Standards of Care for Juvenile Sexual Offenders of the International Association for the Treatment of Sexual Offenders

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Minimal standards for treatment of adult sexual offenders were adopted by the membership of the International Association for the Treatment of Sexual Offenders (IATSO) at its first membership General Assembly in Toronto, Ontario, Canada in May 2000 (Coleman, Dwyer, Abel, Berner, Breiling, Eher, et al., 2000; 2003). These standards, initially developed in 1990 with input from attendees at the Second International Conference on Sexual Offender Treatment held in Minneapolis, Minnesota (Coleman & Dwyer, 1990; Coleman, Dwyer, Abel, Berner, Breiling, Hindman, et al. 1996), were refined by a committee of professionals at the Fifth International Conference on Sexual Offender Treatment (Coleman et al., 2000). With these standards in place, the Governing Board of IATSO designated a committee in summer 2004 to develop similar standards for treatment of Juvenile Sexual Offenders. This committee consisted of representatives from a number of countries with differing traditions of sexual offender treatment and juvenile justice, including Austria, Germany, Norway, South Africa, Switzerland, and the United States. Developing standards of care for juvenile populations can be a challenging endeavor. Adolescence is a time of rapid change, and thus, there is great heterogeneity in those youths who commit acts that can be defined as sexual offenses. These differences are influenced by the developmental stage of the youth, which may roughly parallel age, and multiple environmental factors. Additionally, studies conducted outside North America find higher base rates of re−offense than those within North America (e.g. Nisbet, Wilson, & Smallbone, 2004; Langstrom & Grann, 2000). This is likely the case because definitions of who is a juvenile offender, what behaviors are sexual crimes, and how the juvenile justice system is organized can differ substantially across countries.

These Standards of Care, which were adopted by the membership at the General Assembly of the International Association for the Treatment of Sexual Offenders in Hamburg, Germany, September 7, 2006, are designed to be minimal guidelines for those developing and implementing treatment interventions for Juvenile Sexual Offenders. These Standards are based on the current state of knowledge on adolescents who

commit sexual offences. Most of the available data are from adolescent males and the state of science in this field is still evolving. Thus, the Committee avoided making specific recommendations about particular procedures, techniques, or instrumentation.

Definitions

Juvenile Sexual Offenders. Youths between the ages of 12 – 18 who have either been officially charged with a sexual crime (e.g., child molestation, rape, exhibitionism, voyeurism), have performed an act that could be officially charged, or committed sexually abusive/aggressive behavior.

Assessment. A formal procedure of information collection that includes evaluations conducted by psychologists, psychiatrists, social workers or others for the purpose of developing intervention strategies, making placement decisions, and/or informing legal or social service agencies.

Treatment. A structured set of interventions based on a specialized assessment. It can include psychotherapy, family therapy, medical treatments, or other psychosocial interventions. While probation supervision and residential placement are not considered treatment, they are important aspects of intervention with juvenile sexual offenders.

Professional Competence

The possession of an academic degree in behavioral science, medicine, or for the provision of psychosocial clinical services does not necessarily attest to the possession of sufficient competence to conduct assessment or treatment of juveniles who have committed sexual offenses. Persons engaged in such services should possess clinical training and experience in child and adolescent psychopathology and problem behavior, as well as specialized training in the sexual development of youth. This would generally be reflected by appropriate licensure as a psychiatrist, psychologist, clinical social worker, or clinical therapist with listed competence or board certification specific to children and adolescents. Additionally, treatment providers must be competent to differentially identify normative vs. problematic sexual behavior.
The following are *minimal standards* for a professional responsible for the assessment and/or treatment of a child or juvenile who has committed a sexual offense.

1. A minimum of a master's degree or its equivalent or medical degree in a clinical field granted by an institution of higher education accredited by a national/regional accrediting board or institution.
2. Demonstrated competence in therapy indicated by a license (or its equivalent from a certifying body) to practice medicine, psychology, clinical social work, professional counseling, or marriage and family therapy.
3. Specialized competence in the assessment and treatment of children and juveniles, as demonstrated by board certification, specialized training, or supervised clinical experience, along with continuing education.
4. Knowledge of child and juvenile sexual development, as demonstrated by specialized training or continuing education.
5. Demonstrated training and competence in providing psychotherapy to juveniles and families.

Principals for Care of Juveniles who have Sexually Offended

1. Juveniles are best understood within the context of their families and social environments

Young people are by definition more dependant on the world around them than adults are. Many do not have any perspective on masculinity and femininity besides what they see in their families and close friends. The characteristics of the family have been shown to be related to troubled adolescent behavior, including sexual offending behavior (Bischof, Stith, & Whitney, 1995; Blaske, Borduin, Henggeler, & Mann, 1989). The environment, including the relative advantage or disadvantage of the neighborhoods in which youths reside, have been shown to have significant effects on many facets of adolescent development, including the development of such concepts as masculinity, use of aggression/force, and acceptance of behaviors that deviate from social norms (Elliott, Wilson, Huizinga, Sampson, Elliott, & Rankin, 1996). It has long been accepted within adolescent psychiatry and psychology that to understand and develop treatment interventions for adolescents, one must view the adolescent within the context of his or her family, school, and other social systems.

2. Assessment and treatment of juveniles should be based on a developmental perspective, should be sensitive to developmental change, and should be an on−going process.

Adolescence is a time of dramatic change. It is a time of awakened sexual interest, and for many youth, a willingness to engage in rule−breaking behavior that will not persist into adulthood. Discussing sexually abusive youth, Prentky and Righthand (2003) observe that, “No aspect of their development, including their cognitive development, is fixed or stable. In a very real sense, we are trying to assess the risk of ‘moving targets’” (p. i). Additionally, the factors that contribute to their behavior are subject to change. Quinsey, Skilling, Lalumiere, and Craig (2004) note that the risk factors for juvenile delinquency change from pre−adolescence to adolescence. Others (e.g. Worling, 2005; Prescott, 2005; Epperson, in press) note that the risk factors for youth who have engaged in sexually harmful behaviors are different from their adult counterparts. Still others have used the term “heterotypic continuity” (Kernberg, Weiner, & Bardenstein, 2000) to describe how the expression of personality pathology can change across childhood.

3. Assessment and treatment should include a focus on the youth’s strengths.

It is understandable that communities are interested in knowing what dangers a young person might pose. However, assessment and treatment should account for the long−term positive development of youth as well as the short−term promotion of safety. Professionals should therefore also focus on the strengths, abilities, and competencies that a young person has. Youth is a time of building resilience and strengths into positive assets. These assets are vital to moving beyond adversity. By focusing only on risk factors and goals based on avoidance related only to community safety, professionals can miss a key element of treatment – the youth’s own strengths−−and in the long run work against the promotion of safety.

4. The development of sexual interest and orientation is dynamic. The sexual interests of youth can change over the course of adolescence and this is the period when sexual orientation immerges.

The sexual arousal patterns of youth have proven to be elusive targets for both assessment and treatment. Given that adolescence is by definition a time of accelerated sexual and social development, it makes sense that sexual interest and arousal is subject to change. The evidence indicates that sexual arousal is fluid and

dynamic across adolescence (Hunter & Becker, 1994). Although sexually abusive youth can engage in sexually deviant behavior, it appears that the majority of them do not experience persistent and entrenched sexual deviance (Hunter & Becker, 1994; Hunter, Goodwin, & Becker, 1994). In fact, for those youth who may be re−enacting their own abuse or situations that they have witnessed (Schwartz, Cavanaugh, Pimental, & Prentky, 2005), it may well be that harmful sexual behavior is not deviant within the context of their experience.

Further, research indicates that the first experience of sexual attraction takes place at about age 7 (Savin−Williams & Diamond, 2000) and the individuals' awareness of their sexual orientation continues throughout adolescence.

5. Youth who have committed sexual offenses are a diverse population. They should not be treated with a "one size fits all" approach.

The current literature on juvenile sex offenders fails to provide an adequate empirical base regarding etiological and maintaining factors or factors that lead to desistence of sexual offending behavior. However, the available data indicate that there are likely multiple pathways to sexual offending and recidivism during adolescence and early adulthood (Boyd, Hagan, & Cho, 2000; Hunter, Figueredo, Malamuth, & Becker, 2003; 2004; Miner, 2002; Sipe, Jensen, & Everett, 1998; Waite, Keller, McGarvey, Wieckowski, Pinkerton, & Brown, 2005).

6. Treatment should be broad−based and comprehensive.

In many areas, treatment response to sexual abuse by juveniles has been based on narrow principles such as relapse prevention, the offense cycle, and the presumption of sexual deviance. However, these have not been empirically demonstrated to be related to youthful sexual offending. In fact, the emerging research suggests that the most successful treatments are those that are community−based and involve the supportive adults in a youth's life (Borduin, Henggeler, Blaske, & Stein, 1990; Borduin, Schaeffer, & Heiblum, 2005; Hunter & Longo, 2004).

7. Labels can be more iatrogenic in children and adolescents than in adults. The juvenile and his/her family/primary care−giving system should be treated with respect and dignity.

Young people are inherently more dependent upon the environment around them. This can be especially true with respect to the language we use to describe them. Adults working with youth who have sexually abused other individuals should take every precaution against actions that label youth as deviant, perverted, or destined to persist in sexual harm. Professionals are increasingly using language that labels the behavior and not the identity of the youth (Chaffin, Letourneau, & Silovsky, 2002). This helps to ensure that youths do not develop a view of themselves as unable to develop into healthy and productive individuals or to ever be greater than the sum of their worst behaviors.

8. Sexual offender registries and community notification, should not be applied to juveniles.

Given the developmental needs of youth, their culpability being different from adults, and the labels and stigmas that adults can place on children through unproven avenues such as registration and notification, IATSO is extremely skeptical of the long−term utility of such policies and is concerned by their potentially harmful effects on the very communities these policies seek to serve (see Letourneau & Miner, 2005).

9. Effective interventions result from research guided by specialized clinical experience, and not from popular beliefs, or unusual cases in the media.

The current state of the science in juvenile sexual offender treatment is primitive and thus, there are many areas in need of clinical innovation and scientific investigation. Changes in these Standards and the use of treatment interventions should be based on scientific investigation, valid tests of efficacy and effectiveness, and should not be based on individual intuition, personal, or popular beliefs. Many changes to the treatment and management process are instigated because of unusual and heinous crimes picked up by the media. Such changes are generally misguided and potentially iatrogenic.

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Sexual difficulties during antidepressant treatment often resolve as depression lifts but can endure over long periods and may reduce self-esteem and affect mood and relationships adversely.Â Two international studies of the prevalence of sexual dysfunction in depressed patients prescribed either a selective serotonin reuptake inhibitor or serotonin-noradrenaline reuptake inhibitor, which take account of the presence of self-reported sexual problems prior to starting antidepressant and of the presence of concomitant medication sometimes implicated in causing sexual difficulties, suggest that 27â€“65% of female and 26â€“57% of male. Sex-offender therapy for juveniles was a new field in the 1980s, and Longo, like other therapists, was basing his practices on what he knew: the adult sex-offender-treatment models. â€œItâ€™s where the literature was,â€ Longo, a founder of the international Association for the Treatment of Sexual Abusers, told me not long ago. â€œItâ€™s what weâ€™d been doing.â€ As it turns out, he went on to say, â€œmuch of it was wrong.â€ There is no proof that what Longo calls the â€œtrickle-down phenomenonâ€ of using adult sex-offender treatments on juveniles is effective. Adult models, he notes, donâ€™t account for adolescen Medications used to treat sex offenders ('antilibidinal' medications) act by limiting the sexual drive (libido). There are two types, those which work by suppressing testosterone (e.g., progestogens, antiandrogens, and gonadotropin-releasing hormone (GnRH) analogues), and those that reduce sexual drive by other mechanisms (i.e., antipsychotics and serotonergic antidepressants (SSRIs)). We reviewed evidence for the effectiveness of such drugs in people who were convicted or thought to be at risk of committing sexual offences. Search date. The evidence in this review is current to July