.
Then there was that classroom discussion, and the questions erupting from the passion of my cohort mobilized first my inquiry, then my decision to step into the work. A practicum with The Center for the Treatment of Problem Sexual Behavior (CTPSB) in Connecticut afforded me the opportunity to work with adjudicated juveniles with problem sexual behavior (PSB). My work with that team, my experiences in training with the Association for the Treatment of Sexual Abusers (ATSA), and my experiences providing individual and family therapy with both adolescents and adults who have sexually abused children, coalesce with my research to present on the following pages, my notion of a theoretically integrated, comprehensively designed outpatient program for adjudicated teenagers who do what we wish was unimaginable: sexually molest other children.

Except when referencing others' work I eschew use of the term “juvenile sex offender” in preference for “adolescent with problem sexual behavior” the latter a more accurate term when describing an individual’s developmental stage and behavior; the former drawn from the criminal justice system, developmentally imprecise, and increasingly provocative. The image often associated with the term SEX OFFENDER does not likely reflect the presentation of most of the teens with whom the CTPSB staff and others work. Remaining connected to this developmental and behaviorally descriptive clinical conceptualization is a core competency for the program design that follows.

Equally essential to this work is an abiding awareness of the intrapersonal and interpersonal consequences experienced by the children whose lives become altered by the pain, the betrayal, the fear and loneliness of having been sexually assaulted. In the end, this work is intended to honor the needs of all children: those who are safe, those who are not safe, and the adolescents who sometimes contribute to the difference between the two.
Chapter 1

The evening newscasts and morning newspapers regularly report incidents of child sexual abuse, while radio and television programs probe the lives of victims or call for more meaningful penalties. Communities host vigils and protests while law enforcement and mental health facilities invest tremendous resources to respond to the crimes and their aftermaths. When the perpetrators are adults, society seems ready to lock the cell doors for decades. When the perpetrators are children or adolescents, society seems more shocked, perhaps mystified. The graphic, often violent descriptions of these assaults are, for many people, unfathomable. But to discuss the scope of adolescent problem sexual behavior, it is important to convey a meaningful representation of the behaviors. The next two paragraphs graphically describe two sexual assaults perpetrated by teenage boys. Ultimately, this dissertation will seek to offer a theoretically grounded program design intended to provide developmentally informed therapy for adolescents very much like those described here, and in the pages to follow.

A trusted teenage neighbor who has provided babysitting services for several families turns a game of hide-and-seek into a family’s nightmare by exposing his penis and asking his charge if she would touch it. He becomes sexually aroused, and puts his hand into the front of the child’s shorts, and he fondles her. She is nine years-old, and the teenager soon knows that he has just changed the lives of his victim, her family, himself, and his family.

Twenty miles away, in another town, a 13 year-old boy is home with his visiting seven year-old cousin. The two boys are alone in the house. The 13 year-old is physically much bigger than the younger boy, and the younger is threatened with harm if he does not pull down his pants. The 13 year-old shoves the face of his young cousin to the floor, and then inserts a capped soda bottle into the boy’s anus while fondling his penis. The seven year-old is assured
that his parents will be very angry with him if he tells what he has done. There was blood in the young boy’s underpants that night, but for that incident, he kept the secret.

This graphic introduction importantly highlights the compelling problem this dissertation intends to address: adolescents perpetrating sexual assaults upon children. The descriptions of these assaults provide only an introductory backdrop for the statistics that follow. The Statement of the Problem is followed by four case vignettes describing the development of four individuals who, while adolescents, committed multiple sexual assaults upon children. These illustrations provide a context for the statistics and for the Literature Review and Program Design chapters that follow.

Statement of the Problem

In 2010, there were more than 2.6 million reports of child maltreatment in the United States. Collected via the National Child Abuse and Neglect Data System (NCANDS), these data suggest that 22% or 436,321 children (under the age of 18) were victims of substantiated maltreatment that year, while an additional 24,976 were indicated to have been abused (the designation of indicated is used by some states to report cases where there was reason to suspect abuse, but investigations fell short of substantiation; U.S. Department of Health and Human Services, 2011). While 78% of these children were found to have been neglected, more than 9%, or 63,527 children were victims of reported sexual assault (U.S. Department of Health and Human Services, 2011). The statistics offered throughout this dissertation refer only to reported assaults and individuals adjudicated through the criminal justice system. Estimates based on speculation abound, but are not included here.

The longitudinal impact on child sexual assault victims can be costly at many levels. Child sexual abuse often leads to a variety of internalizing and externalizing behaviors.
Examples of internalizing symptoms associated with child sexual abuse include anxiety, depression, diminished self-esteem, fear, and guilt. Externalizing symptoms may include temper tantrums, school failure, substance abuse, self-harmful acts and atypical sexual behavior manifesting in avoidance of sexual relationships in adulthood, or engaging in sexual behaviors that are exploitive of self or others (Browne & Finkelhor, 1986).

Sexual assault is defined by the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Programs (OJJDP) as acts including forcible rape, forcible sodomy, sexual assault with an object and forcible fondling (See Appendix A for a glossary of sexual acts and crimes). It is estimated that in 2004, there were 89,000 juvenile sexual offenders in the United States, with juveniles making up 25.8% of all identified sexual offenders, and committing more than one third of all reported sexual offenses against children (U. S. Department of Justice 2009). The age of juvenile sexual assault perpetrators peaks and plateaus between the ages of 12 and 14 and only one out of eight juvenile sex offenders is under the age of twelve (U. S. Department of Justice, 2009). Youth who commit sexual offenses are more likely than adult offenders to have younger victims and male victims (U. S. Department of Justice, 2009). More than ninety percent of juvenile sex offenders are male, and most of their offenses are committed alone, and against a young child (U. S. Department of Justice, 2009).

It was once estimated that the average untreated sexually offending adolescent would go on to commit 380 sex crimes during his lifetime (Barbaree, Hudson, & Seto, 1993), and that about one half of all adult sex offenders began sexually assaulting their victims before adulthood (Righthand & Welch, 2001). This statistic is importantly informed by data that points to the heterogeneity of the adolescent with problem sexual behavior (APSB) population (Langton & Barbaree, 2006; Rich, 2003; Rich, 2009). These adolescents differ in the types of sexual
behavior preferred, their selections of victims, the age of behavior onset, and the persistence with which they commit sexual assaults (Hunter, 2006). Adolescents aged 15 to 17 are more likely to sexually offend against children who are between the ages of 11 and 13, while victims under age 12 are more likely to have been abused by teens aged 13 to 14 (U. S. Department of Justice, 2009). Adolescents age 15 and older are more likely to victimize post-pubescent youth (U. S. Department of Justice, 2009). Importantly, as evidenced in the vignettes below, and as discussed later in this work relative to assessment and treatment, adolescents who commit sexual offenses are most likely related to, or known to, their victims (Rich, 2003). More than 88% of young sexual assault victims of 13,471 identified juvenile offenders in 2004 were known to, or related to, their abuser (U. S. Department of Justice, 2009).

Four Case Vignettes

The four case vignettes that follow are compilation narratives of individuals who exhibited adolescent PSB. The details have been merged and pseudonyms have been assigned so as to protect identities, but the stories have not been weighted to make them extraordinary. These vignettes are presented to elucidate the data presented thus far, and to help provide a touchstone for the theories and design that follow.

First case vignette. Allen is a 14 year-old foster child living in a group home, his 13th foster placement since age eight. He is one of five children born to a mother herself the product of alcoholic biological parents, the victim of incest, and nearly a decade in the foster system. Allen’s mother carries multiple psychiatric diagnoses, including poly-substance dependence, anxiety and depressive disorders (American Psychiatric Association, 2000). Birthing complications resulted in Allen’s low APGAR (the five factors used to asses a newborn’s physical condition immediately after birth), and he had numerous hospitalizations in infancy and
early childhood related to respiratory distress. His mother did not seek or receive early childhood services for Allen, and she noted no delays in his meeting developmental milestones. At the same time, his mother acknowledged significant impairment in her own daily function, and so the reliability of data relative to his early development was somewhat questionable. She did, however, report that in early childhood Allen was hyperactive and difficult to manage. An active substance abuser, Allen’s mother had numerous substance-using boyfriends, some of whom resided with the family for brief periods, and at least one of those men is reported to have sexually molested Allen. Allen reports also having been sexually molested by an older brother. The family moved multiple times before, at the age of eight, Allen and his family were forced to move to a shelter. Shelter staff felt concerned for Allen’s safety, and contacted child protective services (CPS). CPS caseworkers followed the family for several months before permanently removing Allen from his mother’s custody.

Allen was 12 years old and in his tenth foster placement when he sexually molested and sodomized an eight year-old foster brother multiple times over the course of several months. The assaults occurred at night in their shared bedroom. Allen was charged and adjudicated, referred for PSB-specific treatment and placed on probation until the age of 17. He spent time in two childless foster homes before being moved to the group home. He carries a diagnosis of Attention Deficit Hyperactivity Disorder (American Psychiatric Association, 2000) for which he has never been medicated. Allen is reported to have a Full Scale IQ in the Low Average range. He has had multiple suspensions from school, the result of habitual tardiness and truancy. He lost his position on the school football team as the result of those suspensions.

Second case vignette. Ben is 13 years old, residing with his biological father, step-mother and younger (non-victimized) half-sister. Ben has three half-siblings, who reside,
as he did, with his biological mother. Ben’s biological parents divorced when he was a toddler. Ben
experienced in-utero cardiac distress, but was born full-term with an APGAR of nine. Ben
is reported to have met developmental milestones without difficulty, but at 13 he is obese and
asthmatic. He was diagnosed with and medicated for Attention Deficit Hyperactivity Disorder at
age three, a diagnosis which was changed to Bipolar Disorder (American Psychiatric
Association, 2000) at the age of five. Ben attends a therapeutic day program, the result of
emotional and behavioral dysregulation that was beyond the scope of traditional classroom
management. Between the ages of five and nine, he engaged in numerous behaviors that
presented a risk to self and others. Among these included attempting to set fire to the family
home, chasing a sibling with a knife, and running into the line of traffic for no apparent reason.
Ben’s biological mother is a survivor of child sexual abuse, has a history of alcohol dependence,
and has been the victim of domestic abuse in adulthood. She is diagnosed with Borderline
Personality Disorder and Depression (American Psychiatric Association, 2000).

The first report of problem sexual behavior came when Ben was eight, when it was
reported that he was sexually inappropriate with two of his sisters. Ben told the investigating
social worker that it was the son of his mother’s boyfriend who had molested his sisters, but this
was not substantiated. Ben’s mother reported that her son seemed atypically interested in
viewing and talking about sexually explicit material, and she expressed her powerfully negative
feelings about these behaviors. He was removed to a relative’s home for several months, but was
returned to his mother without intervention either for himself or for his sisters. Child protective
services again became involved with the family when Ben was 11, following substantiated
reports of physical abuse and neglect. Ben presented to the school nurse with bruises that he
reported were inflicted by his mother’s boyfriend. Ben would later add that this man also kept
pornographic magazines and videotapes, which Ben and his siblings viewed. His mother was told that Ben could not live in the home if her boyfriend remained, and mother replied that she did not believe her son; that he was not welcome back into her home. Ben moved into his father’s home at that time.

At 12 years old, Ben sexually molested and raped a sister four-years his junior during a weekend visitation with his mother. The assault began as fondling on the sofa while the two watched television together in the family room. Ben then began to “tickle” his sister in private areas of her body, leading to a physical chase to her bedroom. Ben describes “throwing her down” on the bed and “having her.” He stated that he ejaculated on her stomach because she was his sister, not a girlfriend. The abuse was exposed after another sister entered the room during the perpetration of the abuse, and she coaxed her sister to report the incident to their mother. Ben described his eight-year-old sister as the aggressor, and suggested that she confirmed the reported incident because she was angry about Ben’s refusal to ejaculate in her vagina. Ben was charged, spent one night in juvenile detention, and was adjudicated. He spent six months wearing an electronic ankle monitor, was required to participate in PSB-specific therapy, and received two years’ probation. Ben is reported to have a Full Scale IQ in the Borderline range of intelligence.

Third case vignette. Carlo is 15 years old, the child of parents who entered this second marriage with four older children. Carlo experienced no in-utero distress, met developmental milestones well within the norm, and has spent his entire life with both parents in the same home located in a middle-class suburban neighborhood. He excels at a sport, playing in town and regional leagues since he was young, and he is an honors student at his suburban high school. The neighborhood is tightly knit, and Carlo was a regular babysitter for the children of his
parents' friends. One afternoon while babysitting, he played hide-and-go-seek inside the home of his two charges. While one child searched the house, Carlo hid in a bedroom with a girl four years his junior. In the closet, with a light on, he unzipped his shorts and asked if she wanted to touch his penis. She hesitantly did so. He then pushed his hand down the front of her shorts, and touched her vulva and labia. He stopped when he heard the sibling approach the bedroom, and told the girl not to tell anyone. The next time he babysat was an evening time slot, and a similar, but longer molestation took place under the covers at bedtime. The next day the doorbell rang at his home, and when he found the girl's mother on the doorstep, he went to his room and waited. He was incarcerated at a juvenile detention facility for seven days. He was adjudicated, required to participate in PSB-specific treatment, and placed on 8 years' probation. Carlo reported no exposure to pornography, no history of abuse or neglect, and is reported to have a Full Scale IQ in the High Average range of intelligence.

**Fourth case vignette.** Daren is now a man in his early fifties. At his birth, his mother was morbidly obese, and when he was nine his mother died from complications of her diabetes. Daren has two older siblings, and their father remarried not long after his wife's death. Daren described having been sexually abused by two unrelated men while he was a child. He reported that these abusive relationships both overlapped and occurred over time. The pattern of abuse included voyeurism, exhibitionism, frotteurism, and fondling. He recalls having been fondled while in his bed at the age of five, and he recalls numerous incidents after that, until the last incident at the age of 18. Daren describes only few childhood memories of his parents and siblings. He recalls being described as a "slow learner" and being placed in a special education classroom from grades one to 11. Daren dropped out of school prior to the start of 12th grade.
He had very few friends in school, and the adults in his life did not engage with him in a
nurturing manner. Daren’s Full Scale IQ is estimated to be in the Low Average Range.

Daren first molested another child when he was 13, while the two boys were in the school
shower room. The child was similarly aged, but was severely cognitively limited. Daren
continued to molest the boy for three years. Today he recognizes the pattern of his abusive
behaviors as similar to the abuse he concurrently suffered. Daren was not reported to authorities
during his adolescence, but was a young adult when first arrested. Over the course of 35 years,
Daren has sexually molested approximately 200 boys, most of who were between the ages of 11
and 13. Daren has been incarcerated four times, twice for charges directly related to his sexual
abuse of boys, and once for violation of probation, and once for possession of child pornography.
In total, Daren has served 12 years in maximum security facilities. The victims of the assaults
for which Daren was arrested were sons of women he met in the workplace or at social service
agencies. However, most of the boys Daren abused attended local child-oriented venues where
Daren worked. He describes that he carefully observed the crowds for isolated boys, enticed
then befriended them before physically isolating them in his trailer where he sexually molested
them. Daren is a Registered Sex Offender who began searching for child pornography on public
computers after he completed his last probationary period. He was detected, and is currently in
the midst of his fourth incarceration.

Summary

The sexual abuse of children often results in profound intrapersonal and interpersonal
impact for the victims. In 2010, sexual assault was perpetrated upon more than 63,500 children
in the United States, and in more than 35% of those incidents, adolescents were the perpetrators.
Statistically, more than 90% of the juveniles who are arrested for sexual offenses are male (U. S.
Department of Justice, 2009), ranging in age from 13 to 17. Some 80% have a diagnosable psychiatric disorder, notably impulse control disorders; and 20% to 80% have themselves been victims of physical or sexual abuse (U. S. Department of Justice, 2000). Demographically, youth referred for treatment after committing a sexual offense reflect the general population in terms of racial, socioeconomic and religious backgrounds. Only a minority of juveniles arrested for sexual offenses have been found to have paraphilic sexual arousal and interest (U.S Department of Justice, 2009).

What becomes clearer with research is that adolescents with PSB act from their own vulnerabilities (Longo & Prescott, 2006). Understanding the developmental seeds and pathways that become etiological factors in the commission of sexual assaults against children is only one important step in a mission to protect them. Therefore, treatment that emerges from a comprehensive understanding of adaptive and maladaptive adolescent development and its behavioral expression logically provides a framework from which to address the shared and unique characteristics of these youth.

The case vignettes presented earlier in this chapter point to the heterogeneity found among adolescents with PSB. Next chapter’s Review of the Literature describes the key facets of developmental psychopathology (Cicchetti, 2006), and relatedly, the Ward and Beech integrated theory of sexual offending, which together provide the treatment framework of the program design. Specifically, concepts drawn from general systems theory and ecological systems theory precede a more detailed description of developmental neuroscience, and its role in interpersonal behavior and relationship.

**Purpose of Study**

This dissertation was intended to contribute to the field of the treatment of adolescents with
problem sexual behavior through an outpatient program design that is theoretically rooted in the
discipline of developmental psychopathology. In the review of literature I explore the discipline
of developmental psychopathology, adolescent development, and facets of the fields related to
the study of problem sexual behavior, including characteristics of problem sexual behavior in
adolescence, various risk factors and theories, and current treatment models. Together these
topics function as the groundwork for the program design.

The literature review precedes the description of the program design for New
Connections, a hypothetical program whose implementation may contribute to a reduction of
recidivism for successful adolescent participants, and so also a reduction in incidences of
children perpetrating assaultive, sexual acts upon other children, by providing tools to heal
wounds, and promote growth, consolidation, competency and opportunities for adolescents to re-
direct, improve their developmental trajectories.
Chapter 2: Review of the Literature

In this chapter I explore facets of the discipline of developmental psychopathology, the nature of adolescent development, and facets of the research related to problem sexual behavior, including characteristics of male adolescents with problem sexual behavior, typology research, the theoretical etiologies of problem sexual behavior and current treatment models related to adolescent problem sexual behavior. The proposed treatment program described in the next chapter emerges from the assertion that developmental psychopathology and the Ward and Beech Integrated Theory of Sexual Offending (2006), together provide a theoretical foundation to inform a comprehensive approach to understanding and treating adolescent problem sexual behavior.

Developmental Psychopathology

Developmental psychopathology (DP) has been emerging for the last quarter-century as a broad and integrating lifespan theory of pathological human development. DP requires incorporation of multiple disciplines, including experimental, clinical and developmental psychology, the neurosciences, embryology, genetics, sociology and philosophy (Cicchetti, 2006). This expansive theory importantly recognizes the multi-systemic influences that interact and interweave in dynamic and probabilistic patterns expressed emotionally and behaviorally in normal and pathological development (Hinshaw, 2008). In the 1970s DP provided an important theoretical framework for longitudinal studies related to the development of schizophrenia, and in the mid-1980s DP informed investigations related to family disharmony and other studies looking at the etiology and sequelae of insecure attachment (Cicchetti, 2006). While DP is a broad and appealing theoretical framework, several core concepts provide important foundation to the discipline’s research and practice.
The concepts of multifinality and equifinality, originating in biology and then in the general systems theory writings of von Bertalanffy (1969/2001), play one of the several fundamental roles in DP theory. These concepts pertain to the notion of pathways to psychopathology. Specifically, multifinality refers to the way in which one specific risk factor can lead to different outcomes in different people, while equifinality refers to the possibility that individuals with divergent pathways can manifest similar behavioral outcomes (Cicchetti, 2006). The content of the case vignettes presented in chapter one illustrate the importance of these concepts in the exploration of questions related to adolescent PSB.

With the concepts of equifinality and multifinality comes the important recognition that while two individuals may share a risk factor (e.g., exposure to pornography during childhood), one may experience a developmentally negative impact while the other does not. The related concepts of risk and resilience are, therefore, likewise key concepts for DP, emerging from the understanding that there is an interaction between poles of health and pathology (Cicchetti, 2006; Hinshaw, 2008). The study and understanding of positive developmental outcomes are essential to the research and interventions related to DP.

Ecological systems theory (Bronfenbrenner, 1989/1992) as incorporated into Bronfenbrenner's more recent bioecological model (Bronfenbrenner, 1994) contributes to DP the important conceptual foundation of nested systems (microsystem, mesosystem, exosystem, macrosystem), which facilitates the description of interacting contexts (including cultures) and their influence on human development. DP bridges the intrapersonal with the sociological in important recognition that even the broadest, most distal facets of our environment interact meaningfully in affecting human development (Hinshaw, 2008). The integration of the origins of Developmental Psychopathology necessarily leads to the exploration, identification, and
explanations of “processes and pathways to maladaptation, psychopathology, and resilience” (Cicchetti & Curtis, 2007, p. 627).

**Developmental Neuroscience**

Developmental neuroscience is another integral element in DP’s foundation (Cicchetti, 2006), and research performed during recent decades has greatly enhanced our awareness of the brain’s structure and functions. The human brain has an estimated one hundred billion neurons, each with approximately ten thousand connections linking it to other neurons. While genes carry the information that defines the brain’s general form, experience cues the expression of genes by activating neural pathways. There is strong research support showing how neural pathways are activated and pruned in response to experience (Siegel, 1999). In infancy and childhood, interpersonal relationships provide the greatest resource of experience. Infants enter the world with innate capacities for bonding, and given opportunity, will distinguish the maternal voice within three to four days. By three months of age, the reflexive smile is replaced by one that is responsive to social stimuli (Arden & Linford, 2009). Maternal and paternal gazes are considered the first of a long series of interpersonal experiences to strongly influence a child’s first experience of attachment (Cozolino, 2006; Schore, 1994). These limbically and cortically mediated reactions to others are thought to represent the earliest development of attachment style, a necessarily interactive process (Arden & Linford, 2009). Our earliest relationships appear to shape the brain’s structure, and that structure is further modified through the relationships that follow (Schore, 2003; Siegel, 1999), both nurturing and harmful. Neuroplasticity, the brain’s ability to change, is facilitated by emotional arousal (Cozolino, 2002) and attuned interpersonal relationships (Siegel, 2007).
In his description of the interrelated systems of the brain as they pertain to psychological trauma, Bessel van der Kolk (1996) emphasizes the interrelatedness of mind-brain functions and their production of mental processes (perceptions and emotions for example) through nerve impulses, neurohormones and neuromodulators. Presentation of emotional/behavioral dysregulation is an observable phenomenon that research suggests is related to these connected functions. When physiological dysregulation occurs, brain studies suggest that it is a sign that multiple biological systems have been over-stimulated (allostatic overload), and fail to effectively respond to one another (Cooper, Feder, Southwick, & Charney, 2007).

Martin Teicher, M.D., Director of the Developmental Biopsychiatry Research Program at McLean Hospital contends that, “Maltreatment is a chisel that shapes a brain to contend with strife, but at the cost of deep, enduring wounds” (Teicher, 2000, p. 10). Teicher points to four facets of brain development that are negatively impacted by childhood abuse, and that are expressed in specific dysfunction: limbic irritability (related to later psychopathology); left hemisphere deficiency (language); deficient left-right hemisphere integration; and abnormalities in the cerebellar vermis (Teicher, 2000).

More specifically, Teicher and others have linked the experience of stress to the alteration of brain development (Kaufman, Plotsky, Nemeroff, & Charney, 2000; Teicher, Tomoda, & Andersen, 2006). In individuals who manifest psychopathology as sequela of childhood physical or sexual abuse, researchers have noted diminution in the size of the corpus colosum (De Bellis, et al., 1999; De Bellis, et al., 2002) and left hemisphere maturation (De Bellis, et al., 2002). De Bellis et al. (2002) noted also (after correcting for socio-demographic differences) that children with abuse-related Post Traumatic Stress Disorder (PTSD) had “smaller prefrontal cortex, prefrontal cortical white matter, and right temporal lobe volumes and areas of the corpus
callosum and it's subregions, and larger frontal lobe cerebrospinal fluid volumes than control subjects” (p. 1066). Male subjects with maltreatment histories and PTSD were found to have more lateral ventricular volume than female subjects with similar histories and the same diagnosis (De Bellis et al., 2002).

Andersen et al. (2008) found evidence that brain development has sensitive periods for childhood sexual abuse effects. The study found reduced hippocampal volume when children between the ages of three and five, and between 11 and 13, are victims of childhood sexual abuse, and found that children similarly abused between the ages of nine and ten experienced a volumetric reduction in the corpus callosum. Likewise, reduction of the frontal cortex was discovered in young people who were sexually abused between the ages of 14 and 16 (Andersen et al., 2008). Authors of this same study point to a cluster of cells residing in the immature hippocampus (not the adult hippocampus) that respond to stress by releasing corticotropin-releasing hormone, a key factor in childhood hippocampal sensitivity (Andersen et al., 2008). Stress effects on the prefrontal cortex occur when victims are older, because growth of this region of the brain is slower in childhood, becoming more rapid between ages eight and fourteen. Sensitivity increases during rapid growth phases (Andersen et al., 2008).

Laurence Steinberg (2010) notes that the adolescent brain differs from the child and adult brain in numerous ways, including form and function, structure, circuitry, grey and white matter, structural connectivity and neurotransmission. He posits that the changes occurring during adolescence are “among the most dramatic and important to occur during the human lifespan” (p. 160). Like previously referenced authors, Steinberg asserts that, similar to all brain maturation throughout human development, the environment influences the course of adolescents’ “neural development and moderates its expression in emotion, behavior, and
cognition” (p. 160). Spear (2000) notes that neurochemical processes contribute to mood and behavioral problems during adolescence, resulting in a developmentally-linked susceptibility to neurological reward systems related to both exploratory and some risk taking behaviors. Siegel describes the period of time when adolescent prefrontal brain changes occur, roughly from age 12 to 25 as a “reconstruction zone” (Codrington, 2010, p. 288). During this period, adolescents are responding from the subcortical area, the limbic amygdala; they are emotionally reactive, and less self-regulated (Codrington, 2010).

The exploration of sensitive periods in brain development adds important dimension to identifying and responding to behavioral disorders. Researchers are increasingly studying clinical interventions when treatment begins either during or after identified sensitive periods. Developmental neuroscience provides increasing evidence that our understanding of young brains leads us to a new frontier of clinical practice.

Mirror neurons, found in the premotor cortex, posterior parietal lobe, insula and superior temporal sulcus appear to have a role in an infant’s imitation of and communication with caregivers. In an interview with Sandra Blakeslee published in the New York Times, neuroscientist Giacomo Rizzolatti (2006) asserted that “mirror neurons allow us to grasp the minds of others not through conceptual reasoning but through direct stimulation. By feeling, not by thinking” (para. 10). Siegel elucidates the concept of active mirror neurons: “If we were to drink from a cup, these specific neurons that were firing when we saw someone else drinking would also become activated. We see a behavior and get ready to imitate it” (Siegel, 2010, p. 36). More than that, mirror neurons are hypothesized to perceive and simulate others’ internal states-tuning into others (Siegel, 2010). It is importantly noted that the study of mirror neurons
and their role in attuning to the states of others is in its infancy, with scientists from multiple disciplines contributing to the data pool.

Developmental neuroscience, interpersonal neurobiology and developmental psychopathology provide essential context for addressing adolescent development and adolescent problem behaviors.

Adolescent Development

The word adolescent is drawn from the Latin verb *adolescere*, meaning to grow up; *adultum* (adult) is the past participle, and so historically, the notion of transition to completion has been embedded within the word (Bucholtz, 2002). For decades following G. Stanley Hall’s 1904 publication, *Adolescence*, psychology’s early theorists have postulated that the developmental period is inherently difficult. Heavily influenced by Charles Darwin and Ernst Haeckel, Hall described the adolescent years as a period of *storm and stress*, a period during which natural passions and tremendous growth manifested in observable, expected problem behavior (Berk, 2004; Stinberg & Morris, 2001). Early writings on adolescence were heavily weighted by the profession’s experience with adolescents inclined (or pressured) to participate in psychotherapy, and less informed by typical adolescent development (Rutter & Rutter, 1993). Sigmund Freud’s theory of *psychosexual stages* of development was heavily influenced by his nineteenth-century work with adults, postulating that adolescents, in the *genital stage* of development, were characterized by emotional volatility, behavioral unpredictability and psychological conflict (Berk, 2004). Erik Erikson’s (1950/1963) *psychosocial stages* emerged from Freud’s psychosexual theory, with Erikson describing a “physiological revolution” (p. 261) during this stage. Erikson, however, importantly incorporated the child’s cultural environment, and the acquisition of skills that help the child enter and contribute to society. Erikson described
adolescence as one of an individual's normative crises, specifically one that focuses on the search for and commitment to elements of an identity. Erikson noted that the adolescent's search for identity takes place not just within the child and within the child's family circle, but also within the wider social circle, including school peers and early work environments. Erikson theorized that adolescents who are unsuccessful in navigating the identity crisis, find themselves with role-confusion experienced internally, and manifested in their relationships with friends and family; and extending into their wider social interactions.

Piaget's cognitive-developmental theory postulated that brain growth and experience facilitate a human's movement through four broad cognitive stages, each identified by qualitatively different ways of thinking (Berk, 2004). Adolescence and adulthood fall within the fourth of these, the formal operational stage of cognitive development, wherein the individual has the capacity to hypothesize that which is not directly in evidence: the capacity for abstraction (Berk, 2004).

Rutter and Rutter (1993) also frame the discussion of adolescent development in terms of a transitional continuum during which pubertal changes and changes in physical appearance and hormonal secretion impact psychology and developing identity, which interacts with familial and social relationships. Normatively, peer relationships (friends) become more influential than others, but teens still seek and rely upon the counsel of their parents (Rutter & Rutter, 1993). Rutter and Rutter assert that broadly cast theories, such as Erikson's stage theory, fail to accurately explain individual trajectories, as evidenced by the commonly observed phenomenon of individuals seeming to step backwards developmentally before proceeding with their unique maturation. Contemporary theories suggest that adolescent development involves some
interaction of biological and social forces coalescing in a time when the individual is not still a child, but not yet an adult (Berk, 2004).

The field of developmental psychopathology emphasizes the dynamic relationship between both the internal and external contexts of the adolescent. More specifically, DP recognizes the influence that biological factors have on psychological processes and the influence of the social environment on brain development. The theory of probabilistic epigenesis, the dynamic, ongoing interaction between biological and experiential facets of life, manifesting in evolving behavior is one of the important theories contributing to DP’s comprehensive foundation (Anderson et. al., 2000; Cicchetti & Rogosch, 2002). DP also incorporates an organizational life span perspective, wherein a reorganization of the biological, psychological, and social systems of the individual occurs as a result of their interactions, leading to growth, consolidation, challenges, vulnerabilities, then competencies or mal-adaptations (Cicchetti & Rogosch, 2002). DP recognizes an individual’s active engagement in self-organization, helping to steer one’s own development, so that prior adaptation does not lock the course of developmental trajectory. From the DP perspective, adolescence provides important opportunities for an individual to participate actively in changing the direction of their unfolding development, even in the midst of other powerful factors.

Adolescence is marked by pubertal changes physically transitioning the body from childhood to adulthood, notably including growth and sex hormone acceleration, which for male adolescents cues the production of testosterone (Arden & Linford, 2009). Increased sexual interest accompanies the growth and development of body. Research has identified associations between variations in Dehydroepiandrosterone (DHEA) and its sulfate (DHEAS) and other adrenal androgens, with increased problem behaviors. Early-maturing teens see a higher
incidence of psychological problems, and in males, there is a corresponding higher rate of substance abuse and antisocial behaviors (Arden & Linford, 2009).

**Problem Sexual Behavior**

Defining the parameters of the term ‘problem sexual behavior’ is essential for this project; it can be a surprisingly complicated task taking into account the range of behaviors, the age, the mingling of culture and society, and determining set-points for terms like *deviant* and *victim*. For the purpose of the present work, the 1993 description published by the National Task Force on Juvenile Sexual Offending will be the guide for defining *problem sexual behavior*. In its description of problem sexual behavior, the task force included sexual behaviors occurring without consent or equality or are coercive (National Task Force on Juvenile Sexual Offending, 1993). Phil Rich (2003), the clinical director of the Stetson School, a residential facility for the treatment of young sexual offenders, describes the range of sexual offenses as including assaultive, hands-on acts (e.g., rape, molestation, penetration); or non-assaultive, hands-off acts (e.g., obscene phone calls, voyeurism, exhibitionism); or other offenses that fall outside of those categories, but that society considers offenses (e.g., creation of child pornography; see Figure 1). Finally, Rich asserts that the factor that most clearly defines a behavior as a sexual offense is the “presence of a perpetrator and a victim” (p. 20).

**Characteristics of male adolescents with problem sexual behavior.** Researchers and clinicians generally describe adolescents with PSB as a heterogeneous group (Caldwell, 2002; Hunter, 2006; Knight & Prentky, 1993; Rich, 2003) because of differences in their (a) psychosocial and psychological histories, (b) histories of victimization, (c) choices of victims, (d) type and persistence of criminal behavior (Hunter, 2006), (e) levels of cognitive function (Knight & Prentky, 1993), and (f) personality characteristics (Worling, 2001). While the four
Range of Sexual Acts and Levels of Threats, Force or Violence

Sexual Act
- Obscene phone calls
- Theft of clothing for sexual purposes
- Voyeurism
- Threats of sexual harm
- Exhibitionism
- Public masturbation
- Distribution or depiction of sexually obscene material
- Frottage
- Fondling and molestation
- Oral sex
- Digital penetration
- Object penetration
- Penile penetration
- Sexual torture and homicide
- Creation of child pornography
- Possession and distribution of child pornography
- Bestiality

Threats, Force or Violence
- None
- Slight
- Moderate
- Strong
- Extreme

*Figure 1:* Range of sexual acts and levels of threats, force or violence (Rich, 2003, p. 19).

case vignettes presented in Chapter 1 offer glimpses into these diverse characteristics, they also suggest some overlapping similarities. Such overlapping characteristics have been studied extensively. Phil Rich (2003) reported that a culling of the literature resulted in a list of 136 factors, which can be found in various constellations in various adolescents with PSB. Understanding these factors as either historically determined and not subject to change (static), such as criminal history, past victimization, history of conduct disorder, stability of family, home and school experiences, or as factors that can change over time (dynamic), such as social attachments, support systems, social competence, anger management, substance abuse, peer
relations, etc., is important in both the treatment and in the assessment of risk for recidivism (Hanson & Bussiere, 1998; Prentky, Harris, Frizzell, & Righthand, 2000; Rich, 2003).

Research has suggested that adolescents with PSB represent one of society’s more vulnerable populations. For instance, studies over the past two decades have reported findings suggesting that adolescents with problem sexual behavior have themselves been victimized sexually. In Worling’s (1995) study 25% to 75% of adolescent sex offenders reported histories of sexual victimization, while through a meta-analysis Seto and Lalumiere (2010), found that adolescent sex offenders had more than five times greater odds of having histories inclusive of sexual victimization than adolescents who were not sexual offenders. From the volumes of research of adolescent PSB and the diverse list of static and dynamic risk factors present in this heterogeneous group, Rich (2003, p. 98-99) offers the following ten characteristics that often, not always, can be found seated in this population:

- Have poor coping skills
- Have limited internal rules for social behavior
- Possess poorly developed or primitive senses of morality
- Experience significant emotional problems
- Exercise limited self-control and act out their emotional experiences through negative or otherwise inappropriate behaviors
- Have little insight into the needs and feelings of others
- Place their own needs and feelings ahead of the needs and feelings of others
- Exhibit a poorly defined sense of personal boundaries and taboos
- Have developed strong and not easily corrected cognitive distortions about others, themselves, and the world
• Have deficits in social skills or at least lack the ability to use social skills appropriately

**Typology research.** In an effort to hone the field’s understanding of the heterogeneous adolescent with PSB population, researchers have attempted over the last decades to develop typologies to clarify both the etiology and the prescriptive treatment. While the research continues, there is some contemporary agreement that subtypes (while not exclusive) would include those with psychosocial deficits, those with adolescent-limited or life-persistent general delinquency, those with co-occurring psychiatric disorders, and those with pedophilic interests or deviant arousal patterns.

Psychosocial deficits found in this population include diminished self-efficacy, low self-esteem, social problems and social withdrawal (Hunter, 2006; Hunter, Figueredo, Malamuth, & Becker, 2003). These youth struggle to engage with and maintain peer relationships and lack self-confidence. They tend to be depressed and socially anxious. Youth who sexually abuse younger children may do so in order to both avoid rejection and to attempt to meet their felt intimacy needs (Miner et al., 2010). These youth report that while engaged in sexual behavior with younger children, they feel accepted and safe, and emotionally connected (Ryan et al., 2010). They are more likely to target prepubescent relatives (Hunter et al., 2003) than those sexually abusive youth who fall more frequently into the conduct-disordered type.

In those with adolescence-limited conduct disorder and general delinquency, youth experiment with rule breaking, but discontinue as they mature and enjoy the inherent rewards of pro-social interactions (Moffitt, 1993). A smaller sub-group of these conduct disordered or delinquent youth are identified as life-course delinquent, and are more likely to have experienced physical abuse and domestic violence, and more likely to be hostile, antagonistic, aggressive toward females, whom they experience as rejecting or exploitive (Ryan et al., 2010). Like their
adult counterparts, life-course persistent delinquent youth tend to break rules and exploit others across a broad, diverse range of delinquency, both sexual and non-sexual.

Co-occurring psychiatric disorders such as ADHD, Post Traumatic Stress Disorder, and mood disorders have been associated with fifty percent and more of juvenile males who have committed a hands-on sexual offense (Cavanaugh, Pimenthal, & Pretsky, 2008). In a co-morbidity study of adult men with paraphilias and paraphilia-related disorders, Kafka and Hennen (2002) found 71.6% of their sample met diagnostic criteria for mood disorders and 35.8% met criteria for retrospectively diagnosed ADHD. These (ADHD) men reported a statistically significant elevation in hypersexual disorders, including frotteurism, fetishism, paraphilia NOS, compulsive masturbation and pornography dependence (Kafka & Hennen, 2002). The participants in this latter study were men who voluntarily sought help for paraphilias or paraphilia-related disorders. A comparison conducted by the authors found that when the DSM-IV (American Psychiatric Association, 2000) ADHD diagnosis was subdivided into its two subtypes, the combined (hyperactive-impulsive and inattentive) type was more closely related to multiple hypersexual disorders, conduct disorder, and persistent socially deviant sexual arousal (Kafka & Hennen, 2002).

While adolescent arousal has been described by researchers as fluid (Hunter et al., 2003; Ryan et al., 2010) pedophilic interests, or deviant arousal, may manifest in a very small percentage of both anti-social and non-antisocial youth. This smaller group shows an established or fixed pattern of deviant arousal, with non-antisocial adolescents in this group demonstrating a higher treatment effect than their antisocial counterparts (Ryan et al., 2010). Within the pedophilic type, sexual arousal is most highly fixed in those youth who target young boys, and
who engage in sexual penetration. Hunter et al. (2003) further suggest that this subtype is more highly correlated with early-onset pedophilia.

**Theoretical etiology of problem sexual behavior.** The voluminous research seeking to address the etiology of problem sexual behavior suggests multiple pathways to a set of behaviors that share in common the victimization of another person (in DP terms, equifinality). Costello and Angold (2006) discuss the epidemiological importance of conceptualizing the development of a behavior, because understanding a behavior’s origin and trajectory facilitates wholly inclusive intervention: both risk and behavioral expression change organically with development. Ward, Polaschek, and Beech (2006) describe the evolution of models and theories relating to problem sexual behavior, ranging from single-factor models (e.g. cognitive distortions and intimacy deficits); to multi-factorial theories such as Finkelhor’s precondition model, and the descriptive theories such as relapse prevention and self-regulation models. They also describe broadly cast treatment theories which are increasingly woven into existing treatment programs. These include the risk-need treatment model and strength based theories such as the good lives model, which derives from positive psychology (Ward et al., 2006).

The juvenile PSB field has been, until recently, searching for the ‘X’ factor, that elusive factor or pathway that explains all or most juvenile problem sexual behavior. Research has failed to uncover the ‘X’ factor, and adolescents with PSB are understood to be a heterogeneous population. The search for a juvenile PSB unifying theory has been similarly stalled.

Increasingly, leaders in the field of research and treatment of adolescent problem sexual behavior are urging a paradigm shift toward a developmental understanding of juvenile PSB (Letourneau & Miner, 2005; Rich, 2011). Rich urges flexibility to allow for incorporating idiographic factors within a structured developmental model (2011), while Letourneau and Miner
(2005) point to developmental literature which suggests greater treatment effect when youth are seen in their ecological context, involving caregivers, peers and school environment (2005). The strength of a theory which is comprehensive is its ability to be applied broadly, to accommodate the individual, and to inform cohesive interventions. The theory described next was developed as a conceptualization of adult sexual offending. The Integrated theory of sexual offending (Ward et al., 2006), appears to offer a developmental foundation on which both adults and juveniles with problem sexual behavior can be understood, and a foundation from which effective treatment programs can be built.

**Integrated theory of sexual offending (ITSO).** Ward et al., (2006) suggest a theory of sexual offending that emerges from the integration of three sets of continuously interacting factors: the biological, ecological and neuropsychological systems of the individual. This integrated theory of sexual offending (ITSO; Ward & Beech, 2006) takes into account many of the facets central to DP, and together these two complimentary theories will inform the outpatient developmental therapy presented later in the program design section of this work (See Figure 2 for a conceptual framework of the ITSO). It is important to note that ITSO was developed and is presented as a theory related to adult sexual offending, and has not been published as a theory specific to adolescent problem sexual behavior. The sexual offender research cited by Ward and Beech in support of their theories comes from the adult sexual offender literature, not from the literature reporting research with juveniles or adolescents. Literature in this field has seen the research pendulum swing from a time when sexual abusers of all ages were viewed and treated via adult models, to a time when the pendulum swung divergently for juveniles with problems sexual behavior. Recent research (Hunter et al., 2003; Kafka & Hennen, 2002) has sought intersecting pathways to elucidate etiology, inform
intervention, and plant seeds for prevention programming. Through its focus, ITSO's unifying theory presents an opportunity to address the broadest developmental spectrum of individuals with problem sexual behavior. ITSO is a theory specific to problem sexual behavior that fits very well with developmental psychopathology's broader perspective of human development.

Ward and Beech (2006) describe their ITSO as built upon the foundation of scientific theory, and drawn from current understandings in biology and ecology, the neurosciences, developmental psychopathology, and clinical work in the sex offender risk-assessment field.
Similar to DP and key to ITSO is the notion of a continuous interaction between biological, ecological (social and cultural environment, personal circumstance and physical environment), neuropsychological systems, and clinical symptomatology (Ward & Beech, 2006). Ward and Beech propose that problem sexual behavior “occurs through the ongoing confluence of distal and proximal factors that interact in a dynamic way” (p. 50). The authors submit that these interacting factors, importantly influenced by social elements, create the clinical symptoms found in those with problem sexual behavior (e.g., emotional problems, social difficulties, deviant sexual arousal, and cognitive distortions). Like Teicher (2002), Ward and Beech point to the importance of experience on neuropsychology. Ward and Beech use the systems theory concept of positive feedback loop and the cognitive-behavioral concept of positive reinforcement to describe the way in which the effects of sexually assaultive behavior impact psychological function and future behavior.

Sexual behaviors are reinforced through arousal and orgasm, during masturbatory fantasies, and during both consensual and non-consensual sexual acts. Deviancy is reinforced through repetition of the companion experiences: the emotional charge of the inherent secrecy, the fantasizing and planning, and the pursuit of the more intense experience and the cognitive distortions that support these behaviors. For the adolescent boy who commits sexual assault, “the perceived positive feelings of power and control combine with physical gratification to outweigh the potential negative consequences of the behavior” (Ryan, Lane, Davis, & Isaac, 1987). Ward and Beech (2006) suggest that ecological variables impact human behavior by influencing the development of neuropsychological systems, and by “activating vulnerabilities present in the individual” (p. 57). When the consequence of the behavior negatively impacts an individual’s ability to enjoy appropriate and supportive peer relationships, for example, the
problem sexual behavior may be repeated, becoming entrenched, in order to regulate the
discomfort of his emotional state, because “cultural factors interact with biological and
individual learning to create ecologies that support or discourage sexual offending” (Ward and
Beech, 2006, p. 57).

**Current treatment models for adolescents with problem sexual behavior.**

Survey-based research of treatment programs serving adolescents with problem sexual behavior
first was conducted by the Safer Society in 1986, as a way to provide referrals (nationally) to
those seeking treatment for children and adolescents (Burton, Smith-Darden & Frankel, 2006).
Referencing results of the 2002 Safer Society survey, Burton et al. (2006) reported that
nationally there were 726 community based treatment programs for adolescents, and 131
residential programs for the same population. However, it is important to note that 64% of those
counted as community based treatment programs, were individual treatment providers working
individually with male adolescents. Given the opportunity to rank-order their program theory,
the vast majority (76%-84%) reported some form of cognitive-behavioral therapy (Burton et al.,
2006). Community based programs report an average of 4 group sessions per month, 2.7
individual sessions per month, and 1 family session per month (Burton, et al., 2006). Residential
programs provide on average 20 group sessions per month, 5 individual sessions per month, and
1.5 family sessions per month. The remainder of the present section will focus exclusively on
community-based programs.

Community-based treatment for adolescents with PSB typically includes group and
family therapies with supplemental individual treatment when indicated. The heterogeneity of
the target population leads programs to provide services geared in intensity to the individual risk
of the adolescent (Page & Murphy, 2007). While each program draws material from varying
resources, Phil Rich (2003) identities 20 "ideal outcomes of sexual-offender-specific treatment" with adolescents:

1. Appropriate boundaries
2. Awareness of others
3. Emotional regulation
4. Engagement and attachment
5. Enhanced support network
6. Healthy sexual development
7. Increased responsibility
8. Improved family functioning
9. Impulse deferment
10. Internalized behavioral control
11. Moral development
12. Prosocial attitudes
13. Prosocial behaviors
14. Remission of psychiatric comorbidity
15. Resolution of sexual deviancy
16. Retention and transfer of skills
17. Self esteem
18. Skill enhancement
19. Social competency
20. Tolerance for emotional distress. (pp. 444-445)
Community programs responding to the 2002 Safer Society survey reported supplementing their core group/family/individual therapy with psycho-educational classes in the following areas: communication skills (87%); dating skills (85.6%); intimacy/relationship skills (85.6%); assertiveness training (84.7%); conflict resolution (83.9%); positive/pro-social sexuality (83.1%); values clarification (81%) frustration tolerance/impulse control (78.0%); sexually transmitted diseases (76.3%); sex role stereotyping, sexual lifestyles, etc. (72.0%); and sexual attitude reassessment (19.5%) (Burton, et al., 2006). The National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online registry through the U. S. Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA). The website (http://www.nrepp.samhsa.gov/AboutNREPP) provides a list and description of empirically supported mental health and substance abuse interventions, with reviews, links to research, ratings and estimates of cost associated with each program. Two of these programs, Multisystemic Therapy for Youth with Problem Sexual Behavior (MST-PSB), and Brief Strategic Family Therapy (BSFT), are noted to offer services to teens with some level of PSB. BSFT targets adolescent behavior problems including drug use, aggressive and violent behavior, conduct problems, sexually risky behavior, and others. BSFT assumes that adolescent problem behaviors stem from maladaptive family interactions, including permeable boundaries. Over the course of 8 to 24 family sessions, the BSFT clinician seeks to transform the family functions, fostering adaptive interactions, and thereby improving the adolescent’s behavior. BSFT lacks the comprehensive, in-depth services that an adolescent with PSB is likely to require.

MST-PSB, an adaptation of Multisystemic Therapy (MST), specifically targets youth who have committed sexual offenses and who have related problem behaviors. MST is lodged
in the assumption that individual youth characteristics, family characteristics, peer relations, school factors, and characteristics of neighborhood and community interplay to result in antisocial, or problem behavior (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). Theoretically rooted in the works of general systems theory (von Bertalanffy) and the theory of social ecology (Bronfenbrenner), MST encompasses nine treatment principles:

1. The primary purpose of assessment is to understand the fit between the identified problems and their broader systemic context.

2. Therapeutic contacts emphasize the positive and use systemic strengths as levers of change.

3. Interventions are designed to promote responsible behavior and decrease irresponsible behavior among family members.

4. Interventions are present focused and action oriented, targeting specific and well-defined problems.

5. Interventions target sequences of behavior within and between multiple systems that maintain the identified problems.

6. Interventions are developmentally appropriate and fit the developmental needs of the youth.

7. Interventions are designed to require daily or weekly effort by family members.

8. Intervention effectiveness is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.

9. Interventions are designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts. (Henggeler et al., 1998, p.23)
Because it seeks to alter the social ecology of the adolescent, MST requires intensive in-home service, with 7-days per week contact via face-to-face meetings or telephone calls. Families receiving MST treatment generally work with a team of therapists who share responsibility for service delivery (Henggler et al., 1998). MST-PSB therapists typically provide five to seven months of treatment to three to five families (NREPP). MST-PSB provides family and individual services, with a focus on the systemic dynamics of the family; MST-PSB does not provide group experiences for either the adolescent or the parents.

The next chapter will describe in detail the program design for the New Connections program, an outpatient, community-based treatment program for male adolescents with problem sexual behavior. The program is theoretically rooted in the discipline of developmental psychopathology, and importantly informed by existing and emerging research in the fields of neurodevelopment (developmental neuroscience) and problem sexual behavior. In addition to impacting the risk for recidivism, this treatment program will seek to provide teens with the tools to heal wounds, and to promote growth, consolidation, competency, and opportunities to re-direct, improve their developmental trajectories.
Chapter 3: Program Design

This chapter presents in detail the design for a community-based program encompassing individual, family and group treatment for forty male adolescents adjudicated for sexual offense(s). The program, hereafter referred to as New Connections, emerges from an integration of the literature in the fields of developmental psychopathology, systems theory, adolescent development, and from the research related to sexual offense recidivism and treatment of youth who have exhibited problem sexual behavior. This chapter describes the mission, structure and evaluation of New Connections.

Mission

New Connections seeks to reduce the risk of sexual offense recidivism, thereby reducing the incidence of sexual assault, by providing developmentally sensitive, theoretically integrated comprehensive treatment services to adjudicated adolescents who have committed one or more sexual offense. The program enhances a broad spectrum of personal awareness facilitating meaningful changes in individual behavior, family function, relationships with others, and community safety.

Vision. Rooted in the discipline of developmental psychopathology, aligned with an application of the Ward and Beech Integrated Theory of Sexual Offending, New Connections seeks to address the individual needs of adjudicated teens, positively impacting their developmental trajectories toward their fullest potentials. New Connections recognizes that complex transactions between multiple factors, including genetic, biological, and psychosocial processes, interact with environment and circumstance, manifesting in behaviors that may be positive or negative. The latter will be generally understood as risk-related behaviors.
New Connections seeks to provide intensive, integrated, community-based individual, family, and group therapies, thereby maintaining adolescents in their homes, schools, and peer environments, while engaging them in a level of care not typically found in community based treatment programs. The program goal is to reduce the risk for sexual offense recidivism through understanding and addressing maladaptive behaviors, increasing the adolescent’s multiple developmental competencies, strengthening their family systems and supporting the development of meaningful, positive peer interactions. New Connections differs from residential programs by providing community-based services, allowing the adolescents to remain in the home (or nearby, if the victim resides in the home); and differs from MST in that New Connections provides a range of treatment modalities over the course of each week, with in-home interventions confined to two hours of face-to-face individual and family therapy. New Connections’ allocation of resources targets individual, family and psychoeducational group treatment, conserving resources to provide treatment to a larger caseload with minimal staffing in multiple modalities.

Sharing the DP and ITSO underpinnings of New Connections, the interpersonal relationship of the adolescent with his therapist will provide a foundation to support client honesty with self, openness with therapist, and commitment to change. The relationship between therapist, client, and family will serve as an ongoing measure of interpersonal skills and dynamics, and as an enduring model for healthy, trusted relationships.

**Stakeholders.** New Connections is designed specifically to serve adolescent males who have been adjudicated for a sexual offense, and who are mandated to treatment and referred through the State of Connecticut Judicial Branch, Court Support Services Division (Offices of Juvenile or Adult Probation). As the primary funder, the State of Connecticut, Court Support
Services Division (CSSD) is a primary stakeholder. By extension, the public is a stakeholder, in particular those communities in which these youth reside, go to school, recreate and work. The New Connections Advisory Board, comprised of professionals in the fields of psychology, social work, education, and community members represents another stakeholder, as they seek to inform and be informed, and to advocate for the best interests of New Connections’ clients. The victims and survivors of perpetrated sexual offenses are stakeholders also, with the expectation that their offenders will come to recognize the harm inflicted, and with hope that New Connections clients will not commit future sexual offenses. The collaborative partners of New Connections are stakeholders, joining together to provide a constellation of services targeting meaningful and lasting changes for the clients and their families. Finally, New Connections’ clients, the youth and their families, are central stakeholders; they trust the care they receive will be effective in helping them to gain insight regarding the needs or factors that lead to the behavior, and to meaningfully, comprehensively address those factors to reduce the risk of future harm to others and self.

Program Structure

New Connections will contract with CSSD to provide 40 clients and their families with a comprehensive intake assessment, five hours of weekly therapy, and any necessary related case management services. The intake assessment will include developmental, psychosocial and psychosocial interviews; and administration of multiple psychological and risk assessment instruments. On a weekly basis, New Connections will provide 200 hours of face-to-face therapy, in addition to assessment and case management services. Details of the structure are delineated below, and the New Connections start up budget is presented in Appendix B.
New Connections will serve male youth ranging in age from 13 to 17 years. As referenced earlier, adolescent sexual offending peaks by age 14, and so it is anticipated that there will be more clients in the 13 to 15 year age range than there are older teens. Statistically, juveniles arrested for sexual offenses more likely to be Caucasian (Rich, 2011). Most youth with PSB have no arrests prior to the sexual offense, although often had prior sexual assault victims and undetected offenses (Ryan, Leversee & Lane, 2010). Ethnic, religious, and socioeconomic status is likely to reflect the general population, and although approximately 70% of these youth will be residing in two-parent homes at the time of their arrests, more than half will report some type of parental loss (divorce/separation, death, illness, etc.) (Ryan, Leversee & Lane, 2010).

**Settings.** New Connections is intended as a community-based program that provides assessment and treatment services statewide, with a leased office space centrally located in Middletown, Connecticut (see Appendix C for the proposed floor plan). Considerations for the office location and space included accessibility to expressways and public transportation; accessibility for clients and staff with physical disabilities; a locked, dedicated file room; a group meeting space large enough for experiential activities; a shared office for staff therapists that would function as a second group room for parent groups; a private office for the psychologist program director to conduct individual clinical supervision and psychological assessment; a centrally located work space for the administrative assistant/office manager and the client/visitor waiting area; an accessible lavatory and a staff kitchen.

Weekly group therapy sessions for adolescents and their parents/guardians are conducted in the Middletown offices two days per week. Parenting groups meet concurrently with the teen groups, to ease the travel burden on the families.
Family and individual therapy is provided in client residences after school and into the evenings, with as many family members participating as is both appropriate and possible. Participation by the client and his parent/s or guardian/s is essential, and every effort is made to meet the family scheduling needs. It is expected that a common area in the home is available for the meetings, and it is also important that the staff therapist is given accompanied access to other parts of the home in order to conduct as-needed safety assessments of the home.

**Staffing.** New Connections will employ one full-time Psychologist/Program Director; four full-time Masters level therapists (including two Spanish-English bilingual therapists) trained to work with adolescents with problem sexual behavior; and two full-time pre-doctoral Interns. A half-time Office Manager/Administrative Assistant will maintain records and provide administrative support as assigned.

The Psychologist/Program Director will carry responsibility for administration of the grant, supervision of all required services, including clinical, supervision, and internal program evaluation tasks. The Program Director will supervise and participate in administration of all assessment services. Clinical supervision hours with staff and interns total nine hours weekly. The Program Director will coordinate ongoing internal program evaluation through the use of pre- and post-testing (BASC-2) and satisfaction surveys completed by clients, their families, and their probation officers. The Program Director will provide training opportunities for staff and the referral agents, and will be responsible for collaboration with funding and related agencies.

Each of the four therapists will carry a caseload of nine clients, conducting comprehensive intake assessment for each client, and weekly providing nine hours of individual therapy, nine hours of family therapy, and one-and-a-half to three hours of group therapy (see Appendix D for an example staff therapist schedule). Staff therapists will provide weekly
progress notes to the supervising probation officer, and will provide other case management services as needed, including but not limited to risk-related conferences with appropriate school personnel and case consultations with other providers working with the clients, including psychiatric or psychological service providers and child protective service personnel. For older teens, case management may include skills for independent living, enhancing competency by preparation and pursuit of employment, and related activities. Each staff therapist will participate in one hour of individual clinical supervision weekly, and the entire clinical staff will meet weekly for two hours of supervision and training. The weekly group supervision and training provides structured time for case-specific and client-general supervision; and for monthly training specific to emerging research and skills-training for staff therapists.

The pre-doctoral Interns will each carry individual caseloads of two clients (and their families); will each co-facilitate two family sessions weekly with other staff therapists, and will each co-facilitate four groups. The Program Director will be responsible for oversight of the psychological testing administered to each entering adolescent. The Interns will each be assigned four psychological evaluations and a minimum of four risk assessments during the training year. Interns will participate in four hours of supervision weekly, including one hour of individual clinical supervision, one hour of assessment-specific supervision and two hours of weekly group supervision. The psychology interns will participate in the internal program evaluation through data collection and tabulation, and will participate in drafting that section of the fiscal year-end report to CSSD (see Appendix G for an outline of the psychology intern range of responsibilities, training and supervision opportunities).

**Referral agent (CSSD).** At the conclusion of the adjudication process, a youth who has been found guilty of a sexual offense in Connecticut may be in the legal and physical custody of
child protective services (CPS), and through that agency placed in a residential treatment center outside of the state, or placed in the Connecticut Juvenile Training School for boys. Alternatively, the youth may be placed on probation, either with or without CPS involvement. Lesser alternatives following adjudication include conditional discharge or having the case dismissed with a warning. However, most convicted youth in Connecticut are placed on probation, with conditions that include any appropriate treatment for problem behaviors, substance use, mental health, medical, and learning or education problems (Office of Policy and Management).

**Referral information.** Probation officers will refer youth who have committed a sexual offense to New Connections for an assessment, to determine what treatment is needed. Referrals from CSSD typically include a police report that includes the complaint narrative, victim and witness statements, any statement made to investigating officers by the client, and a statement of the charges pursued by police. Charges first pursued often vary from the adjudicated charges. Additionally, the referral will include any pre-sentence investigation report submitted to the court by the assigned probation officer, and reports related to client interactions with community supervision prior to the current referral. Documentation related to the juvenile justice system process, including adjudication details, will accompany a record of the client’s criminal history. Finally, conditions of probation will specify with what activities and restrictions the youth need comply in order to remain in the community.

**Screening.** In response to the referral, the program director will provide an initial screening of the provided documentation, to determine whether the case is appropriate for New Connections’ assessment and treatment services. Exclusion from services would be considered for adolescents with a documented I.Q. below 70, for those who are actively using alcohol or
illicit substances, or for those teens whose reality testing is impaired and not responsive to psychotropic medication. Exclusion from treatment with New Connections would also be likely for adolescents whose access to the identified victim has not been adequately prohibited by CSSD, and for adolescents who have a recent attempt or imminent intention to harm themselves. Those initially excluded because of victim access or risk for self-harm could be referred again once these concerns have been adequately addressed. Those referred adolescents who appear appropriate for the New Connections program will be assigned to a clinical staff member for assessment.

Assessment. Receipt of the referral documentation is the assigned therapists’ first contact with the adolescents’ stories. Following a thorough review of the juvenile justice system documentation, the staff therapist contacts the parents or guardians, arranging to acquire collateral documentation (evaluations and records) in order to provide a sound and broad framework within which the New Connections assessment will be lodged. Only after all available documentation has been received, reviewed, and documented will the New Connections staff meet with the client and his family.

For each adolescent whose referral to the program is appropriate, New Connections will conduct and report to the probation officer a comprehensive, developmentally sensitive evaluation that relies on a broad spectrum of information gathered through a review of records, multiple interviews, and an integrated assessment protocol.

Collateral documentation. The assigned New Connections therapist will seek to know as much as possible about the adolescent’s developmental, medical, psychological, substance abuse, social, familial, educational and trauma history before first meeting him. This holistic approach to preparation permits the therapist to have a sense of the client’s strengths and
vulnerabilities, facilitating interactions in which the client senses that he is understood, even at a time in his life when he is far from understanding himself. In addition to the juvenile justice-related documentation listed in the preceding paragraph, the following records are gathered, in cooperation with the youth's parents and via signed releases, prior to conducting initial interviews:

- School records, including report cards, attendance records, Individual Education Plans, psychological evaluations and/or behavior observation records, behavioral incident reports and any records of suspensions or expulsions, and results of standardized testing. Records related to group or individual therapy provided by school psychologists and social workers should be sought. These records should include the youth's entire school history, in order to integrate with the developmental history of the client.

- Medical records, including records of primary care and specialist physicians. These records will contribute to the holistic developmental understanding of the client, and may provide information relative to trauma or abuse suspicions or history.

- Previous Evaluations and treatment records, including psychological evaluations/records and educational evaluations conducted outside of school, evaluations conducted within the context of individual, family and marriage therapy and/or treatment records from the same, evaluations conducted after the offense behavior, and any evaluations conducted by the Department of Children and Families, if accessible.

**Clinical interviews.** Choosing the order in which to conduct interviews with parents or guardians ("parents" will be used from this point forward for literary ease) and the adolescent clients may, for some clinicians, be a matter of stylistic preference, but New Connections will routinely interview parents first, in recognition of their role as protector and legal guardian. If an
unusual circumstance presents, the staff therapist will consult with the Program Director to
determine an adjustment to this approach. The parents of adjudicated youth are likely to feel
exhausted, ashamed, and/or culpable (Ryan et al., 2012). This may be particularly true if the
victim is one of their own children, or otherwise related. As described in the first chapter of this
work, adolescents account for nearly half of all sexual assaults of children under age six, and the
victim is likely to be related or known to him prior to the offending behavior. When the victim is
a sibling or step-sibling, or other relative, the shame and culpability felt by parents is likely to
play a dynamic role during the first interviews, and throughout treatment. Sensitivity to these
dynamic processes will enhance cooperation and rapport, thereby improving treatment outcome.

Assessment of the adolescent’s development is achieved through separate interviews with
the parents and with the adolescent. Strayhorn’s (1988) model identified nine broad areas of
functioning related to developmental competence:

1. Closeness, trust, relationship building
2. Handling separation and independence
3. Handling joint decisions and interpersonal conflict
4. Dealing with frustration and unfavorable events
5. Celebrating good things, feeling pleasure
6. Working for delayed gratification
7. Relaxing, playing
8. Cognitive processing through words, symbols, images
9. An adaptive sense of direction and purpose

**Parent/Guardian Interview.** A thorough developmental history of a child begins with
the parental history, including history of victimization (and outcome), history of the courtship,
marriage, domestic violence or other significant stressors in the marriage. Significant events around the births of other children, caretakers (related and non-related) upon whom the parents relied, losses that resulted in physical or emotional absence of a parent from the home and from the client are all importantly queried.

The developmental history continues with exploration of the prenatal, perinatal and early childhood periods of the client’s story. Exposure to environmental insults during any of these sensitive periods of development can manifest in neurobiological changes that can impact a child’s interaction with his environment (Siegel, 1999; Teicher et al., 2006; van der Kolk, 1996). Maternal malnutrition or consumption of alcohol or other substances during pregnancy, fetal distress during birth, complications related to prematurity, and early medical issues are all importantly discussed during this interview. Careful observation of the way in which parents discuss these events can provide useful information regarding temperament, parental relationship, and worldview. Do parents talk about the birth of client or his entry to the family in a way that suggests the child and the timing were both regarded as a ‘good fit’ for the family?

Parenting styles differ widely, and assessing the parenting style is important, including the physical and emotional bonding, beginning from birth and extending to adolescence. How did individual temperaments of child and parents impact the nurturing and consistency of the parenting? If there are multiple children in the family, discussion of how these developmental experiences may differ for each child might provide useful information, and this is especially true if the victim is a sibling or step-sibling.

Careful queries regarding the client’s attainment of developmental milestones are critical to the parental interview. While the list of milestones is long, it is important to address language acquisition, toilet training, expression of concern or affection for friends, awareness of gender,
knowing the difference between what was real and what was make believe, agreeing with rules, playing cooperatively and taking turns with others are some important questions for the period prior to age six. These questions lead naturally into questions regarding social development, as earlier delays may impact interpersonal relationships. Inquiring about the client’s lifetime social development, regarding peers, parents and caretakers, and other significant adults (clergy, coaches, teachers) as well as observations of the client’s interactions with younger children will all provide essential information regarding the possibility of impaired interpersonal relationships. As noted previously, psychosocial deficits are commonly found in youth with problem sexual behavior. Beginning to identify this during early intervention points will provide useful information for both assessment and treatment planning.

The developmental history should include queries regarding family functioning, expression of affect and affection, influences of culture and religion on the family system and its interactions with others. The history will include exploration of family’s psychiatric history, family secrets, attitudes toward modesty and sexual behavior generally. How and when did the client learn about sexuality and sexually intimate relationships? It is important to ask a variety of sexually related behaviors that may have manifest from pre-school years forward. These behaviors include interest in sex and sexuality expressed through storytelling, play, physical proximity to others, self-touch, imposing interest in seeing others, or being themselves seen naked, bladder or bowel control problems, frank communication about wanting to be sexual with other children, pattern of violating the physical privacy of others, noticeable erections while in public, and articulation of distorted sexual attitudes (Friedrich, 2007; Leversee, 2010). If the client has had exposure to pornography or sexually inappropriate media, the timing and circumstance is importantly queried. Similarly, it is important to know the extent to which the
parents are aware of the client’s sexuality and sexual behavior, how the parents first became
aware of the client’s problem sexual behavior, and how this information was first addressed.
Finally, exploring the larger family system’s knowledge of the problem sexual behavior,
adjudication and treatment requirement is inquired before ascertaining the extent to which the
extended family might be supportive and involved or unsupportive and disengaged with the
client’s New Connections treatment.

*Individual adolescent interview.* With the records review completed and the
developmental history acquired from parents, the New Connections therapist will next interview
the adolescent client. While the strategies for interviewing youth with problem sexual behavior
represent general good practice (estabishing rapport, being respectful, employing open-ended
questions and reframing statements, etc.), the nature of the reason for the meeting, the *what
brought you here to meet with me?* is powerfully difficult for most young men (Ryan et al.,
2010). While some adolescent boys might present as recalcitrant during a substance abuse
evaluation after being arrested for drinking beer on a public beach, clients like Carlo (presented
earlier as a case vignette), who at 15 put his hand down the shorts of his 9-year-old babysitting
charge, fondling her in the dark closet, present more typically with shame and embarrassment.
The therapist here will be prepared for the embarrassment and for working with the multiple ego
defense mechanisms as they present themselves. The therapist will provide an environment in
which the youth feels safe telling his story, describing his behaviors, and exclaiming his utter
bewilderment with regard to his own question: Why?

*Adolescent’s sexual history interview.* The adolescent’s sense of being understood and
being perceived as a whole person, not simply seen with a *sexual offender* label is a powerful
force in the therapeutic relationship. This was effectively described by Robert McGrath in 1990:
Underneath his defenses of denial and minimization are often feelings of shame, confusion, and inadequacy. It is unlikely that he as ever encountered someone he feels could understand his deviant urges and behaviors. The evaluator who can communicate understanding about the offender’s private sexual life is therefore in a powerful position to create an atmosphere in which the offender can discuss his problem. The goal of this portion of the interview is to let the offender know that he is not alone and that the evaluator is knowledgeable about his experience. (p. 511)

Inquiring about sexual knowledge, sexual interests, and sexual history is only approached after a comfort level has been built, and the therapist has had an opportunity to integrate the client’s expressed thoughts and feelings about other facets of the his development, notably his experience with relationships (parents, family, friends, peers, others), with his education, and his developmental and current levels of competence. The New Connections therapist will approach the sexual history facet of the client interview with a focus on details associated with empirically-based variables related to the risk for juvenile sexual offense recidivism. Working and Langstrom (2006) noted that there is empirical support for the following sexual recidivism risk factors: number of victims, pre-pubescent male or female victims and/or violence or aggression involved in sexual offenses (deviant sexual interest), sexual offense recidivism, social isolation, and the absence of completed treatment for problem sexual behavior (see Appendix F for the fuller, current list of empirically-related risk factors used to code two juvenile sexual offense risk instruments). Working together, the therapist and client will build an initial timeline related to sexual development, thoughts, and experiences. The information gathered will be used not just to inform the estimated risk for re-offense, but will importantly inform the work that lies ahead in treatment.
Amenability and responsivity. While the CSSD-referred adolescents are required to participate in treatment as a condition of their community supervision, New Connections' therapists will assess the youth and families with regard to their ability, interest, readiness, and motivation to participate in the treatment program. Assessment of physical, language, cognitive, and mental health capacities to fully participate either without, or with any noted required supports will be followed by consideration of the families' beliefs and perceptions of the problem sexual behavior. While some youth and their families experience the problem behavior as uncharacteristic, others may completely deny or significantly minimize the behavior. It is important in this assessment to identify strengths and vulnerabilities of the client, his family members, and the family system as a whole. Together, these factors inform decisions regarding safety and the level of supervision recommendation made to CSSD, as well as the approach to treatment planning for each client generally.

Psychometric assessment. A battery of standardized, psychological and psychosocial assessment instruments can provide information related to the personality, cognitive, behavioral and social functioning of the client. In cases where this or related testing has been recently completed, the results would be sought, and the testing not duplicated. The information garnered from these tests will be woven into the full evaluation, a document that informs treatment planning, including any necessary referrals to collateral services. The instruments listed below represent the core assessment battery for New Connections clients.

Minnesota Multiphasic Personality Inventory – Adolescent Version. The MMPI-A (Butcher et al., 1992) was first developed as an adolescent version of the MMPI-2, and was revised in 2006. It assesses personality and psychopathology in youth ages 14 – 18, through 478 true/false items. It is written at a fourth grade level. The MMPI-A is generally noted to be a
strong measure benefitting from the long empirical history of the MMPI. The MMPI-A normative sample (N=1620) is noted as especially diverse while the clinical sample (N=703) is noted to be less so, with the entire sample found in Minnesota settings, and most participating in substance abuse treatment (Claiborn, 1995). The MMPI-A has 69 scales in total, including 7 validity scales; 10 clinical scales (1-week test-retest reliability estimates of .65 to .84; internal consistency reliability coefficients range broadly from .40 to .91). Forty alpha coefficients are reported for the clinical scales, by gender and by normative and clinical samples, results ranging from .35 to .91 (Claiborn, 1995). The MMPI-A Clinical Scale includes Hypochondriasis, Depression, Hysteria, Psychopathic Deviate, Masculinity-Femininity, Paranoia, Psychasthenia, Schizophrenia, and Hypomania. The MMPI-A also has 28 Harris-Lingoes Subscales, including, among others, Subjective Depression, Psychomotor Retardation, Mental Dullness, Brooding, Need for Affection, Inhibition of Aggression, Familial Discord, Authority Problems, Social Alienation; the 3 Si Subscales, Shyness/Self-Consciousness, Social Avoidance and Alienation; and 15 Adolescent Content Scales, for example, Anxiety, Obsessiveness, Depression, Anger, Low Self-Esteem, and Negative Treatment Indicators; and 6 Supplementary Scales, including Repression, Alcohol/Drug Problem Proneness, and Immaturity (Butcher et al., 1992).

The MMPI-A will be administered to New Connections clients during the assessment phase in order to significantly inform and thereby enhance both treatment planning and therapeutic rapport, and to identify strengths and vulnerabilities that may inform referrals to collateral services. Identification and active consideration of strengths, vulnerabilities, personality, and interpersonal style early in the assessment phase fosters therapeutic rapport and facilitates efficient treatment targets, promoting the opportunity for earlier learning and change.
New Connections will purchase and use as appropriate the MMPI-A English, Spanish and Audio versions will be purchased to increase the accessibility to clients. The audio version of the MMPI-A is useful with clients who have specific learning or reading difficulties, or those with visual impairment.

**Millon Adolescent Clinical Inventory.** The MACI is intended to assess the adolescent’s personality, self-reported concerns and clinical syndromes (Millon, Millon, & Davis, 1993). The MACI would be employed only for those New Connections clients for whom the MMPI-A is not possible, notably due to age. It is importantly noted that the MACI normative sample (N=1,017) was made up entirely of teens identified as ‘patients’ and so the instrument is not appropriate for the assessment of adolescents from the general population. The MACI is intended for youth ages 13 - 19, and is written at a sixth grade level. The 27 scales include Personality Patterns, (such as Introversive, Submissive, Dramatizing, Egotistic, Unruly, Forceful, Self-Demeaning, and Borderline Tendency); Expressed Concerns (Identity Diffusion, Self-Devaluation, Sexual Discomfort, Peer Insecurity, Family Discord, and Childhood Abuse); and Clinical Syndromes such as Substance-Abuse Proneness, Delinquent Predisposition, Impulsive Propensity and Suicidal Tendency). The MACI has three Modifying (response bias) Indices, including Disclosure, Desirability, and Debasement). Cronbach alpha reliability ranges from .73 to .91, with most internal consistencies in the .80’s. The MACI has 160 items, which are keyed 923 times across 30 scales, or on average, each item is keyed on 5.7 scales. While the reliance on relatively few total items to inform 30 scales contributes to the brevity of the instrument, a few items carelessly answered can significantly impact a profile (Retzlaff, 1995).

The MACI, like the MMPI-A, will be purchased and utilized in the English, Spanish and Audio versions to maximize accessibility to referred clients.
Wechsler Intelligence Scale for Children – Fourth Edition. The WISC-IV (Wechsler, 2003) is designed to assess the cognitive ability of children ages 6 – 16, including assessment for the presence of learning disabilities and attention-related disorders. The WISC-IV provides four Index scores (Verbal Comprehension Index, Perceptual Reasoning Index, Working Memory Index, and Processing Speed Index) and a Full Scale IQ score. The scores are derived from 10 core and 5 supplemental subtests. The WISC-IV includes seven Process scores for use with qualitative interpretation, but not used in composite scores. The normative sample for 14 of the WISC-IV subtests (N=2,200) was representative of the U. S. population in March 2000, in terms of age, gender, race ethnicity and parent education level. The sample represented four geographical regions. The Arithmetic subtest was reported to have a sample size of 1,100. Internal consistency was revealed for all 15 subtests, Process scores and Composite scales, using the split-half method with Spearman-Brown correction. Average coefficients for core subtests ranged from .79 to .90 and for supplemental subtests .79 to .88. The Full Scale IQ reliability coefficients exceeded .96 across all ages. Test-retest reliability was measured on average over a month period of time, rendering score stability (subtest coefficients ranging from .70’s to .95). Convergent and discriminant validity is noted in the moderate to high range when the WISC-IV sample scores were correlated with the WISC-III, the Wechsler Individual Achievement Test – Second Edition, and the Children’s Memory Scale.

The WISC-IV will be administered to New Connections clients who have a history of learning or attention difficulties, or who appear to process information atypically. Each of these cognitive issues can impact treatment success, school achievement, self-esteem, and the experience of interpersonal relationships. The approach to treatment can be modified to meet the individual needs of clients, enhancing success.
The WISC-IV will be available in both English and Spanish versions, to best meet the needs of referred clients. Additionally, for older adolescents, the WAIS-IV will be purchased and available. The WAIS-IV is not yet available in a Spanish version. The EIWA-III is the Spanish version of WAIS-III. This instrument will be available to Spanish speaking adolescents over the age of 16 years, 11 months.

*Trauma Symptom Checklist for Children (TSCC).* The TSCC (Briere, 1996) is a 54-item self-report measure for children ages 8 – 16 (with normative adjustments for youth age 17). The TSCC was developed as a psychological assessment of symptomatology related to childhood trauma, including physical and sexual assault. The scale also indexes traumatic effects of neglect, experienced and witnessed interpersonal violence, and trauma associated with natural disasters and major accidents. The TSCC consists of two validity scales (Underresponse and Hyperresponse), and six clinical scales (Anxiety, Depression, Anger, Posttraumatic Stress, Dissociation, and Sexual Concern). The Dissociation scale has subscales for both fantasy and overt dissociation, while the Sexual Concerns scale has subscales for sexual preoccupation and sexual distress. A four-point Likert scale ranging from 0 (never) to 3 (almost all of the time) is used by subjects to rate the frequency of occurrence for each symptom. Standardization of the TSCC was based on three non-clinical samples (N>3,000), across inner-city, urban and suburban settings. Of the normative sample, 47% were male, 44% were Caucasian, 27% were African American and 22% were Hispanic. Multivariate analysis of variance (MANOVA) revealed significant effects for age and gender, resulting in separate norm tables for males and females grouped by ages 8 to 12 and 13 to 16. Cronbach alpha coefficients for the TSCC scales and subscales in the standardization sample ranged from .58 to .89; Mean alpha .84 (Boyle & Viswesvaran, 2003).
The TSCC is used with New Connections clients to assess whether behaviors and difficulties revealed through other instruments may be tied directly or in part to a traumatic experience not previously identified. The use of this more defined instrument is appropriate with New Connections clients because of the research that points to the role of experienced or witnessed trauma as an exogenous developmental factor in the etiology of problem sexual behavior (Ryan, Hunter, & Murrie, 2012).

The TSCC is not available in a Spanish version. The Spanish-speaking therapists can facilitate the administration with Spanish speaking clients.

**Behavior Assessment System for Children – Second Edition (BASC-2).** The BASC-2 (Reynolds & Kamphaus, 2004) is described by the developers as a multi-method and multi-dimensional instrument assessing both the observable and the self-perceptions of young people aged 12 – 25 years. The BASC-2 assesses both positive (adaptive) and negative (clinical) behaviors through five components: a student Self-Report of Personality (SRP), a Parent Rating Scale (PRS), a Teacher Rating Scale (TRS), a Structured Developmental History (SDH) and a Student Observation System (SOS). The SRP provides a structured framework within which the child assesses his or her emotions and self-perceptions of behavior. The adolescent version of this form is intended for use with teens aged 12 to 21, and is written at a third grade level. The SRP includes scales for Anxiety, Attention Problems, Attitude to school, Attitude to Teachers, Atypicality, Depression, Hyperactivity, Interpersonal Relations, Locus of Control, Relations with Parents, Self Esteem, Self-Reliance, Sense of Inadequacy, Social Stress and Somatization. The PRS includes scales for Activities of Daily Living, Adaptability, Aggression, Anxiety, Attention Problems, Atypicality, Conduct Problems, Depression, Functional Communication, Hypcractivity, Leadership, Learning Problems, Social Skills, Somatization, Study Skills, and
Withdrawal. Both the SRP and the PRS employ 4-point Likert scales, with the SRP additionally employing a True/False response section. The SRP for youth aged 12 to 21 years has 176 items. Internal consistency coefficients for the TRS composite scores fall in the low to mid .90’s, and in the mid to high .80’s for the SRP composites. PRS composite scores likewise fall in the .80’s to .90’s. Test-retest reliabilities were based on a median span of approximately six weeks for both the TRS and PRS, and on a three-week span for the SRP. SRP composite score test-retest reliabilities yielded results in the upper .70’s to low .80’s. TRS test-retest reliabilities ranged from .64 to .90. PRS test-retest reliabilities ranged from .78 to .92. Median adjusted intrarater reliabilities for the TRS (adolescent group) were .53 and .77 for the PRS. Concurrent validity of the TRS and PRS was strongest for the Externalizing Problems composites, and overall comparison revealed moderate to high correlations with both the Achenbach System of Empirically Based Assessment (ASEBA; Achenbach & Rescorla, 2001) and the Conners’ Teacher/Parent Rating Scales (CTRS-R, CPRS-R; Conners, 1997).

New Connections will purchase and use, as appropriate, the English, Spanish and Audio versions of the BASC-2 to address the specific language or learning needs of referred clients.

Use of the BASC-2 with all New Connections clients, parents and teachers is an essential facet of the assessment phase of treatment, providing information specifically around observable behaviors and perceived experience and highlighting notable vulnerabilities and resiliencies. The BASC-2 is accessible to wide age range, has lengthy and reliable competence scales, and is closely linked to the DSM-IV definitions of behavioral disorders. Used in tandem with the MMPI-A, the TSCC, and the WISC-IV, the BASC-2 will support a clinical profile with multi-dimensional confirmatory data to strengthen the development of the treatment plan.
The Juvenile Sex Offender Assessment Protocol – II. The J-SOAP-II (Prentky & Righthand, 2003) is a 28-item, four-scale checklist for boys aged 12 to 18 who have been adjudicated for a sexual offense. The authors note it is an experimental scale, with data collection samples and research still very active. The J-SOAP-II assesses both sexual and non-sexual recidivism. The four scales include: Sexual Drive/Preoccupation; Impulsive/Antisocial Behavior; Intervention; and Community Stability/Adjustment. The authors report a construction/validation sample of 96 juvenile sexual offenders who ranged in age from 9 to 20 (average age was 14). Follow up data at 12 months was obtained on 75 of the sample, and revealed an overall recidivism rate of 11% (sexual and non-sexual). Two clinicians independently coded the protocols using documentation only. Inter-rater reliability (IRR) ranged .75 to .91 for all items expect Caregiver Instability, which the authors report had an IRR of .59. The authors note the item has since been amended. The Clinical/Treatment scale demonstrated an internal consistency of .85, the other scales had alphas ranging from .68 to .73 (Prentky & Righthand, 2003).

While much of the J-SOAP-II research conducted does not appear to support the instrument’s ability to meaningfully predict sexual offense recidivism (Murrie, 2012), Martinez, Flores and Rosenfeld (2007) found predictive values for general reoffending, AUC = .76, and sexual reoffending, AUC = .78. In this study, the raters were treating clinicians, and the ratings were coded months or years after intake assessments, and the ratings may have inadvertently included information known later by the clinicians, but not actually known at the time of the intake assessments (Martinez, et al., 2007), therefore impacting the internal validity of their study. A 2008 study (Caldwell et al.) coded the J-SOAP-II for 91 juveniles with sexual offenses,
finding that only the Impulsivity/Antisocial Behavior scale offered predictive validity, but of future non-sexual offending charges.

The J-SOAP-II remains a relatively young, experimental instrument, with too few studies yet to reach solid actuarial status. Some research suggests that the J-SOAP-II scale scores may be better related to risk than the instrument’s total scores (Murrie, 2012). Specifically, in a study of 253 adolescents, those with high scores on the Impulsivity/Antisocial Behavior scale but undiscriminating total scores were three times more likely to sexually re-offend. Studies using the J-SOAP-II continue, and New Connections will use the J-SOAP-II as one piece of a multi-faceted assessment of relative risk for sexual re-offense.

_Treatment Progress Inventory for Adolescents Who Sexual Abuse (TPI-ASA)._ The TPI-ASA (Oneal, Burns, Kahn, Rich & Worling, 2008) is 64-item tool designed for administration at the start of treatment, and at regular intervals during treatment. This relatively new instrument requires that the adolescent clients be assessed across nine dimensions, including inappropriate sexual behavior, healthy sexuality, social competency, cognitions supportive of sexual abuse, attitudes supportive of sexual abuse, victim awareness, affective/behavioral regulation, risk prevention awareness, and positive family caretaker dynamics (Oneal et al., 2008). The authors note that there are no empirically supported instruments designed to assess treatment progress or efficacy, and the goal of the TPI-ASA is to measure those as well as treatment efficacy.

The developers reported an initial study involving 90 males between the ages of 12 and 17, each of whom had been identified as having demonstrated problem sexual behaviors within the preceding 12 months. Internal consistency values (Cronbach alpha) for eight of the nine dimensions ranged from .71 to .92, with only two falling below .82 (victim awareness and
cognitions supportive of sexual abuse). The authors note that the internal consistency value for inappropriate was expected to be low, and at Cronbach alpha .63, was the lowest of the nine dimensions. The authors suggest that the lower internal consistency was anticipated because high scores for one type of problem sexual behavior (child molestation, for instance) would not be associated with high scores for another type of problems sexual behavior (exhibitionism, for instance) (Oneal et al., 2008). However, the item adolescent blames the sexual abuse on his/her own history which is lodged in the cognitions supportive of sexual abuse dimension showed a surprising low corrected item-total correlation (.17). The authors suggest this may have been an anomaly of an under-reporting sample, but as noted in chapter two of this work, researchers have suggested that a substantial percentage of adolescents with problem sexual behavior have a history of sexual victimization themselves. The TPI-ASA authors argue that while the item had a low endorsement by the sample, future samples may provide meaningful clarification, and the item remains in the cognitions supportive of sexual abuse dimension. Positive inter-dimension correlations were reported among healthy sexuality, social competency, victim awareness, affective/behavioral regulation, risk prevention awareness and positive family caregiver dynamics, with p values < .01 between all except the dimensions of positive family caregiver dynamics and healthy sexuality (p > .05). The TPI-ASA is a young instrument with only one published study, but the tool targets ongoing assessment of an adolescent’s progress while in specialized treatment for problem sexual behavior. New Connections will employ the TPI-ASA for all admitted clients at intake, at three month intervals, and at discharge.

**Comprehensive assessment.** The referral and collateral documentation, interviews with the parent/s or guardian/s and with the adolescent, and the results of the assessment protocols together provide a broad, holistic understanding of the characterological, cognitive and
intellectual, developmental, behavioral, family and environmental, psychiatric and sexual factors that mutually influenced one another over time (DP's ecological -- transactional framework) to manifest in a behavior that created one or more victims, and led the adolescent to the present point of intervention. The assessment process occurs over a period of six to eight weeks, and the resulting report provides a recommendation for supervision level, a conceptualization of the development and manifestations of the problem sexual behavior, and recommendations related to integrated, goal-oriented treatment planning addressing multiple factors related to risk for future problem sexual behavior. The recommended treatment for all New Connections clients includes weekly individual, family and group interventions. However, while the modalities and meeting frequency is fixed for all youth, the specific interventions and duration of overall treatment varies depending on assessed need and responsibility issues. Participants in family treatment include the adolescent, his parent/s or guardian/s, and any other identified and appropriate family members. The assigned probation officer participates in facets of the treatment plan, and New Connections works collaboratively with the probation officer for the period of time the youth is in treatment. New Connections provides weekly progress notes to CSSD, provides initial and interim recommendations regarding the appropriate, risk-related level of community supervision, and provides a discharge summary delineating the goals achieved during treatment, and recommendations related to aftercare.

**Integrated treatment planning.** New Connections employs an individualized, goal oriented, integrated treatment plan that addresses the multi-systemic influences that dynamically interact with one another and manifest in problem sexual behavior, specifically, in an adolescent male perpetrating a sexual offense. Adolescent clients participate weekly in group therapy, family therapy and individual therapy. Group treatment is time-limited, while individual and
family treatments each continue through successful completion of the program. Likewise, parents participate in a time limited parenting group (during the same time block that their son is in his group session). When the parenting group concludes, parents continue participation in the home-based family therapy, through the teen’s successful completion of the treatment program. During the initial phase of treatment, each family receives a total of five hours of face-to-face contact. New Connections’ focus on careful assessment of the factors contributing to each client’s trajectory to problem sexual behavior (equifinality) is importantly factored into the treatment planning phase. Generally, the overall goal of treatment is to increase health and psychosocial competency, and to decrease dysfunction and deviancy. Treatment addresses areas of concern that are intrapersonal, interpersonal, and environmental.

Much of the work that follows in treatment begins during the assessment phase, when the client and his family interact with the person of the therapist, and with New Connections’ program and requirements for them. The therapist’s entry to the client’s life involves opening the door to their home, to their relationships, and to their secrets. The therapist presents as empathic and encouraging, knowledgeable, flexible and firm. Navigating and using the therapeutic relationship is the first treatment target, and one that endures throughout the course of the client’s participation with New Connections. While the specific treatment plan varies for each client, the areas addressed may include any or all of the following:

1. Development of social skills and related competencies, including self-esteem, self-efficacy, communication skills; involvement in pro-social activities

2. Awareness of healthy sexuality

3. Introduction to the brain’s structure and impact on adolescent behavior

4. Self-regulation of affect and behavior
5. Development of improved interpersonal relations, including attunement, empathy, and conflict resolution (family, peer, others)

6. Problem solving & decision making skills

7. Identification and correction of general thinking errors (cognitive distortions found in everyday life)

8. Development of healthy & respectful physical and personal boundaries

9. Awareness of and adoption of a sense of healthy masculinity

10. Exploration and resolution of the impact of trauma (victimization, disrupted development, etc.) in one's own life

11. Exploration of one's own sexual history and beliefs; current expressions of sexuality, and atypical fantasies and arousal

12. Identification, comprehension and ability to communicate all facets of the sexual offense/s, including honest disclosure and acceptance of responsibility or specific denial, acknowledgement of harm to others, understanding of victim issues and trauma, concern for victim/s, identification of potential triggers, and identification of thinking errors related to the offense/s

13. Identification of and treatment for co-occurring diagnoses

14. Identification of and improvement in non-sexual behavioral problems (non-compliance with supervision, violence, general criminality, oppositional behaviors, truancy)

15. Identification of emerging psychosocial stressors (individual or familial) and reliance on identified strengths to manage these appropriately

16. Development and presentation of a relapse prevention plan

**Group therapy for adolescents.** The 16-week skill-building group component for adolescents includes modules on learning and practice of pro-social skills, improving communication (including listening) skills, learning related to healthy boundaries and sexuality, self-regulation and modulation of affect and behavior, interpersonal attunement, and problem solving. The skill building groups are interactive and experiential, relying heavily on the
neurodevelopmental theories described earlier in this work and in the work of Kinniburgh and Blaustein (2010) and Longo (2004). A few examples follow.

Robert Longo has worked with adolescents with problem sexual behavior in residential settings for decades. In his 2004 publication, Longo promotes the use of multiple approaches to this work, because of the multiple learning styles found among teens. A vocal proponent of experiential exercises as vehicles to give teens voice, one of Longo’s well known tools is paint chip cards. The exercise is very straightforward: have the teens each choose a paint chip card (a color) that reminds them of a person, or a relationship, or of an experience, and then ask them to talk about why they chose that color, what it means to them, and then more about the person or the experience.

Attachment, Self-Regulation, and Competency (ARC; Kinniburgh & Blaustein, 2010) is a treatment model developed for work with complexly traumatized children and adolescents and their caregivers. While not all New Connections’ clients will have trauma histories, many will have some level of affect and behavioral dysregulation. The attunement exercises described in the ARC manual can be conducted in groups or in dyads with the client and therapist, or with the client and parent. One example involves rhythmic drumming, in which two people each drum (on instruments, or on their legs), with one following the other, replicating the rhythm (p. 73). In order to do this, each must tune in to the other while excluding distractions from the environment. Teens and parents benefit from attunement, as do therapists and clients, and each of us in interpersonal relationships. Siegel (2010) describes mirror neurons playing a critical role in attunement, which facilitates our ability to accurately perceive the signals from another person. By introducing the exercise in the group format, drumming and attunement become learning moments around communication. When the exercise is brought into the home, the
application easily shifts to strengthening the attunement between parent and child. Kinniburgh and Blaustein extend the description of attunement in adolescence to the concept of balance. The authors suggest that attunement to teens sometimes means knowing (being attuned) to the need for privacy versus the need for safety, or the need for independence versus the need for parental connectedness. As a topic, attunement moves from the adolescent groups and parent groups, into the homes for both family and individual therapy.

Siegel (in Codrington, 2010) suggests that mindful meditation may contribute to development of brain regions that are associated with the regulation of emotion and attention (p. 290). Kinniburgh and Blaustein (2010) suggest diaphragmatic breathing and visual imagery to modulate affect arousal states. Likewise, they recommend yoga poses, ball tossing, and progressive muscle tensing and releasing for work with adolescents who struggle with modulation.

Placement of adolescent clients in groups is approached with concern for chronological age and developmental maturity, readiness, type of offense and range of problem sexual behaviors, and after for assessment of antisocial traits and the possibility of iatrogenic effects. While group composition is delicate, the benefits of group therapy for adolescents are many, including skill building, social connections and a sense that they are not alone with a history and struggle about which they don’t typically share outside of their immediate family. Responsibility for the health and safety of the group rests with the therapists and by extension, with the training provided to staff by the program director.

**Psycho-education group for parents.** A 12-week skill building group for parents of adolescents participating in treatment with New Connections provides important information and tools related to safety, communication skills, neurodevelopment and its implications for their
child’s behavior and for the family function, boundaries, and extended family and community involvement in their personal lives. The safety component spans several weeks, and covers material related to approved-supervision for their child, safety concerns in the home, neighborhood and community, and warning signs related to their child’s safety. Oftentimes parents of sexually abusive youth feel embarrassed or ashamed and so one of the goals of the parenting group is to help parents learn to talk about what has happened, and how not to talk about it. The healthy (normal) sexuality module relates to boundaries within the home and the boundaries module will include an expansion of the topic to more general boundaries within the home.

**Individual and family treatment in the home.** The individualized treatment plan addresses both individual and family treatment issues. Sessions for the adolescents and their parents occur on different days, and all sessions are held after the teen’s school days. All therapy sessions occur in a common room of the residence, and during the teen’s individual sessions the family needs to provide privacy for their son’s work. The therapist only meets with the teen however, when there is a parent also in the home. The use of multiple therapeutic approaches, cognitive behavioral interventions, neurodevelopmental interventions, and family systems approaches are employed in recognition of the DP and ITS0 foundations of the New Connections program. The material learned in the group is referenced as acquired strength to support the more personal, individualized work in the home. Attunement and communication work continues, as does self-esteem and self-efficacy work. These will help as the individual work moves to the client’s own victimization or trauma history and/or to the general and offense specific sexual facets of the work.
While the developmental history obtained during the assessment process importantly informs the conceptualization of the etiology of problem sexual behavior and development of the integrated treatment plan, the history also is a therapeutic tool, as the therapist is able to help the adolescent client make sense of his behaviors and relationships using his developmental history as a framework. During the course of individual treatment, the client develops an autobiographical timeline that tracks significant events in his life. He also develops a dynamic genogram that emphasizes the quality of the relationships in his family. Together, these documents become therapeutic tools for helping the client to fully understand the context of his life story. The client uses this material to write, over time, his narrative autobiography. This document will include the sexual offense/s, and much more. With each identification of shared cognitive patterns, emotions, and beliefs around relationships, sexuality, competencies, power and the like, the therapist is able to help the client understand that his experience and behaviors are, for better or worse, connected to something more than his self, and having been influenced before, can be influenced again. The enhanced perception of self-efficacy or endogenous locus of control will be a treatment goal for many adolescents.

Approaching the offense specific details of the client’s history begins to find integration in the sessions not long after the therapy begins. This work unfolds over time, opening and leading to other topics over and over again. The goal is to find the subject, the details, and the related affect increasingly speak-able. As the adolescent speaks, the therapist notes and brings to the client’s attention the thinking errors, the affect, the level of responsibility, the empathy, and the patterns of thought and behavior that emerge. As the work proceeds, the client will write a letter of clarification to the victim (which may only be a therapeutic tool if the victim is no longer available). If reunification with the victim is a goal of treatment, and the victim’s
therapist and family agree, then the clarification would also be done verbally. Likewise, letters or verbal statements of clarification would be addressed to the others harmed by the adolescent’s behaviors. These might include the victim’s family, the client’s parents and siblings, and others as appropriate.

The family therapy component of the New Connections program occurs in a common room of the family residence at a time when most (appropriate) family members can be present. Decisions about who will participate, and with what frequency, will be importantly discussed during the assessment phase, and throughout treatment. The therapist’s will hold physical and psychological safety as the utmost important requirement, and will make sure that every family member is heard and respected during each meeting. In families where the sexual abuse emerged from a chaotic or inattentive or uncaring environment, or one in which sexual boundaries have been blurred, or in which interpersonal violence has occurred in the past, the therapist will assess weekly the safety of the home for the client and any other children who reside there.

During family therapy exploration of the family structure, dynamics, parenting style, and communication are all addressed. Family boundaries, problem-solving skills, discipline, sexual beliefs, patterns and behaviors are addressed. Exploration of any abuse cycle is critical, as family secrets give way to honesty and safety. Throughout the family sessions, the therapist works to help the family identify strengths and resources, as well as vulnerabilities. The goal of family treatment here is to increase the health of the family system, and reduce the risk for additional victimization.

During the treatment period, the client and his family will be involved with the youth’s probation officer. The therapist submits monthly treatment progress notes to the probation
officer, and the officer alerts the therapist if there are any concerns regarding supervision issues. When the treatment goals have been met, with improvement along all identified areas, and no new problems have emerged, the client is ready for discharge. The length of time in treatment will vary for each youth, likely ranging from 6 to 24 months. The duration of treatment will be longest for families in which the victim was a sibling or step-sibling, and in which reunification is a goal.

**Unsuccessful discharge.** New Connections assesses each referred adolescent and family for their ability to participate fully in treatment. Parents are required to cooperate with the safety measures included in the treatment agreement, and they are required to actively participate in treatment. Adolescents too are required to participate actively in treatment, to engage the material and experiential exercises emerging from their work with the therapist. Teens and families who are not compliant with safety measures, who repeatedly miss appointments, or who engage in unapproved victim contact, violate essential facets of the contract, and may have to be unsuccessfully discharged from treatment with New Connections. Committing an additional sexual offense while in treatment would also suggest that community-based treatment is insufficient. Ongoing non-sexual criminal behavior may also make participation difficult. Finally, a teen whose parents fail to participate in treatment is a poor fit for New Connections, since the integration of family work is at the core of the treatment plan. Youth who are unsuccessfully discharged from New Connections are referred back to their probation officers with recommendations for alternative treatment.

**Program Evaluation**

The Context, Input, Process, Product (CIPP) evaluation model is designed to evaluate social programs (Mertens, 2005). This method considers questions across four components, or
domains, and in reporting results, the evaluator will make recommendations in the context of the fourth domain, for the program’s future. As a state-grant-funded program, New Connections and its stakeholders will be well served by this evaluative method. CSSD, the taxpayers who entrust their dollars will be well spent, the adjudicated clients and their families, and the New Connections staff will all benefit from an evaluation process that is designed to consider multiple non-equivalent variables.

The first two components of CIPP function as a needs assessment. In the first domain, context, the evaluator assesses both the program goals, and whether the program’s goals reflect the needs of the participants. Earlier chapters of this work have documented the need for developmentally informed treatment for adolescents with problem sexual behavior, through the statement of the problem, and the description of the population. Assessment of the program’s vigilance to cultural competency of all staff with regard to race, ethnicity, religion and issues/questions around client sexual orientation (gay, bisexual, transgender, and questioning) is important. The program design emerges from that identified need, while the mission, vision and structure together represent the framework for a direct response to that need.

In the second component, CIPP evaluates input, including the stated plan for utilization of human and funding resources. New Connections provides a level of care that is atypically found in the community, providing that service for 40 teens across the state. The budget, articulated in as an appendix, demonstrates that some 80% of the budgeted funding is invested in human resources. The varied levels of training and skills represented among the staff therapists, interns and program director; along with the diverse assessment instruments and accessibility features of those instruments; and the varied treatment modalities provided, together speak to resources required to meet program goals. Assessment of the diverse representation on the New
Connections Advisory Board, and the level of active involvement in ongoing programming, evaluation and governance is another facet of human resource utilization.

The third domain assesses process, specifically, an examination of how program participants were informed and the actual allocation of resources in meeting the program's stated goals. The goal of the program is to reduce the risk of sexual offense recidivism, thereby reducing the incidence of sexual assault. Four distinct data sources are employed to gather this information:

1. New Connections will utilize the Treatment Progress Inventory for Adolescents Who Sexually Abuse (TPI-ASA) (Oneal, Burns, Kahn, Rich & Worling, 2008). This recent instrument was designed for treatment planning and for monitoring treatment progress with this special population. The TPI-ASA requires that youth be assessed across nine dimensions with 64 items, using 3-point Likert scales. The nine dimensions include Inappropriate sexual behavior; Healthy sexuality; Social competency; Cognitions supportive of sexual abuse; Attitudes supportive of sexual abuse; Affective/behavioral regulation; Risk prevention awareness; and Positive family caretaker dynamics (Oneal et al., 2008). The authors recommend that the instrument be coded at intake, and at regular intervals throughout treatment. New Connections will code the TPI-ASA at discharge, to provide a comparison score with the intake data. A one-way Analysis of Variance (ANOVA), comparing the intake and discharge (pre & post) Means will be recorded for each adolescent client.

2. Feedback from stakeholders will be sought via forms completed by the referring probation officer at the time of a client’s discharge, a staff satisfaction feedback
survey completed at six month intervals for the purpose of tracking staff therapists’ experience and recommendations, and finally, a client family feedback survey querying their experiences and satisfaction with New Connections’ treatment and staff will be completed at discharge.

3. An annual budget analysis will be performed to assess the actual allocation of resources will help guide budget development for the following fiscal year. This data will be viewed within the context of the other outcome data.

4. Recidivism data will be collected annually via CSSD records. The adolescents who are referred to New Connections generally have probationary periods extending years beyond the completion of their treatment. Recidivism of both sexual and non-sexual crimes will be collected.

Finally, CIPP evaluates product, or outcomes, and uses these data to provide recommendations regarding the program’s future (Mertens, 2005). The data and resulting recommendations will be provided to the funding agency, CSSD, annually, and will be considered in responding to future Requests for Proposals from them.
Chapter 4: Discussion

This dissertation sought to design a community-based, developmentally informed treatment program for adjudicated male adolescents with problem sexual behavior. The New Connections program is theoretically rooted in the disciplines of developmental psychopathology, and aligned with an application of the Ward and Beech Integrated Theory of Sexual Offending. The program seeks to provide a level of care atypically found in community treatment, offering five hours of face-to-face contact with the adolescent and his family during the first three months of treatment. The program provides adolescent group, parenting group, family and individual therapy to 40 boys. This chapter will address perceived implications of this program for participants, some thoughts regarding restorative justice and implications for public policy, and finally, a few last thoughts.

New Connections is designed to bring enormous resources to adolescents and their families in the midst of a vulnerable period of their lives. For the teen, the juvenile justice process has shined a light on what may be his worst moments, having sexually assaulted one or more human beings one or more times. For the parents, the process has been emotion-laden and may have left them wondering for their child’s future, worrying for the health and well-being of one or more victims, and wondering perhaps, how this happened. New Connections seeks to meet this family with empathy and hope, working with them to identify strengths and vulnerabilities, and providing the help that gives them reason to hope that this will not happen again. Empirically we know that sexual offense recidivism rates are quite low for youth who have engaged in treatment. We know too that they are more likely to re-offend non-sexually, than sexually. The New Connections goal-oriented, integrated treatment plan targets multiple
areas of concern, building competencies and improving relationships, giving each youth the
skills and, preparing the home environment, for a reduced risk of sexual and general recidivism.

**Fifth case vignette.** Ben’s story was described in Chapter 1 of this dissertation. If
referred to New Connections, Ben would present with three known victims, all his half-siblings,
all female, all younger. It is reported that Ben first sexually molested his young sisters when he
was eight years old. Ben is reported to have sexually assaulted (molestation and rape) a third
sister, who was four years his junior, when Ben was 12 years old. Ben was reportedly exposed
to pornography by one of his mother’s boyfriends; and Ben was the victim of substantiated
physical abuse at the hands of another of mother’s boyfriends. Ben has a history of risky
impulsive behaviors, fire setting, and impulsive, aggressive behaviors. At the time of referral
Ben is living with his father and step-mother, and their four year daughter, Ben’s half-sister. Ben
is required to abide by the stipulations of his juvenile probation until his 18th birthday.

Assessment for his risk to recidivate and participation in any recommended treatment is one of
many significant stipulations tied to Ben’s community supervision. Ben’s ability to successfully
navigate those stipulations is directly linked to his ability to remain in the community. Violation
of probation would likely result in Ben’s placement in a residential facility.

Ben presents with multiple vulnerabilities, the details of which emerge through the
review of received documentation, interviews and assessments. In addition to diagnoses of
ADHD and Bipolar disorder, Ben was exposed to adult pornography at an early age, was
physically abused, and was first neglected and then rejected by his mother, herself a childhood
victim of sexual abuse. The repeated interactions between Ben’s ecological, biological, and
neuropsychological systems, contributed to state factors (or dynamic risk factors) including poor
peer relationships, deviant arousal, and cognitive distortions. Ben’s description of his most
recent sexual assault has the distorted quality of a pornographic video: ‘I threw her on the bed and had her... [ejaculated] on her stomach because she’s my sister, not my girlfriend.’ Ben suggested that his sister reported the assault because she was angry that he refused to ejaculate inside her vagina. Ben was 12, his sister was eight.

Interviews with Ben’s father and stepmother reveal a commitment to try to provide Ben with a stable and healthy home-life. They negotiate for permission to have him placed there, in steadfast denial that their four-year-old daughter would be at risk. Probation will permit the placement with the stipulation that Ben is never to be alone in any room with his young half-sister, at any time. The family will be permitted to have a computer with internet access, but it is password protected. Ben’s access to the internet, to adult television programming, and other potentially sexually-arousing materials is strictly monitored. Ben is not permitted to play in the neighborhood or to visit classmates without an informed adult present.

Following the assessment phase, Ben will meet weekly with his New Connections therapist in the family home. Ben, his father and step-mother will meet with the therapist weekly for family work. Once weekly for four months, the family will travel to the New Connections office, where Ben will participate in group therapy with similarly-aged boys while his father and stepmother participate for three months in a specialized parenting group. Ben’s ADHD and Bipolar disorder, his disrupted relationship with his mother, and his repeated difficulties at school have resulted in severely limited social skills. Ben has not learned how to enter relationships; he has poor boundaries and he avoids prolonged conversations for several significant reasons. Ben believes he is not likeable. He ‘knows’ he is unlovable. School reports indicate that Ben is dismissed from the classroom often because of his disruptive behavior and interpersonal conflicts. The New Connections adolescent group will provide Ben with 16 weeks
of skill-building with experiential opportunities targeting self-regulation, interpersonal skills, healthy boundaries, age-appropriate sexuality, and problem solving. Early in the group experience, Ben and the other boys are given simple drums, and are paired with a drumming partner. They are introduced to rhythmic drumming, which involves listening to and following, keeping the beat with partner. The exercise meets Ben’s need to move, while also introducing him to the concepts of interpersonal attunement and communication. For Ben, this exercise will importantly be replicated and recur in other modalities both in group and in his home. Ben has felt alone and unheard for years, and in this simple exercise he feels he is together with another person in an enjoyable and meaningful way. Over the course of four months, Ben and his group will increase their pro-social skills, gain skills to self-regulate, learn about and practice healthy boundaries, and devote significant time in this safe group environment to learn age-appropriate material related to healthy sexuality.

While Ben is in his adolescent group, his father and stepmother are participating in the skill-building group for parents of adolescents who have committed sexual offenses. Safety is an important component of this work, and the peer group dynamic provides an empathic base from which the group will address parental behaviors that might support offending behavior rather than healthy boundaries. This is likely a challenge for Ben’s father and stepmother, who emphatically state their belief that Ben would never touch their daughter inappropriately. As the parents’ group moves through their process, covering the areas of communication skills and boundaries, they work on the ability to talk about their sons’ sexual offenses. Ben’s father and stepmother will have to remain aware and alert to protect both their daughter and Ben from an impulsive sexual act that would create a new victim, and that would send Ben to residential placement.
In the family home, the New Connections therapist begins Ben’s individual work by discussing the individualized treatment plan and helping him to see the relationships between his history, his behaviors, and the articulated goals of the plan. Development of the therapeutic relationship is the first (and ongoing) treatment target, as this will be the vehicle for entry to Ben’s very challenging history and behaviors. The therapist will have Ben begin the project of developing his own timeline, an interactive and unfolding project to help Ben discover the connections between biological, ecological, neuropsychological, clinical symptoms and behaviors, including problem sexual behaviors.

In his individual work, Ben and his therapist work on attunement to facilitate a stronger therapeutic relationship, and to help Ben improve his relationship with his parents and others. Affect and behavioral regulation will another significant treatment goal, using both material from Ben’s days, and experiential exercises to provide Ben with practiced tools. Like the attunement work, the use of these tools designed to increase Ben’s self-competency, and so increase the quality of his interpersonal relationships.

Ben’s trauma history is importantly explored and addressed because of its relationship to his offenses, and its role in his disrupted development. Ben’s peer relationships suffer in part because of his exposure to material not intended for children; and the physical violence perpetrated on Ben negatively impacted his relationships with self and others. Ben’s mother did not believe he was assaulted by her boyfriend, and when Ben sexually molested his half-sisters, Ben’s mother rejected him. This too is an important facet of Ben’s trauma history.

Exploring the details of Ben’s problem sexual behavior, including his sexual assaults of his sisters, is work which abides throughout his time in treatment. At times the material occupies large portions of the sessions, and other times it is approached as a discrete topic among others.
Ben’s embarrassment, shame, denial, cognitive distortions and anger will all play important roles in how this work proceeds, and will, at times, present significant challenges to the process. The strength of the relationship with his therapist, and his ability to engage in affect and behavioral regulation will help with these challenges. The group work his parents engage, and the family work will also help Ben navigate the powerful feelings associated with this work. Before Ben completes treatment he will engage in some form of victim reunification. This will follow the development of his relapse-prevention plan.

Family sessions in the home always include a review of safety measures and treatment expectations regarding supervision of Ben, particularly around his young half-sister, and neighboring children. Ben longs for time with his mother, and early in the family sessions a plan is developed to approach visits with her. Ben’s mother agrees, and after a family session which includes her, she begins a short period of weekly visits wherein she picks Ben up at his father’s home, takes Ben to dinner and then returns him. Unfortunately, Ben’s mother becomes unreliable, and the decision is made to temporarily suspend these visits in order to help Ben build stronger coping skills, including affect regulation and problem solving skills. Ben’s father begins engaging Ben in attunement exercises at a specific, reserved time every day, and their relationship develops positively while Ben begins to feel more strongly that he belongs there.

Ben’s participation in New Connections will likely be 18 - 24 months in length. During this time, his therapist reports regularly on Ben’s progress to his probation officer, attends Pupil Placement Team meetings at Ben’s school, and coordinates reunification with the therapist working with his victims. Ben and his siblings will not see each other for a year. When one sister began asking about him, Ben’s mother will begin to talk with the Victim Advocate who was teamed with Ben’s probation officer. Before the first contact, the Victim Advocate will
consult over time with the therapists working with the victims, and will meet with the therapists and each victim to assure that adequate preparation occurs. Before the first visit occurs, Ben will write carefully reviewed letters of clarification and apology to his sisters. During the first visit, Ben will read the letters aloud to each sister, in the company of Ben’s therapist, the victim advocate, and Ben’s parents. The process will be slow and respectful of the needs of Ben’s sisters, and of Ben. While Ben will not live with his victims, they will begin a visitation schedule which includes visual monitoring at all times, by at least one parent. Ben will remain on probation until it’s scheduled conclusion, and it is likely he will not re-offended.

**Restorative justice.** While the New Connections treatment plan includes the youth writing a clarification letter to those he has harmed, and reading same aloud to the victim if reunification is sought, this is within the context of the post-adjudicative treatment process. In its classical sense, restorative justice takes place in lieu of the criminal justice processes, and involves the offender, the victim, and people closest to them meeting together in conference (Koss, Bachar, & Hopkins, 2006). They describe the process:

Then the perpetrator is asked to tell the group what he or she did. Next, the victim is asked to respond, telling how these acts affected him or her, followed by an invitation to friends and family to describe the impact of the victimization on them. The family of the perpetrator is also asked to describe the impact they have experienced, as there is often a stigmatization attached to having a family member involved in offending. Once the impact has been thoroughly aired, the perpetrator is asked to respond to what he has heard; at this point, many spontaneously apologize, although that is not required. The conference participants then turn their attention to developing a plan to make reparations
to the victim, rehabilitate the offender, and undertake steps that will strengthen
community bonds and make amends for the harm caused to the fabric of relationships.

(p. 345)

Restorative justice is a process that seeks to heal the wounds, and improve the chances that the
youth who committed the offense will get the treatment he needs when he needs it, without
proceeding through a divisive process that often re-traumatizes the victim. For the victim, the
client, and their families, restorative justice provides a transformative experience, on the
intrapersonal, interpersonal, and social levels.

**Closing thoughts.** Public policy is most often driven by those who stand up, organize,
and give voice to an issue about which they care deeply. In Connecticut recently, thousands
stoop up and successfully argued that those who commit murder should not be put to death. A
few weeks later another group stood up and declared that it was unfair that the state’s liquor
stores were required to remain closed on Sundays. That law has been repealed. While
recidivism rates for violence are unquestionably higher than the recidivism rates for sexual
offenses, we have a sex offender registry that displays the photos and addresses of most adult
sexual offenders. The public fears the stranger coming into their neighborhoods and molesting
our children, when statistically most sexual offenses are committed by someone who knows, or
by someone who is related to the victim. Sexual assault is, and should be illegal. The effects of
sexual assault are often profoundly harmful. Harmful too is a juvenile justice system that holds a
15-year-old boy in a detention center for seven days, places him on probation for eight years, but
offers no opportunity to apologize to the victim, her family, and their community for his actions.
The program design set forth in this project is restricted to adjudicated male adolescents. Adding facets for female adolescents who have sexually abused, and for non-adjudicated youth, would require additional staffing resources for treatment based on a dearth of data.

The New Connections program design has been developed with the hope that all services are possible. The reality is, the program is expensive, and the published research regarding treatment for juveniles with problem sexual behavior has not yet provided evidence pointing to the best and most cost effective service delivery. Research is costly, and the base rates related to juvenile sexual offense recidivism are relatively low. Until that research is done, programs such as New Connections will provide the treatment available, informed by the best data available.
References


Appendix A

National Incident-Based Reporting System Definitions of Forcible Sex Offenses

_Forcible sex offenses_ are sexual acts committed a person’s will, or committed against a victim who is not capable of giving consent (e.g. A child or an adult with a disability."

_Forcible rape_ is defined as a the “carnal knowledge” of a person forcibly and/or against that person’s will, or perpetrated on an individual incapable of giving consent. The use of, or threat of force would classify an act as forcible regardless of age or disability.

_Sexual assault with an object_ includes use of an instrument to unlawfully penetrate the genital or anal opening of another’s body against their will or against one incapable of giving consent. An “instrument” is defined as an object other than the perpetrator’s genitalia, and might include a finger, a bottle, or a stick.

_Forcible fondling_ includes the touching of an individual’s private body parts for the perpetrator’s sexual gratification forcibly/against the victim’s will, or when the victim is incapable of giving consent. These acts might include “indecent liberties” and “child molesting” and in general is only reported in the absence of forcible rape, forcible sodomy and sexual assault with an object, because forcible fondling would typically be an element of forcible rape.

- _Sexual assault of young children as reported to law enforcement: Victim, incident, and offender characteristics (2000)._ U.S. Department of Justice, Office of Juvenile Programs, Bureau of Justice Statistics. NCJ182990.
Appendix B

New Connections Annual Budget/Year One

Staff Salaries

<table>
<thead>
<tr>
<th>Position</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologist/Program Director</td>
<td>$ 70,000</td>
</tr>
<tr>
<td>Bilingual Master’s Level Therapist</td>
<td>$ 50,000</td>
</tr>
<tr>
<td>Bilingual Master’s Level Therapist</td>
<td>$ 50,000</td>
</tr>
<tr>
<td>Master’s Level Therapist</td>
<td>$ 45,000</td>
</tr>
<tr>
<td>Master’s Level Therapist</td>
<td>$ 45,000</td>
</tr>
<tr>
<td>Administrative Assistant/Office Manager (1/2 time)</td>
<td>$ 18,000</td>
</tr>
<tr>
<td>Psychology Intern (Pre-doctoral)</td>
<td>$ 25,000</td>
</tr>
<tr>
<td>Psychology Intern (Pre-doctoral)</td>
<td>$ 25,000</td>
</tr>
</tbody>
</table>

Employee Benefits & Taxes (28%) $ 91,840

Total Staffing Expense $419,840

Office Space Lease (1000 sq. ft. @ 12.95 sq. ft./year) $ 12,950

Technology/Furniture/Supplies

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Laptops, 3 Desktops, Related Software</td>
<td>$ 15,000</td>
</tr>
<tr>
<td>8 Smartphones with Data Contract</td>
<td>$ 7,000</td>
</tr>
<tr>
<td>2 Phone and Internet (landline)</td>
<td>$ 1,500</td>
</tr>
<tr>
<td>Copier/Printer/Fax Business Machine Lease(s)</td>
<td>$ 3,000</td>
</tr>
<tr>
<td>Stationary &amp; Office Supplies</td>
<td>$ 5,000</td>
</tr>
<tr>
<td>High Security Commercial Shredder</td>
<td>$ 1,200</td>
</tr>
<tr>
<td>Desks (8) &amp; Small Conference Tables (2)</td>
<td>$ 3,600</td>
</tr>
<tr>
<td>Desk &amp; Reception &amp; Group Chairs</td>
<td>$ 4,310</td>
</tr>
<tr>
<td>Security File Cabinets (4) &amp; Bookshelves (4)</td>
<td>$ 2,800</td>
</tr>
</tbody>
</table>

Total Supplies (Start up costs) $ 43,410
Assessment Instruments & Licensing

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q-Local Network License Fee</td>
<td>$ 250</td>
</tr>
<tr>
<td>MMPI-A (English &amp; Spanish w/ Audio)</td>
<td>$ 1,920</td>
</tr>
<tr>
<td>MACI (English &amp; Spanish with Audio)</td>
<td>$ 2,193</td>
</tr>
<tr>
<td>WISC-IV (English &amp; Spanish)</td>
<td>$ 3,150</td>
</tr>
<tr>
<td>WAIS-IV w/ Report Writer Software</td>
<td>$ 1,609</td>
</tr>
<tr>
<td>EIWA-III (Spanish version of WAIS-III)</td>
<td>$ 1,245</td>
</tr>
<tr>
<td>BASC-2 (English &amp; Spanish w/ Audio)</td>
<td>$ 2,679</td>
</tr>
<tr>
<td>TSCC (Spanish version not yet available)</td>
<td>$ 265</td>
</tr>
</tbody>
</table>

**Total Assessment Instrument & Licensing**  $ 13,311

Travel (Mileage @ .30 per mile per therapist)  $ 11,700

**Contracted Services** (Information Technology, 300 hours)  $ 6,900

**Insurances**  (Group Liability; property; etc.)  $ 5,000

**Total New Connections Start up/First Year Budget**  $513,111
Appendix C

New Connections Office Floor Plan (1000 Square Feet)

Accessible

Lavatory
8’ x 7’

Emergency Exit

Group Room
18’ x 18’

File/Storage Room
4’ x 7’

Administrative Assistant & Waiting Area

Kitchen

Emergency Exit

Program Director
7’ x 10’

4 Staff Therapists/
Small Group Room

18’
Appendix D

New Connections Staff Therapist Schedule

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00 – 8:30</td>
<td>11:00 – 6:30</td>
<td>1:00 – 8:30</td>
<td>OFF</td>
<td>1:00 – 8:30</td>
<td>9:00 – 4:30</td>
</tr>
<tr>
<td>Individual Clinical Supervision</td>
<td>Group Supervision</td>
<td>Case Management &amp; Paperwork</td>
<td></td>
<td>Case Management &amp; Paperwork</td>
<td>Case Management &amp; Paperwork</td>
</tr>
<tr>
<td>1:00 – 2:00</td>
<td>11:00 – 1:00</td>
<td>1:00 – 2:00</td>
<td>1:00 – 2:00</td>
<td>9:00 – 10:00</td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td>Case Management</td>
<td>Clients at:</td>
<td>Clients at:</td>
<td>Clients at:</td>
<td>Group at: 10:00</td>
</tr>
<tr>
<td>2:00 – 3:00</td>
<td>1:00 – 2:00</td>
<td>3:00</td>
<td>3:00</td>
<td>3:00</td>
<td>Clients at: 12:30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4:30</td>
<td>4:30</td>
<td>4:30</td>
<td>2:00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6:00</td>
<td>6:00</td>
<td>6:00</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7:30</td>
<td>7:30</td>
<td>7:30</td>
<td>3:30</td>
</tr>
<tr>
<td>Clients at:</td>
<td>Clients at:</td>
<td>2:30</td>
<td>4:00</td>
<td>5:30</td>
<td></td>
</tr>
<tr>
<td>3:00</td>
<td>4:30</td>
<td>6:00</td>
<td>7:30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary: Client Contact Hours: 19.5
Supervision Hours: 3.0
Case Management/Paperwork Travel Hours: 15.0
Appendix E

Psychology Intern Responsibilities, Training & Supervision Opportunities

Psychology interns will have the following responsibilities:
- Minimum of two clients and their families, totaling 4 hours face-to-face weekly contact
- Co-therapist for two additional families, totaling 2 hours face-to-face contact
- Co-facilitate four group therapy sessions weekly, totaling 6 hours face-to-face contact
- Minimum of four psychological evaluations and other assessment as appropriate
- Post-test and survey data collection and tabulation for internal program evaluation
- Two presentations to staff or CSSD on topics agreed upon with Program Director

Psychology interns will participate in the following training opportunities:
- Monthly attendance at training opportunities hosted by the Connecticut Association for the Treatment of Sexual Offenders (CATSO)
- Attendance at the annual Association for the Treatment of Sexual Abusers (ATSA) conference (November)
- Attendance at the annual Massachusetts Adolescent Sex Offender Coalition/Massachusetts Association for the Treatment of Sexual Abusers (MASOC/MATSA) conference (April)

Psychology interns will participate in four hours of clinical supervision, weekly:
- 1 hour of individual clinical supervision
- 1 hour of joint assessment supervision
- 2 hours of group all-staff clinical supervision
Appendix F

Empirically Based Risk Factors Related to Juvenile Sexual Offense Recidivism

The Juvenile Sex Offender Assessment Protocol – II (J-SOAP-II; Prentky & Rithband, 2003) is a 28-item, four-scale checklist for boys aged 12 to 18 who have been adjudicated for a sexual offense. The J-SOAP-II assesses both sexual and non-sexual recidivism; it is not yet an actuarial tool, and is used as one facet of a comprehensive assessment.

<table>
<thead>
<tr>
<th>J-SOAP-II Item List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale 1</td>
</tr>
<tr>
<td>Sexual Drive / Preoccupation</td>
</tr>
<tr>
<td>- Prior legally charged sex offenses</td>
</tr>
<tr>
<td>- Number of sexual abuse victims</td>
</tr>
<tr>
<td>- Male child victims</td>
</tr>
<tr>
<td>- Duration of sex offense history</td>
</tr>
<tr>
<td>- Degree of planning in sexual offense/s</td>
</tr>
<tr>
<td>- Sexualize aggression</td>
</tr>
<tr>
<td>- Sexual drive and preoccupation</td>
</tr>
<tr>
<td>- Sexual victimization history</td>
</tr>
</tbody>
</table>
The Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR; Worling & Curwen, 2001) is a 25-item, five-scale instrument to assess the risk for sexual offense recidivism in boys age 12 to 18 who have been adjudicated for a sexual offense. The ERASOR is intended to provide an “empirically-guided clinical judgment methodology to predict adolescent sexual recidivism” (p. 3).

<table>
<thead>
<tr>
<th>ERASOR Item List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale 1</td>
</tr>
<tr>
<td>Sexual Interests, Attitudes Behaviors</td>
</tr>
<tr>
<td>• Deviant sexual interests</td>
</tr>
<tr>
<td>• Obsessive sexual interest/ preoccupation with sexual thoughts</td>
</tr>
<tr>
<td>• Attitudes supportive of sexual offending</td>
</tr>
<tr>
<td>• Unwillingness to alter deviant sexual interests / attitudes</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>