ASSESSING AND TREATING
JUVENILES WITH SEXUAL BEHAVIOR PROBLEMS

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UNDERSTANDING WHY YOUNG PEOPLE BECOME SEX OFFENDERS
TRAUMA SURVIVOR
POWER
CONTROL
ANGER
NEUROBIOLOGICAL TRAUMA

- Developmental Trauma: Bessel Van der Kolk, M.D.

- Acute Trauma: Bruce Perry, M.D., Ph.D.
IMPORTANT STATISTICS

- 1/6 boys and 1/4 girls will be raped or molested by age 18
- Less than 30% will report
- 74% do not disclose in the first year
- 50% have not disclosed in 5 years
- 94% have a preexisting relationship with the perpetrator
- The majority happen at home
- Male victims are more often unreported than female victims
One out of 4 children attending school has been exposed to a traumatic event.

Trauma can impact school performance.
1. Higher rate of school absences
2. Increased drop-out
3. More suspensions and expulsions

Trauma can impair learning.
1. Adversely affect attention, memory and cognition
2. Reduce a child’s ability to focus, organize and process information

*The National Child Traumatic Stress Network*
DEVELOPMENTAL TRAUMA DISORDER:
Bessel Van Der Kolk, M.D.
(www.traumacenter.org)
Exposure

- Family Chaos
- Poor Attachment
- Poor Bonding
- Lack of Quality Adult Contact
- Too Much Screen Time
- Inadequate Sleep
- Failure to Develop Empathy
Persistently Altered Attributions and Expectancies

- Negative self-attribution
- Distrust protective caretaker
- Loss of expectancy of protection by others
- Loss of trust in social agencies to protect
- Lack of recourse to social justice/retribution
- Inevitability of future victimization
ACUTE TRAUMA

- Substance Abusing Homes
- Family Violence
- Community Violence
- School Violence
- Bullying
- Sexual and Physical Abuse
“Trauma is not the event; it is the outcome.”
Effect of Trauma
YOUTHFUL
SEX
OFFENDERS
FAMILY FACTORS

- Instability
- Disorganization
- Violence
SOCIAL SKILLS AND RELATIONSHIPS

- Inadequate social skills
- Poor peer relationships
- Social isolation
SEX AS A WAY TO:

- Demonstrate loss 33.3%
- Feel power and control 23.5%
- Dissipate anger 9.4%
- Punish 8.4%
ATTRIBUTES IN COMMON WITH VICTIMS

- Reduced empathy
- Inability to recognize appropriate emotions in others
- Inability to take another person’s perspective
- Cognitive distortions
MENTAL HEALTH ISSUES OF OFFENDERS

- Conduct disorders
- Antisocial traits
- Impulse control problems
- PTSD
- Higher rates of depression than in peers
Brain Activity in Bullies

- Conduct disorder diagnosed adolescents vs. controls
- Controls’ functional MRI’s showed amygdala activated at the same time as prefrontal cortex
- Conduct disordered subjects showed activity in amygdala and ventral striatum which is associated with pleasure and reward
- Bullies do not respond to people being hurt with negative emotions, but with pleasure
FEMALE VS MALE OFFENDERS

- Similar offenses
- Both tend to victimize children of the opposite gender
- Females have more severe victimization histories
SEXUALLY ABUSIVE PREADOLESCENTS
INDIVIDUAL CHARACTERISTICS

• Common age of first offense is 6 to 9
• Larger number of females
• Victims usually siblings, friends or acquaintances
• Higher rates of abuse and neglect than adolescent offenders
FAMILY CHARACTERISTICS

- High levels of poverty
- Single parenting
- Sexual abuse
- Domestic violence
- Parenting stress
CLASSIFICATIONS*

• Normal sexual exploration
• Extensive mutual sexual behaviors
• Sexually reactive
• Child perpetrators

T. Johnson*
NORMAL SEXUAL EXPLORATION*  
(K-4)

- Uses “dirty” words
- Plays doctor, inspecting others’ bodies
- Shows others his/her genitals
- Looks at nude pictures
- Pretends to be of the opposite gender
- Touches/rubs own genitals
- Erections
- Puts objects in own genitals
- Wants to compare genitals with peers

*T. Johnson, Ph.D. - www.tCavJohn.com
INTERVENTION AND TREATMENT WITH OFFENDERS!
SB 890 JUVENILE SEX OFFENDER TREATMENT PROGRAM

- San Joaquin, Fresno and Ventura
- 4 year project
- 277 offenders treated
- 14.9-average age
- 13.7-average months of treatment
Victimization History

- 75% - abused or neglected
- 14% - sexual abuse alone
- 35% - mix of sexual, physical and psychological abuse
- 15% - physical abuse alone
- 10% - psychological abuse alone
Sex Offending Profile

- 29% - annoying and molesting a child
- 25% - oral copulation
- 20% - lewd or lascivious behavior with a child under 14
- 13% - sexual battery
- 6% - sodomy of a child
Profile of Offenders’ Victims

- 277 offenders had 402 victims
- 67% female, 33% male
- 9%~0-3, 37%~4-7, 36%~8-11, 15%~12-15 (Age of Victim)
<table>
<thead>
<tr>
<th>Relationship</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Sister</td>
<td>23%</td>
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<tr>
<td>Brother</td>
<td>5%</td>
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<td>Extended Family</td>
<td>18%</td>
</tr>
<tr>
<td>Peer</td>
<td>29%</td>
</tr>
<tr>
<td>Neighbor</td>
<td>20%</td>
</tr>
<tr>
<td>Babysitting</td>
<td>3%</td>
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<tr>
<td>Stranger</td>
<td>2%</td>
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</table>
SCREENING TOOLS

- Juvenile Sex Offender Assessment Protocol II
- Traumatic Events Screening Inventory For Children (TESI-C)
- Trauma Symptom Checklist for Children (TSCC) or (TSCYC)
TREATMENT OF JUVENILE SEX OFFENDERS

- Address deviant arousal
- Involve families
- Use Cognitive Behavior Therapy (TF-CBT)
- Use a relapse prevention model
- Use Mindfulness
- Combine individual, group and family therapy
- Minimum of 18-24 months
- *Issues with short term individual or group*
TREATMENT PROTOCOL

- Individual Therapy
- Group Therapy
- Family Therapy
RECIDIVISM
(Up to Three Year Follow-up)

- Sex offenses 2.5%
- Non sexual offenses 11.2%
- No re-offense 86.3%
WEBSITES

www.zerotothree.com (zero to three)
www.childtrauma.org (Bruce Perry MD, Ph.D.)
www.apsac.org (American Professional Society on the Abuse of Children)
http://tfcbt.musc.edu (Online CBT Training)
www.casacolumbia.org (Columbia University)
www.johnbriere.com (Complex Trauma)
www.pcit.tv (UC Davis PCIT)
www.traumacenter.org (Bessel Van Der Kolk MD)
www.NCTSN.org (National Child Traumatic Stress Network)