Level One:
In-Home / Outpatient Psychosexual Education

Client Profile:

Youth appropriate for a Level One intervention are typically in one of two categories:
1) Younger children and adolescents with no previous known history of sexual acting out, or who have engaged in sexual misconduct on one occasion, or who have displayed low-frequency sexual behaviors. Sexual incidents are isolated, exploratory and/or situational in nature with no use of coercion or violence, and there is no evidence of progression of offense behavior; or
2) Adolescents who, in the course of a normative* consensual, "non-coercive" relationship, administer sexual touches or receive or perform sexual behaviors. However, based on the age or development of one of the parties, these behaviors are illegal (i.e. sixteen-year-old with a fourteen-year-old). Specifically, one party may not legally consent based on the legal definition of the age of consent. The problem must strictly lie in the issues of consent, not in equality, coercion or level of understanding.

Both categories of youth have typically had little exposure to healthy sexual information and experiences, present with low culpability and their sexual behavior tends to be less intrusive. They have little insight in the wrongness or consequences of their behavior. These youth may be impulsive. They may have gained sexual information beyond their developmental readiness. Their sexual misconduct is usually as a result of deficits in their fund of sexual knowledge and understanding of consequences rather than distortions in their cognition or deviancy. These youth are a ***low risk*** to the community, as assessed by nationally-recognized risk-assessment tools, and the majority of them have a good parental support system that is fairly functional. These youth may or may not be adjudicated; however, adjudication may be helpful and is recommended to ensure compliance.

> * Moral, social, and/or familial rules may restrict, but these behaviors are not *abnormal*, developmentally-harmful and/or illegal when private, consensual, equal and non-coercive. Stable monogamy is defined as a single sexual partner throughout adolescence. Serial monogamy indicates long-term (several months or years) involvement with a single sexual partner that may be preceded or followed by similar long term monogamous relationships (Ryan, G. and Lane, S. Editors; Juvenile Sexual Offending; Causes, Consequences, and Correction, Jossey-Bass Press, 1997).

Treatment Goals:

Level One programs include public and private community-based mental health programs that provide a short-term, age-appropriate collateral psycho-educational module on human sexuality and healthy human sexual behavior, including detailed material on sexual misconduct and child

sexual abuse definitions, consequences and strategies for identifying, avoiding and coping with the contributing factors and risky sexual behavior situations (David S. Prescott and Robert E. Longo, *Current Perspectives: Working with Young People Who Sexually Abuse,* Current Perspectives: Working with Sexually Aggressive Youth & Youth With Sexual Behavior Problems, Longo, Robert E. & Prescott, David S., Editors, NEARI Press, 2006, page 51).

The primary goals of Level One treatment are to:

1. Educate the youth to ensure that he or she understands what is appropriate versus inappropriate and legal/illegal sexual behavior;
2. Develop and/or augment a healthy fund of sexual knowledge;
3. Enhance his or her responsible adaptive level of functioning socially, emotionally and sexually; and
4. Place youth on (or back on) normal developmental trajectory of sexual development.

Treatment Modalities and Frequency:

The primary treatment modalities are short-term individual or group therapy. The youth's family should be included in the treatment. Treatment is weekly and short-term (approximately two to three months based on curriculum and the youth's need). Treatment **is not** traditional individual therapy and should be provided in an educational manner (although treatment may occur in an individual session). A structured 8-12 week curriculum with stated objectives, assignments, and goals is recommended. Treatment includes homework (individual and family assignments), psycho-educational assignments as well as parent involvement. Treatment interventions can include experiential exercises, sensory interventions, observation in the community, parent education, development of social skills and ongoing assessment of risk. If there has been a "hands on" victim, additional victim empathy work may be necessary. This would typically be 3-9 individual sessions if programming is provided in a group setting and an additional 3-9 sessions if provided in an individual setting.

Targeted sex-specific treatment is contra-indicated for Level One youth. Every effort should be made to avoid the "contagion effect" for these youth by ensuring that youth placed in a psychosexual educational group are similar in age, development and social ability, as well as sexual risk. For example, it would be inappropriate for a Level One youth to participate in a Level Two Sex-Specific Group (where detailed information about sexual-offense behavior is discussed) and/or be introduced to targeted sex-specific curriculum.

Treatment is more about aiding youth to understand their sexuality and sexual development, owning responsibility for their sexuality (thoughts, feelings and behavior), identifying that there are consequences for their choices and entering or re-entering a normative developmental pathway for their sexuality.

Treatment Focus:

Group or individual therapy should follow a structured curriculum, ideally 8-12 weeks in duration, with the inclusion of the youth's parent(s) in the process. There should a systematic

manner to measure the attainment of the psycho-sexual education provided. The treatment should incorporate, enhance, and provide psycho-education for the following:

- Sex education (including maturation, sexual anatomy, sexual physiological responses, etc.);
- Sexuality education—recognition they are a sexual being and sexuality is a part of their life and current stage of development; that sex has meaning and purpose in life, and an understanding of what meaning sex plays in their life; and developing the competency to establish healthy sexual relationships (as defined by personal values); how to communicate effectively regarding sex and sexuality;
- The distinction between healthy versus unhealthy sexual functioning and behavior; Developmentally-expected child/adolescent sexual behaviors and sexual development;
- Current abuse laws and consequences governing sexual behavior;
- Accountability;
- Values clarification and healthy sexual attitudes;
- Self-esteem and healthy identify development, including positive body image;
- Teaching emotional and self-regulation skills;
- Identification and healthy expression of feelings;
- Anger management skills;
- Stress management and emotional-coping skills;
- Increased understanding of interpersonal boundaries;
- Empathy development;
- Interpersonal relationship skills and assertiveness; and.
- For those with hands-on victims, clarification work should be included.

Treatment Providers:

Those individuals providing targeted sex-specific therapy interventions must be certified by NOJOS as a sex-specific provider with training in adolescent development, trauma and neurophysiology, as well as etiological and maintenance factors that impact developmental trajectory. However, if the psychosexual education is not provided by a licensed mental-health clinician, the individual must be trained and competent to provide the service and be supervised by a NOJOS certified sex-specific clinician.

Monitoring:

NOJOS certified sex-specific clinicians and youth's parents/guardians monitor non-adjudicated youth while the Juvenile Court monitors adjudicated youth. Cases involving sibling incest may benefit from protective supervision by the Division of Child and Family Services (DCFS). Chaperones for youth who have engaged in sexual misconduct need to be approved by the NOJOS certified sex-specific clinician(s). All chaperones/approved supervisors must be educated of the youth's risk factors in order to provide appropriate supervision.

Criteria for Discharge:

Criteria for treatment progress include, "Accomplishment of the specific treatment goals and objectives, cooperativeness in treatment, maintaining control and self-responsibility, changes in thinking, and observable changes of behavior over time" (National Task Force on Juvenile Sexual Offending, 1993, page 52). More specifically, each client should demonstrate increased understanding and fund of sexual knowledge regarding their sexuality and sexual development, responsibility for their sexuality (thoughts, feelings, and behavior), understanding of the consequences for their choices and evidence of entering or reentering a more normative developmental pathway for their sexuality and adolescent development and be able to demonstrate this increase through a consistently applied tool (i.e. a quiz regarding the content taught) as well as general observation. Additional recommendations based on observations may be made, but youth completing the requirements for discharge should "successfully complete" the assigned course.