# Level Two:
# In-Home / Outpatient Sex-Specific Psychotherapy

## Client Profile:

Level Two youth not only need psychosexual information (as outlined in Level One), but they also present with a need for directed sex-specific clinical intervention. Typically, these youth are first-time offenders, or they may have successfully graduated from a higher level of care and need ongoing outpatient services for step-down transitional and aftercare purposes. These youth may present with a slightly greater frequency and duration of sexual misconduct than a Level One youth. They may have one or more victims, but typically do not have indiscriminate choice of victims (i.e., male and female victims, related/unrelated victims and/or toddler and peer victims). Their sexual behavior may have been more intrusive, but displays minimal evidence of progression from less-intrusive to more-intrusive sexual behaviors. Additionally, these youth typically meet one or all of the following: 1. lack of consent, which means one of the parties does not a) understand what is proposed without confusion or trickery; b) know the standard for sexual behavior in the culture, the family and the peer group; c) posses awareness of possible consequences including stigma, punishment, pain and disease; and d) have respect for the agreement or disagreement without repercussions; and/or 2. a lack of equity between parties, meaning there is a inequality in the authority, power and control within the relationship; and/or 3. the presence of coercion, meaning pressure to comply (either explicit or implied) has been exerted in order to get someone else to do something (Bonta and Andrews, 2016).

Overall, these youth are disclosing and acknowledge some accountability for their sexual misconduct. They generally display feelings of guilt or shame, although they do not always demonstrate empathy, either due to their developmental stage or lack of understanding of the impact on others, or they have barriers that have prevented the development of empathy. These youth typically present with adequate community support, are willing and able to comply with safety restrictions and are amenable to treatment. In limited circumstances, these youth may present with moderate risk; however, the youth's family or caregivers are able and willing to provide appropriate supervision and comply with treatment recommendations, and it is determined that this supervision provides an accepted protective factor to ameliorate risk of re-offense. These youth typically do not present with a strong patterns of oppositional behavior or conduct disorder; however, they may present with other diagnoses including clinically-significant depressive symptoms, anxiety and/or impulsivity/attention problems. The majority of Level Two youth are ***low and/or low-to-moderate risk*** as assessed by nationally recognized risk assessment tools.

Adjudication is strongly recommended. Few providers, if any, will treat this population on an outpatient basis without court involvement.

The significant difference between Level Two and Level Three and Level Four youth lies in the protective factors, resiliency and internal and external assets of the youth. Level Two youth present with more protective factors internally, as well as in their environmental and family functioning and school functioning—they also have higher levels of resiliency and internal assets that act to lower or offset their risk to offend. Further, Level Two youth, based on clinical assessment, are able to be managed safely in their home environment and traditional school setting.

## Treatment Goals:

Level Two programs should provide individual, group and family therapy, as needed, offering traditional adjunct mental-health services (with variations in focus, model, and duration) and sex-specific services. These programs should provide abuse-specific interventions, cognitive-behavioral content, risk management, and strength-based skill building. Sex-specific treatment also often includes modules based on healthy living and decision-making, increasing self-monitoring of behavior, understanding thoughts, feelings, behaviors and consequences associated with sexual misconduct, and strategies for managing inappropriate sexual behavior, etc. (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 52).

Identified sex-specific treatment issues or goals include increases in the youth's adaptive levels of functioning behaviorally, emotionally, socially, cognitively and psychologically. In addition to these goals, the youth should improve their executive functioning, social competency and relatedness, use of social skills in demonstrating mastery in their environment, as well as stabilization of behavior in social, school and home settings.

Overall, the goal is to assist the youth to increase competency and skills necessary to ensure their ability to control or eliminate etiological and maintenance factors influencing their pathway to offend, re-establish a healthy developmental trajectory (in all developmental stages), obtain their needs and human goods in a healthy way and place themselves back on a healthy pathway towards becoming a functional, healthy and happy adult (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006).

*A full list of Sex-Specific Treatment Goals is presented on pages 14-15.*

## Treatment Modalities and Frequency:

Based on the youth's presenting problems and needs assessment, Level Two treatment can vary in focus, intensity, duration and frequency. This typically can be expected to last 6-10 months, but may take longer based on individual issues and/or needs. Nevertheless, Level Two treatment must include targeted sex-specific therapy and psychosexual education, as well as adjunct with traditional mental-health therapy. However, in some circumstances some youth may only need traditional non-sex-specific therapy with adjunct Level One Psychosexual Education. Further, in rare circumstances where the youth presents as vulnerable and naïve (i.e. low ego strength,

extremely immature, etc.), group intervention may not be beneficial and/or appropriate. The primary Level Two treatment modalities include individual/family, group and parent-group sessions. At a minimum, individual and targeted sex-specific group sessions should occur weekly. In some circumstances, based on the youth's needs, it may be necessary for a youth to participate in more intensive sex-specific outpatient services to include two to three sex-specific sessions per week. Parent* groups and family therapy should occur at least bimonthly. Family therapy should focus on family dynamics associated with the youth's misconduct and/or problematic functioning, as well as supervision, safety and assisting the youth to manage his/her risk. Family therapy should also include education of the parents/caregivers regarding the youth's current risk factors, treatment goals and supervision needs. It is important to view the
parent/guardian as part of the treatment team and empower them to be an active participant in the youth's treatment. If there is a greater degree of conflict or problems in the youth's home environment, more frequent and/or intensive family therapy should occur focused specifically on these family issues. Additionally, Level Two youth may require psychiatric/medication management services, skills development services and/or psychological services.

*Given that some youth may not have parents, when the term "parent" is used, it includes the youth's parents, caregiver, and/or primary-support system.

## Treatment Providers:

Those individuals providing targeted sex-specific therapy interventions (whether it is individual, family or group therapy), should be certified by NOJOS as a sex-specific provider. Individuals providing trauma-specific treatment (whether it is individual or group therapy), should be licensed mental-health clinicians with some experience and training in working with youth who have been traumatized. Sex-specific treatment providers should have training in understanding adolescent development and trauma, as well as neurophysiology and etiological (including maintenance factors) impact on developmental trajectory. They also need to be aware of the influence of family, environment, social and culture on the youth.

## Monitoring:

Ideally, all Level Two youth should be referred to the Juvenile Court for delinquency (not just dependency). Court involvement provides additional supervision for community protection and sanction supporting youth accountability. The juvenile justice authority and/or DCFS/DJJS treatment team, in conjunction with the NOJOS certified sex-specific clinician(s), act as a clinical intervention team to ensure the youth's compliance and progress in the treatment program. Chaperones for youth who have engaged in sexual misconduct need to be approved by the NOJOS certified sex-specific clinician(s). All chaperones must be educated about the youth's risk factors in order to provide appropriate supervision. A safety plan and/or supervision guidelines are recommended to be implemented in the youth's home to ensure environmental and community safety. Guidelines should include those adults who have been approved to supervise the youth, contact restrictions (if any), restrictions around bathroom use, hygiene practices (bathing, dressing, etc.), nighttime routines, caretaking responsibilities and involvement in, and supervision of, extracurricular activities.

## Criteria for Discharge:

The NOJOS certified sex-specific clinician(s) and the treatment monitoring team evaluate the youth's treatment progress. Criteria for treatment progress include accomplishing the treatment goals and objectives, self-responsibility, changes in thinking, and observable implementation of skills. The youth should also demonstrate increased competency and skills necessary to ensure their ability to control or eliminate etiological and maintenance factors influencing their pathway to offend, re-establish a healthy developmental trajectory (in all developmental stages); the ability to obtain their needs and human goods in a healthy way; and to place themselves back on a healthy pathway towards becoming a functional, healthy, happy adult (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006).

The National Task Force on Juvenile Sexual Offending also identified specific treatment progress indicators in their revised report (1993). Adaptations of these guidelines include:

1. Understand, identify, and interrupt thoughts, feelings, beliefs, and behaviors that contribute to abuse and all unhealthy choices and behaviors;
2. Develop responsibility for personal choices and behavior without minimization or justification;
3. Understand the impact of past trauma on self-image, functioning, difficulties, and behaviors;
4. Develop awareness, sensitivity, and compassion for others;
5. Learn and understand how to differentiate normative and unhealthy sexual development;
6. Identify, interrupt and control, unhealthy and/ or inappropriate sexual arousal, thoughts, and fantasies;
7. Learn and use adaptive coping and social skills;
8. Build and engage in non-coercive, reciprocal relationships; and
9. Develop and demonstrate effective use of self-management strategies and a relapse prevention plan.

The client's self-regulation/healthy living plan must include identification of personal risk factors and knowledge of community resources in case of a relapse. Youth who are uncooperative with treatment, deny or minimize sexually-abusive behaviors, resist treatment intervention, are unable or are unwilling to comply with treatment recommendations and/or identify and manage risks, or continue to exhibit sexually inappropriate behavior, will require additional intervention. It may be also be appropriate to refer such youth to a more intensive/restrictive level of treatment and supervision. However, while all the above potentially indicate that the youth's risk has increased, a reassessment of the youth's risk and current Level of treatment should be conducted. Further, all changes in placement or clinical level should be based on increased or decreased risk as measured by nationally accepted risk assessment tools rather than solely on resistance and/or noncompliance.

It is recommended that Level Two youth undergo a discharge assessment to determine if:

1. Co-morbid issues have been addressed/stabilized;
2. Risk has been lowered;
3. Level of functioning/skills have improved;
4. A stable support system has been developed;
5. Etiological and maintenance factors, as well as treatment issues identified in the intake assessment, have been addressed;
6. Protective factors, resiliency, internal and external assets have been increased; and
7. Progress has occurred on sex-specific treatment goals.

*As detailed in the NOJOS Assessment Protocol an updated sex-specific assessment is recommended prior to any discharge or step-up or step-down in the NOJOS continuum.*