Cliff Notes When Working with Adolescents Who Have Engaged in Sexually Harmful Behaviors

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Objectives for the Day

- Identify best practices for completing a risk assessment for an adolescent who has engaged in sexual behaviors.
- Understand best practices for treatment for an adolescent who has engaged in sexual behaviors.
- Identify best practices for safety planning for an adolescent who has engaged in sexual behaviors.
- Understand best practices for clarification/reunification for an adolescent who has engaged in sexual behaviors.

2

Assessment

It all starts here

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Assessments are:

- Assessments are only as good as the information gathered during the interview and record reviews.
- Assessments are ongoing - they are never static! If anything changes; Risk – Need – Responsivity, living space, school, development, family, etc. the assessment should be updated to reflect the changes.
- No matter what, the assessment is only good for 6 months

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Assessment Are To

- Inform decisions about the adolescent's care and treatment
- Inform on adolescent's risk, needs, and responsivity factors
- Reviews both sexual and general delinquency risk factors
- Determine adolescent's risk relevant intervention strategies and provide information on factors impacting responses to treatment
- Determine when and if needed more intensive services, no specialized services warranted, or for when services are no longer warranted

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R-N-R Review

- Risk = factors within the adolescent's environment associated with sexual and/or general abusive behaviors. Treatment should match risk.
- Need = what will reduce the adolescent's risk for sexual or general abusive behaviors? What should be the treatment target?
- Responsivity = effective methods to maximize the adolescent's and his/her family's ability to benefit and learn from rehabilitative interventions; tailored to the individual

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Brain Development should also be considered

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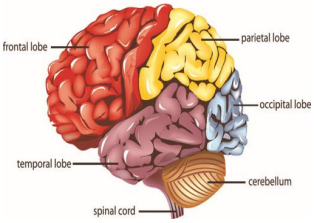
Parts of the Human Brain



Brain Development Process

https://www.simplypsychology.org/anatomy-of-the-brain.html

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Brain Development in Adolescent

- Brain is in final stages of development while personal and social demands
- Adolescents are at a higher risk for risk taking behaviors
- As Prefrontal lobe is developing, the adolescent is working to learn emotions, decision making, and problem solving skills
- Technology/social media/ Apps- how do they influence a youth's development.
- Empathy – is DEVELOPING – this means they may not have it, express it, show it; but all that is normal

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Pause for Brain Development

- Neuroplasticity – allows for the brain to change structurally and functionally related to experiences
  - Use it or lose it
  - Adolescent time = most impressionable time for memories
- Equates to hope that new things can be learned

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Left or Right Hand Exercise

- Let's practice your Neuroplasticity ….

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Physical Impact- Brain Development

What fires together will wire together – even if not best fit

- Trauma causes misfires in brain - triggers
- Pop rockets going off all the time (in theory)
- Everything is on fire all the time

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ATSA Adolescent Practice Guidelines are based in the empirical framework of the Risk – Need – Responsivity Principles

- How do we go about finding risk?
  - Appropriate assessment = youth's need for structure, supervision, and treatment
- Needs are what?
  - Adolescent's or family dynamic factors (identified in the assessment initially) that can reduce the adolescent's risk for sexual or general reoffending
- Responsivity
  - Effective methods to maximize the adolescent's and family to benefit from treatment and rehabilitative interventions based on what we learn from assessment on risk

*** Note RNR is an adult model, focused on criminal risks ***

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Thoughts for Risk

- Need to look at both nonsexual and sexual risk – as we have learned more likely to commit a nonsexual crime than sexual crime in the future.
- Need to understand protective and risk related factors – to best provide recommendations based on needs and responsivity
- Responsivity needs to be driven individually to the youth
- Risk factors are dynamic….They can change! Numbers do not matter
- What does the current research say?

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Research says

- 2016 – Dr. Michael Caldwell, PsyD., - completed a research study on 20,008 Juvenile Offenders – he found that **Sexual recidivism for sexual offenses since 2000 is 2.75%** ***regardless of the intervention***
- 2023- Dr. Lussier and co-authors found via a systematic review and quantitative meta-analysis over timeframe of 1940-2019;
- 30,396 adolescent perpetrators of sexual offenses were examined for general, violent, and sexual recidivism
  - Study did not find convincing evidence that sexual recidivism rates for youth are declining, but that ***rates have consistently been low over the years***

Hope

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Recidivism is more than risk factor or a score on a risk tool (Lussier, et.al, 2023)

- Social, Cultural, and Legal Factors play into recidivism
- Youth are far more likely to re-enter the justice system for crimes other than sexual behaviors
- Recidivism is different everywhere – so how can there be a "recidivism rate"
- Recidivism is not just about the youth, it is also reflective of the functioning of the juvenile justice system and its response to criminal offenses (policies, laws, etc.)

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Risk Assessment are

Appropriate for	Not Appropriate for
Sexual risk assessment for youth ages over 12 years old and youth involved with the juvenile or CHINS legal system	Assessment for youth ***under 12*** years old who engaged in sexually reactive behavior, risky to self, or harmful behaviors

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When to do the Assessment

The preferred practice to complete the Risk Assessment is post-adjudication; however, there are situations that warrant consideration of a pre-adjudication assessment, such as:

- All the legal professionals involved in the case are seeking information to assist in formulating a plea agreement or to support moving a plea agreement forward.
- The judge is seeking additional information prior to accepting to a proposed plea agreement.
- The court is withholding the charge, providing the adolescent an opportunity for treatment, resulting in no formal action on the offense.
- Diversion Cases

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But? Is it as simple as it seems?

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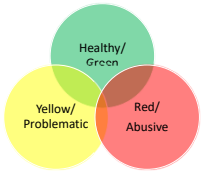
Defining Sexual Behaviors: What sexual behaviors are we assessing?



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Are There "Normal" Childhood Sexual Behaviors?

"Further, it is important to note that while the term sexual is used, the intentions and motivations for these behaviors may or may not be related to sexual gratification or sexual stimulation. The behavior may be related to curiosity or anxiety, or may be imitative, attention-seeking or self-calming in nature."

Eklovitch, N. Latzman, R. Hansen, D. Flood, M "Understanding child sexual behavior problems: A developmental psychopathology framework." Clinical Psychology Review 29 (2009) 586-598

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Healthy Childhood Sexual Play and Exploration

Healthy childhood sexual play and exploration is behavior that occurs spontaneously, intermittently, is mutual and noncoercive when it involves other children, and does not cause emotional harm or distress.

Healthy childhood sexual play and exploration is not a preoccupation and does not involve advanced sexual behaviors such as intercourse or oral sex.

Some degree of behavior focused on sexual body parts, curiosity about sexual behavior, and interest in sexual stimulation is a healthy part of child development.

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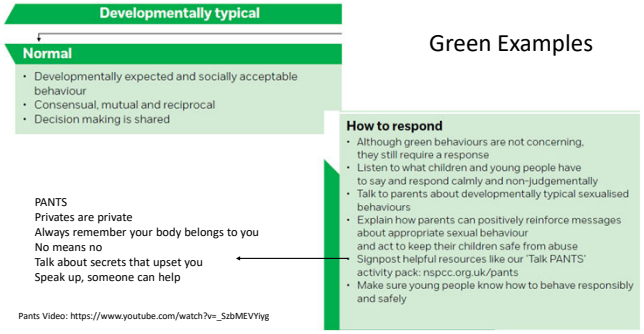
Green Examples



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What Language is Green?

- Penis
- Vagina

- Proper anatomical terms creates a land of prevention
- Important to identify the terms the adolescent is using/knows to best assess what sexual behaviors have occurred

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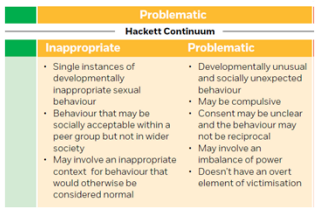

How to respond

- Amber behaviours should not be ignored
- Listen to what children and young people have to say and respond calmly and non-judgementally
- Consider the child's developmental age as well as their chronological age, alongside wider holistic needs and safeguarding concerns about the problematic sexualised behaviour
- Follow your organisation's child protection procedures and make a report to the person responsible for child protection
- Your policy or procedure should guide you towards a nominated child protection lead who can be notified and will provide support
- Consider whether the child or young person needs therapeutic support and make referrals as appropriate

1. whether the behavior is common or rare for the child's developmental stage and culture;
2. understanding if the behavior violates shared cultural norms/expectations;
3. the frequency of the behavior;
4. the extent to which sex and sexual behavior has become a preoccupation for the child; and
5. whether the child responds to guidance and correction from adults or continues unabated after healthy corrective efforts.

Yellow Examples

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Children with Sexual Behavior Problems are Defined

- as those aged 12 and younger
- who initiate sexualized behaviors that are developmentally inappropriate or potentially harmful to themselves or others

The phrase "sexual behavior problems" does not refer to a medical or psychological condition or a particular diagnosable disorder. Instead, it encompasses a range of behaviors that can be directed at oneself or directed toward others and that fall outside of acceptable societal limits. These behaviors could also be associated with technology or social media apps.

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- But yet some adolescent's behaviors are problematic too and labeled harmful ……..

- This is where language meets the road,
  - What we say matters
  - What we ask to define the behavior matters
  - How we address it
  - Prevention

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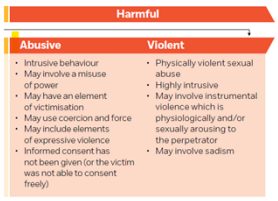

Red Examples

How to respond

- Red behaviours indicate a need for immediate intervention and action
- If a child is in immediate danger, call the police on 999
- Follow your organisation's child protection procedures and make a report to the person responsible for child protection
- Your policy or procedure should guide you towards a nominated child protection lead who should be notified and will provide support
- Typically referrals to children's social care and the police would be required. Referrals to therapeutic services should only be made once statutory services have been informed and followed due procedures

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No Matter What

- Abuse is abuse

We aim to focus treatment on

- stopping sexual harm
- reducing all abusive behaviors
- creating healthy, developmentally appropriate sexual relationships
- creating healthy families

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In determining whether the behavior includes potential for harm, consider:

- The age/developmental differences of the children involved;
- Any use of force, intimidation, or coercion;
- The presence of any emotional distress in the child(ren) involved;
- Whether the behavior appears to be interfering with the child(ren)'s social development; and
- Whether the behavior causes physical injury

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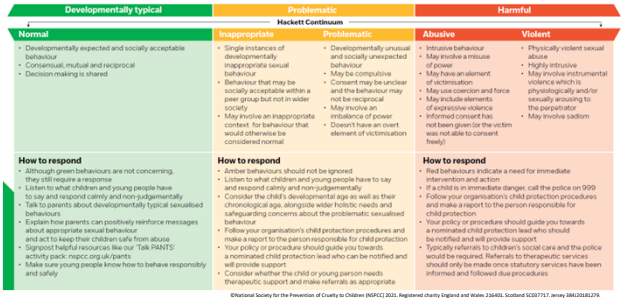
Fluid Continuum



Developmentally typical	Problematic		Harmful	
Hackett Continuum				
Normal	**Inappropriate**	**Problematic**	**Abusive**	**Violent**
• Developmentally expected and socially acceptable behaviour • Consensual, mutual and reciprocal • Decision making is shared	• Single instances of developmentally inappropriate sexual behaviour • Behaviour that may be socially acceptable within a peer group but not in wider society • May involve an inappropriate context for behaviour that would otherwise be considered normal	• Developmentally unusual and socially unexpected behaviour • May be compulsive • Consent may be unclear and the behaviour may not be reciprocal • May involve an imbalance of power • Doesn't have an overt element of victimisation	• Intrusive behaviour • May involve a misuse of power • May have an element of victimisation • May use coercion and force • May include elements of expressive violence • Informed consent has not been given (or the victim was not able to consent freely)	• Physically violent sexual abuse • Highly intrusive • May involve instrumental violence which is physiologically and/or sexually arousing to the perpetrator • May involve sadism
How to respond • Although green behaviours are not concerning, they still require a response • Listen to what children and young people have to say and respond calmly and non-judgementally • Talk to parents about developmentally typical sexualised behaviours • Explain how parents can positively reinforce messages about appropriate sexual behaviour and act to keep their children safe from abuse • Signpost helpful resources like our 'Talk PANTS' activity pack: nspcc.org.uk/pants • Make sure young people know how to behave responsibly and safely	**How to respond** • Amber behaviours should not be ignored • Listen to what children and young people have to say and respond calmly and non-judgementally • Consider the child's developmental age as well as their chronological age, alongside wider holistic needs and safeguarding concerns about the problematic sexualised behaviour • Follow your organisation's child protection procedures and make a report to the person responsible for child protection • Your policy or procedure should guide you towards a nominated child protection lead who can be notified and will provide support • Consider whether the child or young person needs therapeutic support and make referrals as appropriate		**How to respond** • Red behaviours indicate a need for immediate intervention and action • If a child is in immediate danger, call the police on 999 • Follow your organisation's child protection procedures and make a report to the person responsible for child protection • Your policy or procedure should guide you towards a nominated child protection lead who should be notified and will provide support • Typically referrals to children's social care and the police would be required. Referrals to therapeutic services should only be made once statutory services have been informed and followed due procedures	

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Assessments Gather

- Multiple reliable sources of information
- Interviews of youth and caregiver/s
- Information from professional sources ie. School, probation, courts, previous treatment providers

- RNR at that time – as we know these factors change and the adolescent is in a development life stage – therefore we are only speaking of RNR at the time of the assessment
- Assessments should be repeated as an adolescent progresses through treatment, if any major changes happen in home or life, and to determine if youth is ready for discharge.

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Assessor – who has it in them?

What should an assessor possess?

- Grounding – engaging demeanor
- Practice within your practice scope – Psychology vs Social work degrees
- Knowledgeable on youth's development on all areas
- Knowledgeable on the range of youth's sexual behaviors
- Unbiased, sensitive, and impartial interviewing skills
- Understanding each youth is different, every time, all the time

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Assessment Report Should Include, but not limited to the following

- Confidentiality – Limitations
- Family Domain
- Developmental History
- Problematic and Abusive Sexual Behaviors
- Home Environment
- Social and Community
- Risk and Needs Measure
- R – N – R
- Recommendations

What are your most important things to ask/include in an assessment?

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Assessment Domains – Sexual Contacts/ Problematic Behaviors/Abusive Behaviors

- Make sure youth and evaluator are on same page of definition for sexual terms
- Sexual History
  - Contact vs. Non-contact
  - Girlfriends vs. sexual encounters
- Pornography – Naked Pictures
- Technology for sexual purposes
  - Omegle, Sexting, Tik Tok, Snapchat, other apps?
- Masturbation
- Sexual Behaviors with animals
- Fantasies
- Documented offense
  - Youth's version
  - Attitude to include sexual attitude regarding offense
- What is missing?

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Assessment Measures - Polygraphs

- In 2017, ATSA published the *Practice Guidelines for Assessment, Treatment and Intervention with Adolescents Who Have Engaged in Sexually Abusive Behavior*. The *Practice Guidelines* provide guidance to practitioners and others who work with adolescents who have sexually abused or are at risk to abuse.

- **ATSA Practice Guideline Regarding the Use of Polygraph**
  - The *Adolescent Practice Guidelines* recommend **against the use** of polygraph with juveniles.

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Risk and Needs Assessment Measures

- Unstructured clinical judgement = best guess?
- Adding a tool or two tools = identifies dynamic risk factors = helps facilitates effective treatment = common language
- Worling, 2018

Issues With Popular Risk Prediction Tools

1. Research regarding risk prediction accuracy levels
2. 33%-100% of the risk factors are static: adolescents are not
3. Research regarding established risk prediction factors
4. Narrow age range (typically 12-18)
5. Dated language does not reflect changes in the field
6. Most tools not applicable for subgroups (e.g., females, noncontact offenses, bestiality, child abuse images…)
7. Arbitrary risk ratings with some tools (e.g., what does "High Risk" mean? "Moderate Risk?")
8. Only risk factors: ***no*** protective factors

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Examples of Measures

1. PROFESOR – Protective + Risk Observations for Eliminating Sexual Offense Recidivism
2. YNPS – Youth Needs and Progress Scale
3. MEGA^{2} - Multiplex Empirically Guided Inventory of Ecological Aggregates for Assessing
4. MIDSA Multidimensional Inventory of Development, Sex, and Aggression
5. JSORRAT- Juvenile Sexual Offense Recidivism Risk Assessment Tool-II
6. J-SOAP – Juvenile Sexual Offender Assessment Protocol – II
7. J-RAT – The Juvenile Risk Assessment Tool

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Risk and Need Assessment Measures ATSA Guidelines for Best Practice

- Improvement over unstructured clinical judgement
- Most empirically supported, independent evaluated, sex-offense-specific risk assessment
- Are not meant to stand alone
- Assessor knows the measure, understands literature around the measure, and understands limitations
- Know who and how to appropriately use the tool. If using it outside of guidelines, must list limitations.

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Assessment

- REVIEW – READ – before intake, during intake, after intake
- As we change improve daily, we would hope that the family/youth have made some changes since assessment
- ASK them

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Risk is DYNAMIC – Own it!

- Do you ever change a diagnosis ?
- Why do we change anything – we LEARN something NEW
- I don't want to assume the Risk tool is still accurate as the youth HAS changed!
- Situation has changed …

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Risk Levels per ATSA

8.17 Practitioners recognize that risk for reoffending is multi-determined and is influenced by individual, familial, situational, and other factors. Consequently, person-specific risk labels, such as "he or she is a high, low, or moderate risk" should be avoided and, if used, must be used cautiously and include the context. (ATSA Adolescent Guidelines, page 37)

- If label is used, must be in context of the environment such as High risk at mother's house!

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ATSA Position on Registration

- It is the position of ATSA that Sex Offender Registration and Notification laws are not appropriate for children and adolescents adjudicated or convicted of sexually abusive behavior, and the application of such practices should be eliminated.
- Efforts should focus on evidence-based interventions that will prevent re-offense, facilitate healthier lives for these youth, and result in healthier and safer communities.

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ATSA Recommendations on Registry

- End policies that subject children or adolescents to sex offender registration and notification requirements and related residence, education, and employment restrictions;
- Implement primary prevention interventions;
- Offer specialized treatment programs grounded within developmentally appropriate research, informed practices that incorporate trauma-informed practices and adhere to the principles of risk, need, and responsivity;
- Offer sexual education programs that address consent, healthy sexuality, and boundaries offered in an age-appropriate manner throughout childhood development;
- Offer treatment and other interventions that are sensitive to and address the adverse childhood conditions often experienced by at-risk youth (Adverse Childhood Experiences);
- A focus on protective factors that increase emotional, behavioral, and educational stability; and
- Engage family members and community support persons in an effort to maximize success in programs and promote stability and prosocial behaviors.

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Best Practice Assessment Review:

- Assessments are only as good as the information gathered during the interview and record reviews.
- ATSA Adolescent Practice Guidelines are based in the empirical framework of the Risk – Need – Responsivity Principles
- Calculated sexual recidivism rate at 2.75% (Caldwell, 2016)
- Assessments Inform – Not Predict
- Post –adjudication completion
- Utilizing a Risk and Need Assessment Measure

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Pause for a Chat about Assessments

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Treatment

Best Practices for Adolescents who have Engaged in Sexually Abusive Behaviors

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Treatment for Adolescents

- Adolescents in general are diverse such as still developing, learning styles vary. For adolescents who have engaged in sexually abusive behaviors protective factors and risk associated with reoffending are also diverse.
- Therefore, Treatment for adolescents who have engaged in sexually abusive behaviors needs to consider all things adolescent and all things associated with risk of sexual reoffending among adolescents
- Treatment is driven by Assessment

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Best Practices for Treatment include:

- A focus on dynamic risk factors
- Promoting safety while assisting with skill development
- Evidence Based Interventions that meet the Risks and Needs
- Include caregiver and/or parent
- Assess risk and protective factors in youth's environments
- Treatment in least restrictive environment
- Treatment is at the adolescent's developmental level
- Addresses both sexual behavior problems and conduct problems

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What the Research is saying for Best Practices for Treatment

- Cognitive Behavioral Therapy (CBT)
- MI
- Skills-Based
- Multisystemic Approaches that involve caregivers
- BUT- is that all? Nope!

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Treatment is MOST effective when includes principles of RNR

- Risk = intensity of treatment
- Need = focusing on factors related to recidivism; specific to the adolescent
- Responsivity = adapting and adjusting what treatment is used to meet the needs of the adolescent

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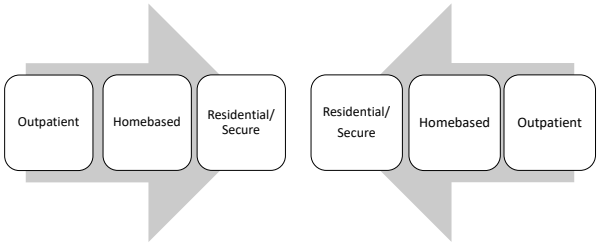
Treatment on a Continuum as Needed



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Providers for Treatment for Adolescents who have engaged in sexually abusive behaviors

- Knowledgeable on current research specific to this population
- Possess skills and knowledge on RNR
- Aware of own strength and weaknesses when treating this population
- Collaboration with other professionals in this population

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What are some primary tactics from the audience?

- What do you focus on?
- How to manage it all?

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Keys to Treatment Best Practice

- Treat the whole adolescent
- Engagement of adolescent and family/caregiver
- Motivate, how can you help the change process?
- Therapeutic Relationship with adolescent
- Assessment drives treatment
- Treatment is needs based that were identified in assessment
- Addressing sexual attitudes
- Includes healthy sexuality concepts
- Social and community supports
- Delinquency
- Social Skills components
- Parent/caregiver relationships

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Treatment Concepts that are important

- Social skills
- Cognitive thinking errors
- The "how did this happen" (cycle, chain) connecting thoughts –feelings- behaviors
- Healthy relationships
- Increase in sexual knowledge

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ATSA Practice Guidelines (2017) Baseline of Best Practices

- Highlights
  - Abuse is Abuse
  - Juveniles are <u>not</u> Mini-Adults
  - Community Safety is <u>A Client</u>
  - Conceptualization
  - Manuals are NOT Treatment

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Pre-Conditions

(i) having motivation to abuse,
(ii) overcoming external inhibitors,
(iii) overcoming internal inhibitors (e.g., values or feelings, and familiar or social punishment),
(iv) overcoming resistance from the victim.

Finkelhor, D. (1984). *Child sexual abuse: New theory and research*. New York: Free Press.

https://www.academia.edu/download/50272028/The_integration_of_etiology_and_risk_in_20161112-21562-y40hq6.pdf

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Assessment is finding the why to treat

We often can make the connections of the youth's behaviors, but the youth cannot -- why not?

- Denial
- Brain Development
- Family
- Shame – Embarrassment – Guilt
- Other

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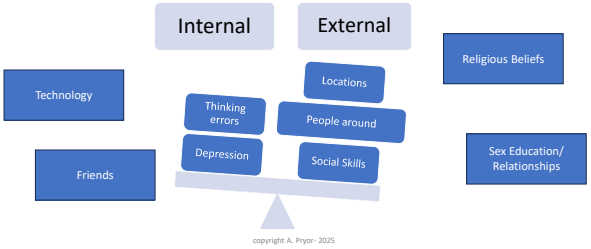
Responding to the Variables that need to be changed or supported



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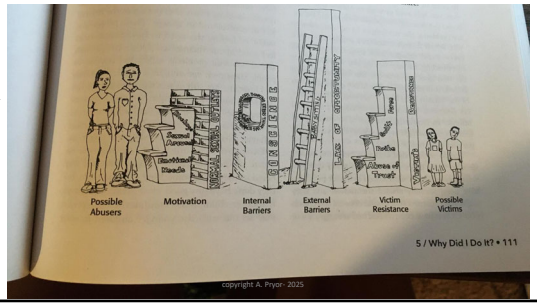
Pathways- chapter 5 – Barriers

Kahn, T. J. (2011b). Pathways: A Guided Workbook for Youth Beginning Treatment (4th ed.). Safer Society Press.



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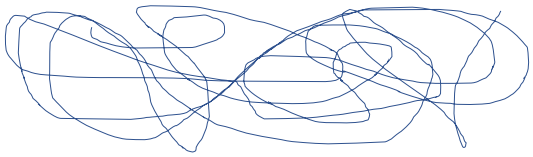
Cycle but not a cycle
Chain but not always connected
Point A to C but not always same B



Helping youth see that from Thought to Behavior are connected but not always in same cycle…

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Keys to Case Conceptualizing

- Look at the whole case – not just the sexual behaviors
- What are the preconditions/amplifiers/pathways/factors that can be identified
- As a therapist – can you go upstream? Make a hypothesis of why the sexual behavior happened?
- TALK with others

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Moving to a lower level of care or Discharge from Treatment

- Established in foundations of RNR
- Does not mean DONE, means made progress. Progress on goals established to reduce the risk of sexual recidivism.
- Who is ever done with treatment?
- NOT based on
  - Completion of chapters
  - Completion of manuals
  - Completion of all goals

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ATSA Adolescent Guidelines says it all….

10.38 Practitioners recognize and communicate that successful discharge from a treatment program/regimen indicates the adolescent and his/her caregivers, when appropriate, have demonstrated progress related to the goals and objectives of the individualized treatment plan designed to reduce the adolescent's risk to reoffend and increase stability and prosocial behaviors to such a degree that the adolescent's level of risk and needs supports a decrease in intensity of services or the ending of formal treatment. Successful completion does not indicate the individual's risk to reoffend has been eliminated completely.

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Special Treatment Concepts for Sexual Behaviors

- Focus on a few tactics that research supports
- Understand that it is dynamic. That as the youth presents we might have to adapt to how we treat.
  - Trauma – then Sexual behavior work
  - Sexual beahvior work, then trauma
  - Both at same time….
  - Substance abuse – mental Health

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Trauma Defined by the PERSON

- Adversity vs Trauma
- Allows youth to define what happened vs others defining what happened
- Adversity allows for the youth to explain their life and express resiliency vs the situation defining the youth

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Examples that people rate on 1-10 scale

- Dead gold fish
- Dead pet that youth hated
- Family member dying
- Tornado
- Car crash
- Fire
- Sexual assault
- Physical abuse

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Symptoms must be present to treat

We have to have evidence of SYMPTOMS to treat

- Identify symptoms - BUT- if no symptoms, then nothing to treat
- Identify treatment goals – only if there are symptoms
- No NEED to hear details of what happened….
  - Understanding presenting symptoms and dysregulation issues, that is what therapy is for, we are doing the assessment only

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Safety Planning

Why- Because it Works!
What did Caldwell say?

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Why do we safety plan?

- Why is someone sitting in back?
- Why did you put your seatbelt on when driving?
- Why do we wear football pads and helmets?
- Coffee in am before talking to others?
- Others in normal day?

- Do we call them safety plans?
- Formal? Informal? Written and signed?
- Why do we have them- based on what?

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What do we safety plan for?

- What does the family/youth/community need?
- Safety planning is for concerning bx, acknowledged bx, ongoing disruptive bx, adjudicated/CHINS bx, and any other harmful bx
- Don't need courts to tell us to make plans
  - What do we do on a daily basis to keep ourselves safe?
    - Back to the beginning of the presentation- what is safety?

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Safety plan is what?

- Current move in treatment to move away from no, can't, don't to do, assist, and keep safe
  - Easy to say no, but let's look at PROTECTIVE factors
    - Examples
  - Our brains like to be told yes, respond and relearn!
- Life Plans
- Good Lives Model

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But really, how do we do this?

- Let's chat
  - What is your favorite way to do safety plans?
  - Templated forms or free forms?
  - Family or no family involvement in creating?
  - What do you call them?

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Remember -- to look for special exceptions!

- Know about exceptions – or extra rules
  - Is there court orders that have to be obtained – if and when?
  - No contact orders in place?
  - Clarification process – how does safety planning fit into it

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How long is a safety plan good?

- Never expires?
- Best by date?
- Updates like software?

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What about technology ?

- How is it included in safety planning?
- My favorite, Live like it is 1989 with technology!
- How do you in your practice handle technology use among youth?

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Peers and Technology

How do kids identify “porn?”

How do they communicate with friends?

What is their favorite app? What app do they want that parents won’t let them have?

What is their opinion about sexting?

Who should be allowed to send pictures?

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Brain responses like the next best thing

- Roller coasters – higher faster more
- Competitive – who is the fastest
- Food- best tasting tastes better
- YouTube – if you don't like it, hit next
- Stories – short time to tell your story, don't like, swipe

- Porn – always having access makes it soooo much easier to find the best, hottest, largest, _____, out there

Let's break down the brain's response...

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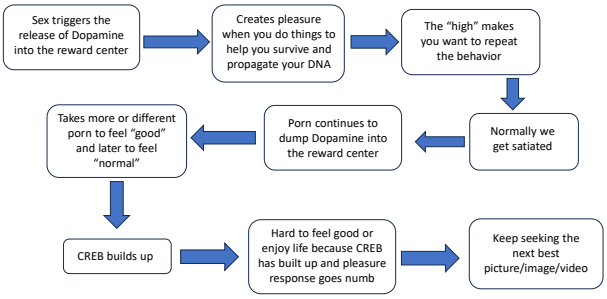

Where you see the word "sex", you can replace with food, alcohol, social media, etc.

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Sex and the Brain

Sex causes a positive wiring in the brain to pleasure mixed with hormones -- We cannot un-program the brain, but we can add new ideas for pleasure

- New brain connections so you can remember and repeat
- The more it is repeated the stronger the connection and ensue cravings
- Also creates connections associated with the experience (Cues)
- Eventually become "sensitized"

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Safety Plan for Technology

- Start where the internet comes from
  - Router
  - Wi-Fi
  - Device
  - Within the App
- Treat technology like it is 1989

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Retrain the brain – a MUST

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Retraining is important….

- Socialization
- Healthy coping
- Trauma Focused Cognitive Behavioral Therapy
- Porn and all objectification is forever off limits for anyone who is sexually healthy
- Behaviorism
  - Abstinence
  - Aversion
  - Masturbatory retraining

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Masturbatory Retraining Example

- Take a break
  - Some say 30 days
  - What is best for the youth
- Develop Healthy Fantasy
  - All types of intimacy
  - Consent
  - Nothing illegal
  - Nothing degrading or dehumanizing
  - No multiple partners
  - Should this be shared in group?
- Masturbation assignments
  - Choose time and place
  - Can never be used as a coping mechanism

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Best Practice Safety Planning

- Includes Components of the following:
  - Dynamic – fluid- adaptive
  - Reviewed -- updated -- always changing
  - Normal – healthy expectations
  - All parties must be in agreement that safety is a necessity
  - Community safety is a client

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Clarification

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What we know …… as clinicians

- Typically the abuser and victim will reunite on some level at some time
- Clarification and reunification processes increase the chances of success significantly over families reuniting independently when an abuser or victim leaves a service system.

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Clarification versus reunification?

Clarification Process	Reunification Process
an ongoing process for family members to talk about the harm caused and the impact on everyone within the family system, - Face to face sessions or other available options - In a safe environment -With professionals to assist in the discussions and safety planning needs -Based on all ages of those involved	systematic and therapeutic process of bringing a family back together may include one or multiple individuals living outside of the nuclear family usually entails incremental visitation, starting with supervised and working towards extended in home visits, prior to a child returning to the primary residence

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So this means what?

- Clarification does not equal reunification
- Reunification does not equal clarification
- ***It is a process- clarify, update safety plan, reunify, update safety plan, clarify, reunify more, update safety plan, reunify more, clarify more, and on and on and on……***

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A non negotiable

- Clarification (on some level) must happen prior to reunification
- And why?

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Five Things needed for Best Practice

1. Definition of who is on the team- family driven
2. Open goal oriented communication among all parties
3. Informed supervision
4. Safety planning for all at all times
5. Trained providers to work with youth with sexually harmful behaviors and children who have experienced sexually harmful behaviors

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Clarification takes on many forms

Youth with harmful behaviors clarifies in many forms

- Parents from day of allegation – what did you do?
- Courts – admitting in court what happened
- On admit paperwork – questions asked of what happened that they are in treatment
- Parents asking more questions once treatment starts
- Providers asking for details as preparation for clarification
- Youth clarifying with self on beliefs and attitudes
- Siblings who are not direct victims

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Victim clarification session looks like?

- What the victim needs!
- At the victim's age/developmental level
- Where the victim chooses. Safety first !
- All therapists are in agreement of the session process
  - Utilization of pre-established questions
  - Utilization of letters
- Structured –
  - Decreases anxiety
  - Roles are known
  - Safety is addressed

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When does Victim clarification Happen?

- Face to face clarification session- may be first time youth see each other since abuse happened – high emotions are expected, here are a few ideas
  - Initial session may need to be a meet/greet supervised visit, then next session is clarifying the harm
  - Letters shared regarding life changes since last seen sibling
  - Pictures shared under supervision to see physical changes
- Activities that can help prepare for face to face clarification session
  - Sharing questions the victim has for the abuser to answer them back in writing or know what to expect
  - Abuser sharing a letter written to victim – addressing harm, planning for safety
  - Pictures – Art – Phone conversations
  - Other ideas?

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Victim Clarification
Overall details Continued ….

- Who does what?
  - All parties are communicating to reach same goal – at least bi-weekly
  - Victim therapist- determines when victim is ready to initially begin clarification
    - Trauma symptoms are stabilized
    - Safety is addressed
  - Abuser therapist- determines when harmful youth is ready to initially begin clarification
    - Acknowledgement of harm
    - Understanding of requirements for safety
  - Family- support, answers questions, follows safety plans, completes own clarification if needed

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Reunification at all levels

- Initially with parents or other support persons
- Safety adherence = increased reunification plans
- Clarification = adding victim into reunification plan
- Safety is ALWAYS addressed

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Safety Planning within clarification and reunification

- For sessions, after sessions, and for visits
  - Safety maybe in back of mind as parties are excited of the family together
- Dynamic – fluid- adaptive
- Reviewed -- updated -- always changing
- Normal – healthy expectations
- All parties must be in agreement that safety is a necessity
- Community safety is a client
- Informed supervisors
  - Who can help the family?

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Clinical adherence necessary – no matter how human we are

- As we stated at the beginning not all are able to do this, even those that do it, need support and guidance.
- Our personal worlds cannot collide with our professional worlds.
- Keeping a focus on the clinical needs of all involved will help guide and keep us on the proper track.

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Combining it all together

- Best practices as each stage, some overlap
- Good quality therapy work goes a long way
- RNR is a base for all that we do
- No specific order on how to do things, it is individualized to each adolescent and family

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The End

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